IN THE SUPREME COURT OF THE STATE OF OREGON

ANDREW ABRAHAM, on behalf of himself, and for all others similarly situated, Plaintiff-Appellant, v. CORIZON HEALTH, INC., fka Prison Health Services, Inc., Defendant-Appellee.	District of Oregon No. 3:16-cv-01877-JR Court of Appeals No.1936077 Supreme Court No. S068265

BRIEF OF *AMICUS CURIAE* DISABILITY RIGHTS OREGON, LEWIS & CLARK LAW SCHOOL'S CRIMINAL JUSTICE REFORM CLINIC, AND AMERICAN CIVIL LIBERTIES UNION OF OREGON IN SUPPORT OF PLAINTIFF-APPELLANT ANDREW ABRAHAM

On Certified Question of Law from the
United States Court of Appeals for the Ninth Circuit

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Other Authorities

INTERESTS OF AMICI

The ACLU of Oregon, Disability Rights Oregon (DRO), and the Criminal Justice Reform Clinic at Lewis & Clark Law School (Clinic) respectfully ask to present this Court with important perspective relevant to the determination of whether private entities responsible for providing healthcare at Oregon jails are exempt from laws prohibiting discrimination on the basis of disability.

ACLU of Oregon is a statewide non-profit and non-partisan organization with over 28,000 members. As a state affiliate of the national ACLU organization, ACLU of Oregon is dedicated to defending and advancing civil rights and civil liberties for Oregonians, including the fundamental rights protected in the Oregon Constitution and the U.S Constitution. That includes the rights of people in the custody of Oregon's jails to receive health care and to be free from abuse as protected by Article I, sections 13 and 16 of the Oregon Constitution and the Eighth Amendment to U.S. Constitution. Among other priorities, the ACLU of Oregon is committed advocating in the courts and legislature for these rights and to ensure there is accountability for entities responsible for providing that care to patients in custody.[1]

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[1] *See e.g.*, *Carlisle v. Douglas County et al.*, Case No. 6-17-cv-00837-AA (D. Or. 2017); Oregon Criminal Justice Commission, House Bill 3289 (2019) Report (Sept. 15, 2020), *available at* https://www.oregon.gov/cjc/CJC%20Document%20Library/HB3289ReportSept2020.pdf; ACLU of Oregon, Testimony in

The Clinic is a legal clinic dedicated to students receiving hands-on legal experience while engaging in a critical examination of and participation in important issues in Oregon's criminal justice system. Under the supervision of Lewis & Clark Law School faculty, clinic students work on a variety of cases and issues, with the goal of improving Oregon's criminal justice system. The Clinic has long participated in cases and acted as *amicus curiae* related to disability rights and prison and jail medical conditions in Oregon.

DRO is federally mandated to protect the rights of people with disabilities in Oregon[2] and has worked for over forty years to transform systems, policies and practices in line with this mandate. DRO monitors prisons and jails to protect the rights of individuals with disabilities and collaborates closely with public defenders and other members of the legal community to ensure protection at all levels of the criminal legal system. Ensuring incarcerated Oregonians have fair access to quality medical services and accommodations for disability is a core goal for DRO.

Support of HB 3229 (April 1, 2021), *available at* https://olis.oregonlegislature.gov/liz/2021R1/Downloads/PublicTestimonyDocument/22868.

[2] *See e.g.*, The Protection and Advocacy for Individuals with Mental Illness Act, 42 U.S.C. 10801, et seq., and Or. Rev. Stat. §192.517

INTRODUCTION

26-year-old Madaline Pitkin was arrested for heroin possession in 2014 and taken to Portland's Washington County Jail, which contracts with Corizon Health for medical services.[3] On intake, Madaline told medical staff that she had used heroin the evening prior to her arrest and that she needed medical help while detoxing.[4] A nurse told Madaline to fill out and submit a form requesting medical care if she felt sick.[5]

Over the next seven days, Madaline became increasingly unwell.[6] During those seven days, she submitted four requests for medical care, begging for help.[7] In her first request, Madaline wrote, "I told medical intake that I was detoxing & they said I was not yet sick enough to start meds."[8] Explaining that she was in "full

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[3] First Amended Complaint and Demand for Jury Trial, *Pitkin et al. v. Corizon Health, Inc. et al*, No. 3:16-cv-02235-AA, (D. Or. Nov 30, 2016), ECF No. 78 [hereinafter Pitkin Compl.]. Shortly after filing a motion for summary judgment in October 2018, the parties settled, and judgement was entered in favor of the Pitkin estate. *See* Maxine Bernstein*, Record $10 million judgment awarded in Washington County jail heroin withdrawal death,* THE OREGONIAN (Dec. 7, 2018), https://www.oregonlive.com/crime/2018/12/record-10-million-judgement-awarded-against-corizon-health-in-death-of-washington-county-jail-inmate.html.
[4] Pitkin Compl. at 2, 9.
[5] *Id*.
[6] *Id.* at 2–3, 9–11.
[7] *Id.* at 3, 9–11.
[8] *Id.* at 10.

blown withdrawal," Madaline implored medical staff to "Please help!" But no action was taken.[9]

The next morning, Madaline's bedding was soaked through with vomit.[10] She was so weak that she was having trouble standing.[11] She sent a second request for help: "detoxing from heroin REALLY Bad. Can't keep any food down. Heart beating so hard that I can't sleep."[12] A nurse wrote an order for anti-diarrheal medication, but no one examined Madaline or took any other action to assist her.[13]

The next day, Madaline submitted her third request for medical help.[14] She wrote, "vomiting and diarrhea constantly. Can't keep meds, food, liquids down. Can't sleep. Everything hurts. My stomach is sour and filled with bright green that I keep puking up. Muscles cramp and twitch. So weak. Cannot stand long, can't walk far without almost fainting. Feel near death . . . "[15] By nighttime, Madaline was so visibly sick that a jail deputy called for a nurse to examine her, who did so but took no further action.[16]

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[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.* at 10–11.
[13] *Id.* at 11.
[14] *Id.*
[15] *Id.*
[16] *Id.* at 11–12.

Two days later, Madaline submitted a final plea for medical care.[17] In it she wrote, "I feel like I am very close to death. Can't hear, seeing lights, hearing voices. Please help me . . . " That day, a jail deputy called multiple times for medical staff to examine her.[18] Eventually, medical staff moved Madaline to the medical observation unit, where she was offered a pitcher of Gatorade and medication to treat her withdrawal.[19]

Madaline Pitkin, www.opb.org

[17] *Id.* at 12.
[18] *Id.*
[19] *Id.*

The next morning, a jail deputy again asked medical staff to check on Madaline, who was sweating profusely.[20] The nurse receiving the request initially refused to do so.[21] The deputy insisted, but by the time the nurse got around to visiting her cell, Madaline was lying on the floor with her eyes open, one arm twitching, and her mouth weakly moving.[22] Brown fluid leaked from her mouth and nose.[23]

She was dead shortly thereafter, her manner of death listed as "Natural."[24] A simple intravenous drip would likely have saved her life.[25] But Corizon medical staff failed to give her the care that Oregon pays them to provide.

* * *

This question certified to this Court presents an issue of substantial public concern: Whether Oregon's most important disability protections apply to private businesses that annually earn in excess of $4 billion dollars from contracts to provide health care to incarcerated people around the country, including those held in Oregon's jails.[26] Before this Court answers that question, *amici curiae*

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[20] *Id.* at 13.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* at 14–18.
[26] 2018 revenue figures for the five largest for-profit jail and prison health care providers follow: Wellpath ($1.6 billion), Corizon ($1.1 billion), Centurion Health

respectfully ask it to take into account the disturbing reality of the health care provided to incarcerated people by Corizon, NaphCare, and other similar for-profit entities.

The need for effective correctional health care has never been more urgent. Over the past 50 years, shifts in policing and punishment policies—broadly referred to as "the criminalization of poverty," the "war on drugs," and "mass incarceration"—have brought about an explosion in jail and prison populations, transforming correctional facilities into some of the country's largest health care providers.[27] Oregon is no exception, experiencing a 260% expansion of jail and

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($585 million), Wexford Health ($314 million), NaphCare ($312 million). *The Prison Industry: How it Started. How it Works. How it Harms.,* Worth Rises, 78 (Dec. 2020), https://static1.squarespace.com/static/58e127cb1b10e31ed45b20f4/t/609577e6911d693d4f905826/1620408309222/The+Prison+Industry+-+How+It+Started%2C+How+It+Works%2C+and+How+It+Harms+%28December+2020%29.pdf [hereinafter Worth Rises, *The Prison Industry*].

[27] *See generally* Kil Huh, et al., *Jails: Inadvertent Health Care Providers, How county correctional facilities are playing a role in the safety net*, The Pew Charitable Trusts (Jan. 2018), https://www.pewtrusts.org/-/media/assets/2018/01/sfh_jails_inadvertent_health_care_providers.pdf; Matt Ford, *America's Largest Mental Hospital Is a Jail*, The Atlantic (June 8, 2015), https://www.theatlantic.com/politics/archive/2015/06/americas-largest-mental-hospital-is-a-jail/395012/; E. Fuller Torrey, et al., *More Mentally Ill Persons Are in Jails and Prisons Than Hospitals: A Survey of the States*, Treatment Advocacy Center (May 2010), https://www.treatmentadvocacycenter.org/storage/documents/final_jails_v_hospitals_study.pdf.

prison populations between 1983 and 2015.[28] Portland-area jails alone see nearly 65,000 people pass through their doors every year,[29] a majority of whom have serious medical needs even before they wind up behind bars.[30]

Providing quality health care to incarcerated people is both a legal and a moral obligation, of course. As Justice Kennedy, writing for the U.S. Supreme Court, explained, "[j]ust as a prisoner may starve if not fed, he or she may suffer or die if not provided adequate medical care."[31] Thus, "[a] prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society."[32]

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[28] *See Incarceration Trends in Oregon*, Vera Institute of Justice at1 (Dec. 2019), https://www.vera.org/downloads/pdfdownloads/state-incarceration-trends-oregon.pdf.

[29] Multnomah County Sheriff's Office, FY 2020 Proposed Budget, at 7, https://multco.us/file/80186/download (31,000 annual bookings into Multnomah County jails); Clackamas County Sheriff's Office, *Clackamas County Jail: Fast Facts*, https://www.clackamas.us/sheriff/jailfacts.html (16,000 annual bookings into Clackamas County Jail); Washington County Sheriff's Office, *Countywide Services Annual Report 2016*, at 42 https://www.co.washington.or.us/sheriff/upload/2016-annual-report-countywide.pdf (17,111 annual bookings into Washington County Jail).

[30] Huh, et al., *supra* note 27, at 15 (noting that more than 60% of people who pass through Multnomah County jails have serious chronic health conditions); Conrad Wilson, *Jail Inmates Could Receive Federal Healthcare Under Sen. Jeff Merkley Proposal*, OPB (Oct. 24, 2019), https://www.opb.org/news/article/oregon-senator-merkley-jail-inmates-federal-healthcare-proposal/ (noting that 29% of people in Oregon jails have a mental illness and 45% have a substance use disorder).

[31] *Brown v. Plata*, 563 U.S. 493, 510–11 (2011).

[32] *Id.* at 511.

But such deprivations are more than illegal and unprincipled—they also amount to public health emergencies afflicting prisoners, detainees, and the general public with equal force. After all, the overwhelming majority of people incarcerated in jails and prisons are released to their communities. From the spread of virulent pathogens to expensive remedial health care, the failure to provide quality health care to incarcerated people is felt far beyond prison and jail walls.[33]

Nevertheless, states and localities have broadly failed to meet their responsibility to provide adequate health care to incarcerated people. In fact, the last two decades have seen sharp increases in already unacceptably high rates of preventable deaths in jails and prisons. From 2008 to 2018, the death rate in local jails increased more than 25%.[34] Even more striking, the death rate behind state

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[33] *See, e.g.*, Nicholas Freudenberg, *Jails, prisons, and the health of urban populations: a review of the impact of the correctional system on community health*, J. Urban Health, 78(2):214–35 (June 2018); Cynthia Golembeski & Robert Fullilove *Criminal (in)justice in the city and its associated health consequences*, Am. J. Public Health, 95(10):1701–06 (Oct. 2005) https://ajph.aphapublications.org/doi/10.2105/AJPH.2005.063768; Eddie Burkhalter, et al., *Covid-19: Infections Among U.S. Prisoners Have Been Triple Those of Other Americans*, N.Y. Times, (Apr. 19, 2021), https://www.nytimes.com/live/2021/04/10/world/covid-vaccine-coronavirus-cases; Sharon Dolovich, *Mass Incarceration, Meet COVID-19*, U. Chi. Law Rev. Online (Nov. 16, 2020), https://lawreviewblog.uchicago.edu/2020/11/16/covid-dolovich/.

[34] E. Ann Carson, *Mortality in Local Jails*, *2000-2018 – Statistical Tables*, NCJ 256002, Bureau of Justice Statistics, tbl. 3 (Apr. 29, 2021).

prison walls increased 42% between 2001 and 2018.[35] Consistent with national trends, the rate at which people in Oregon jails die has grown in recent years.[36]

During this same period, municipalities and states have increasingly outsourced their obligations to provide quality health care to incarcerated people. Today, five corporations—Corizon, NaphCare, Wexford Health, Centurion Health, and Wellpath Holdings—are collectively responsible for prison health care in 28 states and 62% of jail health care in the United States, pocketing 40% of all correctional spending.[37] In Oregon, about half of the State's largest jails contract with private companies for medical care.[38]

Providing health care to jails and prisons is big business. Combined, these companies make $4 billion annually.[39] Corizon alone had almost $1.1 billion in

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[35] E. Ann Carson, *Mortality in State and Federal Prisons, 2001-2018 – Statistical Tables*, NCJ 255970, Bureau of Justice Statistics, tbl. 9 (Apr. 29, 2021).
[36] *See* Wilson, *supra* note 30 (noting that jail death rate in Oregon "show an upward trend" and "have increased compared to total bookings, state population and projections of daily jail populations").
[37] Worth Rises, *The Prison Industry, supra* note 26, at 76; Kil Huh, et al., *Prison Health Care: Costs and Quality - How and Why States Strive for High-Performing Systems*, The Pew Charitable Trusts (Oct. 2017); https://www.pewtrusts.org/-/media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf.
[38] Jason Szep, Ned Parker, Linda So, Peter Eisler, and Grant Smith, *Dying Inside: The Hidden Crisis in America's Jails*, *Focus on Oregon*, Reuters (Oct. 16, 2020), https://www.reuters.com/investigates/special-report/usa-jails-graphic/ [hereinafter, Reuters, *Dying Inside*]. According to Moody's Investors Service, jails are a more attractive sector than prisons because they involve higher margins.
[39] Worth Rises, *The Prison Industry, supra* note 26, at 76.

revenue in 2018.[40] Investors have taken notice, and private equity ownership has become the norm in the industry.[41] As one expert explained, "[t]heir strategy is to make industries and companies ruthlessly efficient and to extract more revenue from the business than there was before they acquired it … And that's not really ideal when you're talking about health care."[42]

But privatizing health services in jails and prisons has only exacerbated deadly trends.[43] Driven by market forces—*e.g.*, the quest for profit, accountability to investors, sky-high executive salaries, patients without choice, patients without political clout—correctional health care providers are incentivized to skimp on care to protect the bottom line. Empirical data show that these market forces—some unique to the correctional context—have resulted in catastrophe. A recent survey of the nation's 523 largest jails revealed that those outsourcing healthcare to

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[40] *Id*.

[41] Marsha McLeod, *Private Equity's Grip on Jail Health Care,* THE ATLANTIC (Sept. 12, 2019), https://www.theatlantic.com/politics/archive/2019/09/private-equitys-grip-on-jail-health-care/597871/. Corizon is the rare exception, having recently been acquired from by a hedge fund called Flacks Group. See Matt Clarke, *Investment Firm Buys Corizon*, Prison Legal News (Nov. 1, 2020) https://www.prisonlegalnews.org/news/2020/nov/1/investment-firm-buys-corizon/.

[42] McLeod, *supra* note 41 (quoting sally Hubbard, the director of enforcement strategy at the Open Markets Institute).

[43] *See generally* Reuters, *Dying Inside*, *supra* note 38; Dan Weiss, *Privatization and Its Discontents: The Troubling Record of Privatized Prison Health Care*, 86 U. Colo. L. Rev., Feb. 12, 2015 at 725, 748; Paul von Zielbauer*, As Health Care in Jails Goes Private, 10 Days Can Be a Death Sentence*, N.Y. Times, Feb. 27, 2005.

corporations experienced had mortality rates between 18% and 58% higher than in facilities with public health care providers.[44]

Despite an incentive structure that encourages low quality health care, a titan of the private jail and prison health care industry now asks for immunity from the consequences of its disregard for incarcerated Oregonians with disabilities. This Court should decline the invitation to remove the last best chance to incentivize private corporations to preserve the health and safety of incarcerated people and the communities they will inevitably rejoin.

SUMMARY OF ARGUMENT

This Court should hold that for-profit corporations responsible for providing healthcare to incarcerated Oregonians are subject to laws prohibiting discrimination on the basis of disability. This brief explains why relying on private healthcare companies—beholden to investors rather than patients—has resulted in unnecessary suffering and death in Oregon's jails. Granting immunity to such mega-businesses would only incentivize additional harm.

First, in Part I, *amici* outline some of the reasons that private correctional healthcare providers deliver substandard care to incarcerated patients. In Oregon and across the country, medical care in jails and prisons is in crisis. This crisis is most acute where for-profit companies provide care. This is because the incentives

[44] Reuters, *Dying Inside*, *supra* note 38.

of such entities are at odds with the legal and moral obligation to provide quality health care to incarcerated people. The process of bidding for contracts to provide care to corrections facilities; the structure of those contracts; and pressure from investors incentivize private health care providers to cut costs. The problem is exacerbated by lack of choice and political power among patients, along with a dearth of mandatory oversight standards or health care provider accountability.

Second, *amici* illustrate how these market forces drive tragic outcomes. Part II focuses on thirteen people in Oregon and elsewhere who suffered or lost their lives as a result of failures by private correctional healthcare companies. When healthcare providers prioritize profit, the immediate consequence is human suffering.

Finally, in Part III, *amici* explain that incarcerated people with disabilities have few avenues available to redress harms they suffer at the hands of profit-seeking healthcare corporations. The U.S. Supreme Court has restrictively read constitutional provisions governing treatment of prisoners and the U.S. Congress has imposed myriad barriers to suits by prisoners through the Prison Litigation Reform Act. As a result, public accommodations and disability discrimination laws like Or. Rev. Stat. § 659A.142 are crucial for protecting the rights of incarcerated Oregonians with disabilities. Stripping for-profit correctional healthcare companies

of liability for the harm they cause in Oregon would leave the state's most vulnerable citizens with nowhere to turn.

ARGUMENT

I. THE FOR-PROFIT CORRECTIONAL MEDICAL CARE INDUSTRY CONSISTENTLY FAILS TO PROVIDE ADEQUATE HEALTH CARE TO INCERCERATED PEOPLE.

A. Correctional Health Care Is In Crisis.

Deaths and illness in correctional facilities had reached disturbing heights even before COVID-19 swept the nation.[45] In the case of *Brown v. Plata*, for instance, the U.S. Supreme Court confronted a prison system in which, according to a federal judge, an incarcerated person "needlessly dies every six to seven days due to constitutional deficiencies in the . . . medical delivery system."[46] The judge added that "[t]his statistic, awful as it is, barely provides a window into the waste

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[45] Alan Greenblatt, *America Has a Health-Care Crisis—in Prisons*, GOVERNING MAG (July 29, 2019), https://www.governing.com/archive/gov-prison-health-care.html#:~:text=Privatization%20and%20years%20of%20inadequate,population%20with%20abysmal%20medical%20care.&text=Prison%20is%20no%20place%20to,the%20start%20of%20this%20century; Steve Coll, *The Jail Health-Care Crisis*, The New Yorker (Feb. 25, 2019), https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis; von Zielbauer, *supra* note 43; Katie Rose Quandt, *America's Rural Jail Death Problem*, The Atlantic (Mar. 2021), https://www.theatlantic.com/politics/archive/2021/03/americas-rural-jail-death-problem/618292/.

[46] *Plata v. Schwarzenegger*, No. C01-1351 TEH, 2005 WL 2932253, at *1 (N.D. Cal. Oct. 3, 2005).

of human life" occurring behind prison walls "due to the gross failures of the medical delivery system."[47]

Clear evidence shows that across the nation, jail and prison medical care is getting even worse. According to the Bureau of Justice Statistics, per capita deaths in state prisons rose 42% between 2001 and 2018, increasing almost every year.[48] In local jails, mortality rates increased steadily between 2008 and 2018, with a more than 25% increase over the period.[49] Similarly, a 2019 study of more than 500 of the largest jails in the United States documented a 35% increase in mortality rate among people in custody over a ten-year period.[50] The story is much the same in Oregon jails.[51]

Where jails and prisons rely on private correctional health care providers, the outcomes are even worse. Data show that for-profit correctional care companies, which Oregon utilizes for roughly half of its largest jails,[52] provide

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[47] *Id*.
[48] Carson, *supra* note 35, at tbl. 9.
[49]Carson, *supra* note 34, at tbl. 3. These increases afflicted all age groups. *Id*.
[50] Reuters, *Dying Inside*, *supra* note 38. This number almost certainly understates the true extent of mortality in jails and prisons, as these facilities are known to take steps to avoid accountability for deaths in custody. *See, e.g.*, Fault Lines, *Sick Inside: Death and Neglect in U.S.*, Al Jazeera (Nov. 6, 2019) (Video at 6:45), https://www.aljazeera.com/program/fault-lines/2019/11/6/sick-inside-death-and-neglect-in-us-jails.
[51] *Id*. (*Focus on Oregon*) at 2 (showing that the death rate in Oregon jails from 2009 to 2019 was virtually identical to the national death rate among incarcerated people).
[52] *Id*.

deadlier care than their public counterparts. The most comprehensive study to date of jail mortality found that risk of death was consistently higher in jails with private contractors providing the medical care. Specifically, mortality rates in jails serviced by the five leading private contractors are between 18% and 58% higher than in jails where government employees provide healthcare.[53]

Such failures are not limited to any one company. After a series of deadly lapses by Corizon, county officials across Oregon dropped the provider.[54] But rather than turning back to public providers, counties merely shifted care for incarcerated patients to other corporations, including NaphCare, which now provides care in Washington and Clackamas counties.[55] Rather than helping, that swap is yielding similarly disturbing outcomes. In fact, across the country, the death rate is highest in jails serviced by NaphCare.[56] And where Oregon officials instead replaced Corizon with Wellpath, such as in Lane County,[57] the outcome is unlikely to be much better. The death rate is virtually identical in facilities served

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[53] *Id*.
[54] *See, e.g.*, Wilson, *supra* note 30; Tara Herivel, *Profits and preventable deaths in Oregon jails*, STREET ROOTS (Jan. 18, 2019), https://www.street-roots.org/news/2019/01/18/profits-and-preventable-deaths-oregon-jails (detailing Lane County's switch from Corizon to Wellpath in 2016 following a $7M judgement against Lane County and Corizon for the family of Kelly Conrad Green, and Clackamas County's switch from Corizon to Naphcare in 2019 after the overdose death of Bryan Perry).
[55] *Id*.; *see also* Reuters, *Dying Inside*, *supra* note 38 (*Focus on Oregon*).
[56] *Id*.
[57] *See* Herivel, *supra*, note 54.

by those companies.[58] Oregon jails that do not outsource their healthcare to private companies, by contrast, have an annual death rate roughly 25% lower than in jails that do.[59]

B. Commercial Incentives, Market Failures, And Accountability Gaps Unique In The Correctional Context Drive Private Correctional Healthcare Providers To Deliver Substandard Care.

At the heart of these disproportionately deadly outcomes is a troubling mix of incentives and accountability failures unique to privately provided correctional health care. From the necessity to win new business by undercutting competitors to perverse obligations to investors, the interests of corporations that provide correctional healthcare are at odds with the well-being of patients. And in contrast to the free-world healthcare market where consumer-choice abounds and political accountability mechanisms exist, in the correctional care context there are no such checks against profits-before-patients incentives.

i. Commercial Incentives Elevate Cost-Cutting Over Patient Well-Being.

Private health care contractors contend with two sources of market pressure not applicable to government providers: (1) the bidding process, in which they compete for contracts to provide care to corrections facilities; (2) the pressure from

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[58]Reuters, *Dying Inside*, *supra* note 38.
[59] Calculations for the 25% discrepancy are based on the data in the Reuters *Dying Inside* report. *Id*. (*Focus on Oregon*).

owners and investors (typically private equity or hedge fund) to maximize profits by cutting costs.

Starting with the bidding process—and putting aside that evidence suggests that private correctional health care is actually more expensive than publicly provided correctional health care[60]—cost-reduction goals are baked into the contracting process in ways that disincentivize quality care.[61] The structure of these contracts can broadly be described as either "capitation" or "cost-plus."[62] Both lead to bad outcomes, but in different ways.

The capitation model describes the majority of correctional healthcare contracts.[63] In this model, payment is provided by government entity via a lump sum fee.[64] If the correctional care provider holds costs below the fee amount, it earns a profit; if costs exceed the fee amount, the provider suffers a loss.[65] It is thus easy to see how this model might incentivize skimping on quality care by, for example, understaffing or denying necessary procedures. As but one example, a

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[60] *See* Rep. to the Ct., *Parsons v. Ryan, et al.*, No. 2:12-cv-00601-ROS, (D. Ariz. Mar 22, 2012), ECF 3379, at 105 ("[P]rivatization of correctional health care costs the state more than self-operation."); Micaela Gelman, *Mismanaged Care: Exploring the Costs and Benefits of Private vs. Public Healthcare in Correctional Facilities*, 95 N.Y.U. L. Rev., 2020 at 1386, 1432 (2020).
[61] *See* Gelman, *supra* note 60, at 1404.
[62] Huh, et al., *supra* note 37, at 12.
[63] *Id.* at 98 (tbl. C.5).
[64] *Id.* at 12.
[65] *Id*.

former Corizon nurse in a Portland jail was retaliated against by the company after she exposed that she had been repeatedly pressured to delay care to people with "major medical problem[s]."[66] As she explained, "if they were released before the ambulance got there, Corizon was not on the hook for the medical bill."[67] The less common "cost-plus" model, where healthcare providers "pass through each expense . . . to the state, plus an additional charge for arranging and managing care," presents a different kind of danger.[68] Because "cost-plus systems pay contractors based on the volume of care provided, and not on the outcomes achieved, they can inadvertently incentivize excessive use of low-value services," at the expense of effective one-time care.[69]

Irrespective of the contracting model, other disincentives to providing quality care abound. For instance, contracts routinely try to entice public officials by promising to limit costs, often in dangerous ways. Take "off-site [or specialty] cost-sharing provisions."[70] These provisions help private correctional medical

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[66] Fault Lines, *supra* note 50, at 6:45–7:40.
[67] *Id*.
[68] Huh, et al., *supra* note 37, at 12
[69] *Id.* at 13; *see also* Jason Furman & Matt Fiedler, *Continuing the Affordable Care Act's Progress on Delivery System Reform Is an Economic Imperative*, WHITE HOUSE: PRESIDENT BARACK OBAMA (Mar. 24, 2015 at 4:35 p.m.), https://obamawhitehouse.archives.gov/blog/2015/03/24/continuing-affordable-care-act-s-progress-delivery-systemreform-economic-imperative (describing a drawback of "fee-for-service" healthcare payment systems, which are functionally identical to the cost-plus model).
[70] Weiss, *supra* note 43, at 751.

service providers win bidding wars, because they assign financial responsibility for off-site medical services—such as ambulance services or hospitalization—to the correctional health care provider, rather than to the state or county correctional system.[71] But such services tend to be expensive and can therefore quickly eat into a health care provider's profits. Providers thus have a financial incentive to avoid using off-site services. Unsurprisingly, incarcerated people treated by providers whose contracts include such provisions are routinely denied emergency medical care, often with tragic consequences.[72] One study found that in the year after Corizon took over health services in a jail, off-site medical care costs declined by 53%.[73] Another study of a contract that assigned responsibility for "specialty care" costs to the provider demonstrated that "[s]pecialty care utilization declined, while complaints about unmet health care needs grew."[74]

Of course, no matter the structure of the contract, the health care provider must first earn it in a competitive bidding process, almost always by agreeing to

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[71] *Id.*
[72] Roland Zullo, *An Input Adjustment Method for Challenging Privatization: A Case from Michigan Prison Health Services*, 42 Lab. Stud. J., Dec. 17, 2016 at 85, 89.
[73] Reuters *Dying Inside, supra* note 38.
[74] Zullo, *supra* note 72, at 89 (citing Office of the Legislative Corrections Ombudsman, *2001-2002 Annual Report to the Legislative Council (Dec. 2002)*.

provide care for less money than any other provider.[75] The necessity to guard against being underbid effectively guarantees that substandard care will follow.[76] This reality is exacerbated by the relative scarcity of options. Because there are only five significant competitors in the market, each providing a virtually identical product, cost becomes the most important metric. One sheriff remarked on the lack of alternatives: "If you're the only dance in town, you can pretty much call your own shots."[77]

And once a provider wins a contract, cost-cutting is the name of the game. In addition to the savings that can be achieved by foregoing hospitalization and specialists, private correctional care providers keep expenses low and profits high by skimping on the quality of medical personnel.[78] Unsurprisingly, assessments of privatized correctional healthcare have consistently faulted it for routinely hiring unqualified staff.[79] For example, an examination of one of the entities that merged to form Corizon, Prison Health Services, described nurses doing tasks "beyond

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[75] *Id*. at 88*; see also* Joseph I. Hallinan, GOING UP THE RIVER: TRAVELS IN A PRISON NATION 167 (2001) ("The success of private prisons . . . is driven by a single premise: They are cheaper than their public counterparts.").
[76] *See* Sharon Dolovich, *State Punishment and Private Prisons*, 55 Duke L. J., 2005 at 437, 475 (explaining how the incentives on contractors to cut costs lead inexorably "to inhumane conditions of confinement").
[77] McLeod, *supra* note 41, (quoting Sheriff Bobby Kimbrough of Forsyth County).
[78] *See* Ahmed A. White, *Rule of Law and the Limits of Sovereignty: The Private Prison in Jurisprudential Perspective*, 38 AM. CRIM. L. REV., 2011 at 111, 143.; Zullo, *supra* note 72, at 95.
[79] *See infra*, notes 78–80.

their training" and doctors who were "underqualified."[80] An investigation of the other half of the Corizon merger, Correctional Medical Services, found that they regularly hired medical personnel whose licenses had been suspended or revoked by state boards.[81] And after Corizon lost a jail contract, an audit by the government resulted in the dismissal of more than 15% of medical staff originally hired by Corizon after a determination that they "presented a potential risk to patient safety."[82]

For-profit correctional health care providers also commonly strive to cut costs by understaffing jail and prison medical units. For instance, in *Parsons v. Ryan* —a class action brought against Centurion for lapses in care in Arizona—the reviewing federal court identified, among other systemic deficiencies, "[i]nadequate staffing levels" that created "inappropriate scheduling gaps in on-site medical coverage" and forced staff to work "excessive hours, creating fatigue

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[80] von Zielbauer, *supra* note 43.

[81] Andrew Skolnick, *Prison Deaths Spotlight How Boards Handle Impaired, Disciplined Physicians,* 280 JAMA, 1998 at 1387.

[82] Caroline Lewis, *Restructuring health care delivery at New York City jails*, CRAIN'S N.Y. BUS., (May 26, 2016) (on file with authors); *see also* N.Y.C. Dep't of Investigation, *Report on Corizon Health Inc. in New York City Jails*, at 1–2 (2015) (finding a lack of proper oversight by New York City government entities, including the failure to conduct background checks and to adequately screen the hiring of Corizon staff); *see also* Michael Winerip & Michael Schwirtz, *New York City to End Contract With Rikers Health Care Provider*, N. Y. TIMES (June 10, 2015), https://www.nytimes.com/2015/06/11/nyregion/report-details-failings-of-corizon-rikers-island-health-provider.html.

risks."[83] A 2015 U.S. Department of Justice audit of a jail serviced by Wellpath was even more blunt, identifying a "potential financial incentive to leave positions vacant . . . because [Wellpath] was paid more for the required positions than it was forced to pay back for each one it left unfilled."[84]

ii. Market Failures And Accountability Gaps Deprive Incarcerated People Of An Effective Non-Legal Remedy.

Traditional free-world incentives to provide quality health care are absent in the correctional health market. As such, the "market" cannot correct the potent disincentives described above to provide quality care. Without consumer choice, political clout, effective oversight standards, or provider accountability to patients, incarcerated Oregonians suffering from inadequate health care have nowhere to turn but the courts.

To start, "prisoners have absolutely no consumer choice."[85] In the typical marketplace for services, consumer choice is a potent incentive to deliver quality care—when a cardiologist provides substandard care, a patient will select another provider should another emergency arise. But correctional medical care patients do

[83] *Parsons v. Ryan*, 754 F.3d 657, 668 (9th Cir. 2014).
[84] McLeod, *supra* note 41.
[85] Coll, *supra* note 45.

not have the luxury of choosing another medical care practice. They are captive consumers in a monopoly market.[86]

The problem is exacerbated by lack of political will to fix it. As an initial matter, incarcerated people are politically disfavored and lack political clout, leaving them "especially vulnerable" to abuses by a for-profit healthcare system.[87] Moreover, unlike public officials, who are subject to political accountability through the democratic process, commercial healthcare providers answer primarily to the needs of investors. That is, private healthcare providers are accountable to investors and jailers, not to the patients they serve. Correctional healthcare is a $4 billion industry on a mission to deliver enticing returns to investors.[88] Corizon, for example, is solely owned by Miami-based hedge fund Flacks Group.[89] In 2018, H.I.G. Capital, a private-equity firm with more than $34 billion in equity capital under management, acquired Wellpath.[90]

While the impact of private equity on health care in prisons has not been studied, its effect on the delivery of care in nursing homes—another congregate

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[86] *See generally* Stephen Raher*, The Company Store and the Literally Captive Market: Consumer Law in Prisons and Jails,* 17 HASTINGS RACE & POVERTY L.J., 2020 at 3.
[87] Dolovich, *supra* note 76, at 480 n.153 (quoting Jody Freeman, *The Private Role in Public Governance*, 75 N.Y.U. L. Rev. 543, 631 (2000)).
[88] Worth Rises, *The Prison Industry, supra* note 26, at 76.
[89] Clarke, *supra* note 41.
[90] McLeod, *supra* note 41.

setting with, arguably, a comparably "captive market" —has been.[91] In 2019, U.S. senators voiced concerns, writing in a letter to the Carlyle Group, "[w]e are particularly concerned about your firm's investment in large for-profit nursing home chains, which research has shown often provide worse care than not-for-profit facilities."[92] One recent study estimates that private-equity involvement in nursing homes "increases the short-term mortality of Medicare patients by 10%, implying 20,150 lives lost due to PE ownership over our twelve-year sample period."[93]

Finally, the oversight systems that are supposed to ensure accountability of this captive market rarely do so. A report by the bipartisan Commission on Safety and Abuse in America's Prisons concluded that "monitoring systems" are "generally under-resourced and lacking in real power."[94] The National

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[91] *See e.g.*, Atul Gupta et al., *Does Private Equity Investment in Healthcare Benefit Patients? Evidence from Nursing Homes,* U. CHI. WORKING PAPER No. 2021-20, NYU STERN SCHOOL OF BUSINESS FORTHCOMING (Feb. 13, 2021), https://ssrn.com/abstract=3785329*;* Rohit Pradhan et al., *Private Equity Ownership of Nursing Homes: Implications for Quality,* 42J. Health Care Fin. 1 (2014), http:/lbealthfmancejournal.com/index.php/johcf/article/view/12.

[92]Letters from Elizabeth Warren, Mark Poca, and Sherrod Brown Letters to Private Equity Firms (Nov. 15, 2019) https://www.warren.senate.gov/imo/media/doc/2019-11-15%20Letters%20to%20PE%20Firms%20re%20Nursing%20Homes.pdf.

[93] Gupta*, supra* note 91*,* at 2–3.

[94] David Fathi, *No Equal Justice US: The Prison Litigation Reform Act in the United States*, Human Rights Watch (June 16, 2009), https://www.hrw.org/report/2009/06/16/no-equal-justice/prison-litigation-reform-act-united-states.

Commission on Correctional Health Care, which accredits private prison health care providers, could ostensibly fill this gap. But experts have noted that NCCHC accreditation provides a convenient rubber stamp, but little real oversight.[95]

Incarcerated people are thus left with few options when provided with inadequate care. "The only de facto oversight system we have is litigation," said Dr. Carolyn Sufrin, an ob-gyn at Johns Hopkins University and the author of *Jailcare*, a book based on her research and experience as a physician in a San Francisco county jail.[96] As one recent report concluded, "the only means of recourse—after filing a grievance slip—is to sue."[97] Without action by this Court, Oregonians in jails across the state—most of whom have not been convicted of any crime—will suffer, while investors turn a profit.

II. PRIVATE CORRECTIONAL HEALTH CARE PROVIDERS ROUTINELY DELIVER DEATH AND SUFFERING.

Although the discussion of market and contract incentives, cost-cutting zeal, and gaps in accountability or democratic oversight can sound academic, it is the genesis of the grave harms inflicted by the for-profit correctional care industry. When jails and prisons fail to provide adequate health care to people in need, the immediate consequence is human suffering. And in far too many cases, that

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[95] Gelman, *supra* note 60, at 1406-1409.
[96] McLeod, *supra* note 41.
[97] *Id*.

suffering leads to needless death, especially in the case of people with disabilities. The following case studies provide a glimpse into that pain and suffering. Many of the following tragedies unfolded in Oregon. Others took place in other parts of the country under the care of the same private providers responsible for the medical well-being of incarcerated Oregonians. [98]

These stories were not selected because they are, in any way, exceptional; rather, they were selected because they exemplify the routine failures that the theory and empirical evidence in Part I would predict from private correctional health care providers. For instance, the prevalence of specialty cost-sharing provisions (discussed *supra*, Part I.B.i) results in a reluctance to spend on specialty or disability care. Wexford displayed this reluctance when it refused to repair the prosthetic leg of 75-year-old Leonard, ultimately leading to his sepsis death from ulcers caused by the faulty prosthesis (described *infra*, Part II.G.iii). Similarly, the common inclusion of off-site care cost-sharing provisions (discussed, *supra*, Part I.B.i) predictably leads providers to avoid sending patients to the hospital, even when critical inpatient care is obviously needed, like in the cases detailed below of Brett Fields, Kelly Green, and so many others.[99]

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[98] The facts in this section are taken from federal court filings, orders, opinions, and neutral monitors reports.

[99] *See e.g., infra*, Part II.B (neglecting to send Brett Fields to the hospital despite his begging for emergency care after his intestines fully escaped his rectum); Part II.E (declining emergency hospital care to Kelly Green despite indications of a

In short, the tragic consequences of these and other themes discussed above in Part I —including understaffing and unqualified staff, inadequate treatment, and the denial of access to mental illness and drug treatment—are not just academic or theoretical concerns. Rather, the real-world impact of a profit-seeking correctional health model comes into sharp focus in cases that follow.

A. Nicholas Glisson (*Corizon*)

One patient under Corizon's care was Nicholas Glisson, who died 37 days after entering custody.[100] Nicholas was arrested when his friend—who was acting as a police informant—convinced him to share a single prescription painkiller.[101] Though he had lived independently outside of prison, Nicholas had severe disabilities requiring regular medical attention.[102] He had trouble speaking, swallowing, and walking.[103] A prior bout with laryngeal cancer left him with an opening in his throat and a "G-tube" that he used when he was unable to swallow.[104] He relied on a neck brace to hold his head upright, without which he had trouble breathing.[105] His family tried desperately to ensure the jail had the

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severe spinal injury); Part II.F (rapidly returning "Olivia" from the hospital without discharge papers while she was in labor).

[100] *Glisson v. Ind. Dep't of Corr.*, 849 F.3d 372 (7th Cir. 2017).

[101] *Id*. at 373–74.

[102] *Id*.

[103] *Id*.

[104] *Id*.

[105] *Id*.

medical devices and information that he needed to survive.[106] Some of those devices went missing, and the information they provided went unheeded.[107]

Despite Nicholas Glisson's need for medical care and disability accommodations that were apparent at a glance, no medical personnel reviewed his medical history for 24 days after his arrest.[108] Nor did a provider ever devise a treatment plan.[109] Lab results were ignored or reviewed weeks late.[110] He was never allowed to use the neck brace that his family provided to the jail, nor given a replacement.[111] He was seen by a wide array of Corizon staff, but because the doctors who saw him did not attempt to coordinate or follow up on previous visits, he began to rapidly decline.[112] He became severely undernourished.[113] His kidneys started to fail.[114] He began presenting symptoms of cognitive decline, insomnia, and hallucinations.[115] Though he was given a mental health evaluation, no one looked at the results of that evaluation in the context of his physical decline.[116]

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[106] *Id*.
[107] *Id*. at 374–75.
[108] *Id*. at 376.
[109] *Id*. Notably, as the Seventh Circuit explained, Corizon did not simply fail to provide Mr. Glisson with a treatment plan, they "consciously chose not to adopt the recommended policies—not for Glisson, not for anyone." *Id*. at 379–80.
[110] *Id*. at 376.
[111] *Id*.
[112] *Id*.
[113] *Id*.
[114] *Id*.
[115] *Id*.
[116] *Id*.

Rather than treat the physical symptoms that were likely causing his mental health decline, he was placed on suicide watch and made to switch from the anti-depressant he had long used to a new medication, abruptly and without evaluation, further exacerbating his condition.[117]

This absence of care continued, even after he was taken to the hospital with kidney failure.[118] Three days after his discharge from the hospital, a Corizon nurse noted that he was disoriented and was not understanding attempts to communicate with him.[119] Two hours later, Nicholas Glisson was found unresponsive and pronounced dead.[120]

B. Brett Fields (*Corizon*)

Brett Fields, an athletic 24-year-old man, entered custody on two misdemeanor charges with a tennis-ball sized bump on his arm.[121] Corizon (then Prison Health Services) staff began treating him for staph infection.[122] But Brett did not have a simple staph infection. As weeks went on, Brett repeatedly asked for help with his now-open wound, telling Corizon staff that the medicine was not

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[117] *Id*. at 376–77.
[118] *Id*. at 377–78.
[119] *Id*. at 378.
[120] *Id*.
[121] *Fields v. Corizon Health, Inc.*, 490 F. App'x 174, 176 (11th Cir. 2012).
[122] *Id.*

working.[123] Brett's arm continued to swell and he started feeling soreness and numbness in his back.[124] His legs began twitching uncontrollably.[125]

From July 24 to August 8, 2007, Brett repeatedly begged medical staff for help, but they neglected him.[126] On August 7, he called for emergency help because the pain had become unbearable, but a nurse told him he would have to wait.[127] By the next morning, he had excruciating pain in his back, his entire lower body was numb, and he had lost the ability to walk or stand.[128] Correctional officers wheeled him to the clinic where a Corizon doctor tested his non-existent reflexes, prescribed Tylenol, and sent him back to his cell.[129]

After a nurse recommended moving Brett to the medical block, he was "thrown into the back of a van…, dragged []from the van, placed []in a wheelchair, [taken] to the medical block…, and placed on the floor in a new cell."[130] After fifteen hours, during which he repeatedly begged for help to no avail, Brett tried to use the bathroom—and felt his intestines escaping from his rectum. [131] He cried out for emergency assistance, once again, begging the nurse who arrived to send him

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[123] *Id.* at 176–77.
[124] *Id.*
[125] *Id.* at 177.
[126] *Id.*
[127] *Id.*
[128] *Id.*
[129] *Id.*
[130] *Id.* at 178.
[131] *Id.*

to the hospital, explaining that his lower body was numb and that he was unable to move.[132] The nurse pushed his intestines back in and ordered him to an observation room where, again, despite "begg[ing] six [Corizon] employees for help… none so much as lifted a finger."[133] All told, he was ignored or dismissed by over a dozen Corizon staff.[134]

When a doctor finally saw Brett on the morning of August 9—nine hours after he was found paralyzed on the floor of his cell, and two and a half hours after the doctor arrived for work—he ordered that Brett be immediately sent to the hospital.[135] Despite the urgency, it took nearly two hours for Corizon staff to call an ambulance.[136]

At the hospital, Brett underwent surgery for an abscess on his spine. [137] By that time, he had missed the crucial window to prevent catastrophe. [138] Only now, after years of rehabilitation, can Brett move with the use of a walker.[139]

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[132] *Id.*
[133] *Id.*
[134] *Id.*
[135] *Id.*
[136] *Id.* at 179.
[137] *Id.*
[138] *Id.*
[139] *Id.*

C. Damaris Rodriguez (*NaphCare*)

On December 30, 2017, Damaris Rodriguez, who suffered from bipolar disorder, experienced a severe mental health crisis.[140] Her husband explained that Damaris required medical assistance and officers on the scene assured him that she would be routed to an appropriate treatment facility.[141] Instead, Damaris was transported to a jail that contracts with NaphCare for medical services.[142] Damaris's husband tried repeatedly to communicate to NaphCare staff that she suffered from severe mental illness but NaphCare staff ignored him and did not otherwise gather information about her condition.[143]

Damaris Rodriguez, www.kiro7.com

[140] *Dawson v. South Correctional Entity*, Case 2:19-cv-01987-RSM, (W.D. Wash. Dec 05, 2019), Compl. and Jury Demand, ECF 1 at 12.
[141] *Id.* at 13-14.
[142] *Id.* at 14.
[143] *Id.* at 13-15.

At intake, "NaphCare personnel deemed her to be 'uncooperative'" and thus did not evaluate her for mental health issues.[144] Once in a cell, she laid face down on the floor before getting up, dancing, stumbling around, and removing all of her clothing while conversing with people who were not there.[145] Over the next two days, she did not eat and barely slept.[146] She threw her food and clothes around the cell, danced, yelled unintelligibly, pounded her chest, struck the mirror, choked herself until she passed out, struck her head on the unpadded bed platform, urinated on the floor, and vomited throughout. [147] The next day, she was moved to a medical cell, but was not provided with medical treatment.[148]

Damaris's condition deteriorated.[149] She became lethargic and did not respond when guards brought her food.[150] Although she refused to eat, she exhibited insatiable thirst.[151] Medical staff noticed Damaris's excessive water intake and noted the possibility of water intoxication.[152] Yet she received no medical care beyond several blood pressure checks and a drug test, which came

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[144] *Id.* at 20.
[145] *Id.* at 15.
[146] *Id*. at 16.
[147] *Id*. at 16-17.
[148] *Id*. at 20.
[149] *Id.* at 21-25.
[150] *Id*. at 25.
[151] *Id*. at 25-27.
[152] *Id*. at 27.

back negative.[153] Had NaphCare staff conducted routine tests, they would have realized that Damaris was suffering from a life-threatening but treatable condition called ketoacidosis, which is brought on by starvation.[154]

But instead of providing the emergency care Damaris needed, NaphCare personnel moved her to a cell without a sink in order to curb her water intake.[155] Eventually, corrections staff put towels in front of Damaris's door because her vomit was spilling into the hallway and NaphCare personnel were not doing anything.[156] On January 4, Damaris was found unconscious on the floor of her cell and pronounced dead.[157]

D. Dale Thomsen (*NaphCare*)

In 2017, Dale Thomsen was arrested and taken to Washington County Jail in Portland, Oregon for failure to appear for a previous offense.[158] After his arrest, Dale's wife repeatedly contacted the jail to say she was concerned for her husband's health.[159] She warned them Dale had a severe brain injury and a seizure

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[153] *Id*. at 22-23, 27.
[154] *Id*. at 2-3, 22-23.
[155] *Id*. at 27.
[156] *Id.* at 26.
[157] *Id.* at 5, 29.
[158] Complaint, *Thomsen v. NaphCare, Inc.*, No. 3:19-cv-00969 (D. Or. Jun. 21, 2019), ECF 1 [hereinafter Thomsen Compl., ECF 1]; Opinion and Order, *Thomsen v. NaphCare, Inc. et al.*, No. 3:19-cv-00969 (D. Or. Mar. 24, 2020), ECF 92 at 3 [hereinafter Thomsen Order, ECF 92]. Additional facts are drawn from the complaint filed by the estate of Dale Thomsen.
[159] Thomsen Order, ECF 92, at 3.

disorder.[160] She also told them he was an alcoholic and would begin to experience alcohol withdrawal symptoms, including seizures, after 24 hours. [161] His wife was assured his health issues would be taken into account and addressed.[162]

Dale Thomsen, www.oregonlive.com

At the time of booking, Dale was assessed by a NaphCare nurse who did not detect any mental health issues.[163] She deemed him alert and cooperative and noted that his vitals were normal. [164] But Dale soon began to display concerning symptoms, just as his wife had warned. [165] He became angry, anxious, and

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[160] *Id.*
[161] Thomsen Compl., ECF 1, at 9.
[162] *Id.* at 3.
[163] Thomsen Order, ECF 92, at 3.
[164] *Id.*
[165] *Id.* at 4.

paranoid. He began to hallucinate and lost his orientation of person, time, and place. [166] On June 28, a nurse encountered him wrapped in a blanket continuously asking a deputy "to tell Debbie I'm going to be late" and calling the deputy "Jim."[167] The nurse checked his vital signs and found them to be abnormal. She ordered a mental health evaluation, but it was never performed.[168]

Later in the day, deputies reported that Dale was kicking the door of his cell while complaining he was being kidnapped.[169] They decided to move him to a holding cell. [170] The deputy transporting Dale stopped at the nursing station on the way to the holding cell so medical staff could examine Mr. Thomsen, but NaphCare staff recommended no further treatment.[171]

Once in the holding cell, Dale pounded and kicked the cell door for hours. [172] The banging stopped just before noon, when Dale collapsed and lay silently.[173] He had died from cardiac arrest. [174]

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[166] *Id.* at 4–5.
[167] *Id.* at 4; Thomsen Compl., ECF 1, at 11.
[168] Thomsen Order, ECF 92, at 4.
[169] *Id.* at 4-5.
[170] *Id.* at 5.
[171] *Id.*; Thomsen Compl., ECF 1, at 12.
[172] Thomsen Order, ECF 92, at 5.
[173] *Id.*
[174] *Id.*

E. Kelly Green (*Corizon*)

Kelly was taken to Lane County Jail in Eugene, Oregon on February 11, 2013, exhibiting symptoms of severe mental illness.[175] The next day, Kelly purposefully ran at—and used his head to ram—a cinder block wall. Corizon medical staff examined him as he lay bleeding on the floor but decided not to send him to the hospital.[176] No neurological exam following the incident was noted.[177]

Kelly was then transported by wheelchair to the jail clinic so that his head could be sutured.[178] No precautions regarding his neck were taken during transport. At one point, Kelly went limp and slid out from the wheelchair.[179]

As Corizon medical staff stitched up Kelly's head, Kelly lost control of his bowels, which is symptomatic of a spinal injury.[180] However, no neurological check was performed.[181] A Corizon nurse later testified that she believed he was faking being paralyzed.[182]

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[175] *Johnson v. Corizon Health, Inc.*, No. 6:13-CV-1855-TC, 2015 WL 1549257, at *4 (D. Or. Apr. 6, 2015)
[176] *Id.*
[177] *Id*. at *4.
[178] *Id.*
[179] *Id.* at *5.
[180] *Id.*
[181] *Id*. at *6.
[182] *Id. at *6 (citing* Dep. of Sharon Epperson (attached as Ex. 12 to the Decl. of John T. Devlin (# 91–12)) at p. 110).

Kelly was then dumped into a cell, where he lay motionless.[183] After less than an hour, the deputy assigned to watch him called the nurses, concerned about his lack of movement.[184] A nurse told the deputy that as long as Kelly was breathing, he was fine.[185] For the next several hours, corrections staff contacted Corizon medical personnel to express concern about Kelly's condition.[186] Eventually, a Corizon nurse examined Kelly and determined that he needed to go to the hospital but clocked out before calling one.[187]

No one called an ambulance for another hour.[188] When Kelly was finally admitted, hospital staff determined he had fractured his neck.[189] Because he had not severed his spinal cord, immediate care could have prevented paralysis.[190] Instead, Kelly was left a quadriplegic, dependent on a ventilator. He later died as a result of ventilator dependence complications.[191]

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[183] *Id.*
[184] *Id.*
[185] *Id*. at 6.
[186] *Id.*
[187] *Id*. at 7.
[188] *Id*.
[189] *Id*.
[190] *Id*.
[191] *Id*.

F. Unidentified Patient in *Parsons v. Ryan* Monitor Report, a.k.a. "Olivia" (*Corizon*)

Olivia was seven months pregnant and classified as "seriously mentally ill" when she was taken into the custody of the Arizona Department of Corrections.[192] Intake forms noted that she suffered from schizophrenia.[193] About two months later, Olivia's water broke and she was sent to the hospital.[194] She returned only a few hours later.[195] A Corizon medical provider ordered Olivia back to her cell but did not order any follow-up from any other staff member and did not contact the hospital. [196] No member of Corizon's medical staff initiated a follow up over the next three days.[197]

Three days later, Olivia went into labor alone in her cell.[198] She began screaming and banging on her cell door for help.[199] The women in nearby cells heard her and began yelling for help as well.[200] No help arrived until after Olivia,

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[192] Index of Exhibits, *Parsons v. Ryan, et al.*, No. 2:12-cv-00601-ROS, (D. Ariz. May 20, 2019), ECF 3255-1 at 70. The facts in the following sections are taken from reports by court-appointed experts responsible for monitoring the implementation of court-ordered or agreed upon reforms. In such reports, case studies are often anonymous.
[193] *Id.* at 71.
[194] *Id.*
[195] *Id.*
[196] *Id.*
[197] *Id.* at 72.
[198] *Id.* at 73.
[199] *Id.*
[200] *Id.*

in excruciating pain, had dragged herself to the toilet and delivered her baby into her own hands—all the while continuing to scream for help.[201]

G. Unnamed Patients in *Lippert* Class Action (*Wexford*)

i. "Maryann"

At the time of her arrest, Maryann had diabetes and cirrhosis.[202] While in jail, she developed a fever, low blood pressure, and swelling around the eyes—symptoms indicating sepsis and warranting hospitalization.[203] Instead of sending her to the hospital, Maryann was sent to the jail infirmary, where she received a phone consultation with a Wexford physician.[204] Without rendering a diagnosis, the Wexford physician ordered Maryann treated with an antibiotic, fluids, and Tylenol.[205] The next day, Maryann had a distended abdomen; the physician diagnosed her with a fever.[206] It took two more days to refer Maryann to the hospital. [207]

When Maryann came back from the hospital she was vomiting dark red blood and had low blood pressure.[208] Despite these red flags, the Wexford

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[201] *Id.*
[202] *Lippert v. Godinez*, No. 1:10-cv-04603, N.D. Ill. Report of the 2nd Ct. Appointed Expert, ECF 767 at 95 (describing the Mortality Review Patient #6).
[203] *Id.*
[204] *Id.*
[205] *Id.*
[206] *Id.*
[207] *Id.*
[208] *Id.* at 95.

physician did not modify Maryann's treatment.[209] She vomited blood four more times during the night; the physician was called but he took no action.[210]

The next morning, a Wexford physician obtained a Do Not Resuscitate ("DNR ") form from Maryann while she was in medical shock.[211] The signature on the DNR form was later determined not to match her usual signature and the court-appointed monitor made a formal finding that her signature appeared to have been obtained by the physician under duress.[212] In other words, the Wexford doctor either convinced or forced a seriously ill patient to sign a form ordering doctors not to save her life.[213] After obtaining her DNR, the physician sent Maryann to the hospital.[214] Because of the DNR, no intervention was taken, and Maryann died at the hospital of internal bleeding.[215]

ii. "Kevin"

Kevin, a 24-year-old with a history of mental illness, swallowed two plastic sporks in direct view of a correctional officer.[216] The Wexford physician who saw Kevin after this incident was informed of this fact yet conducted no physical

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[209] *Id.*
[210] *Id.*
[211] *Id.*
[212] *Id.*
[213] *Id.*
[214] *Id.*
[215] *Id.*
[216] *Id.* at 97 (describing the Mortality Review Patient #15).

evaluation.[217] Instead, the physician ordered an x-ray, which could not show the presence of ingested plastic.[218] Ten weeks later, a nurse practitioner evaluated Kevin, but failed to recognize that he had lost 33 pounds.[219] At that appointment, Kevin told the nurse practitioner that he had ingested a spork and needed it removed, which the provider noted, but did not address.[220]

Kevin continued to go untreated, eventually losing 54 pounds and experiencing repeated episodes of severe abdominal pain.[221] He lost the ability to eat without pain, nausea, and diarrhea.[222] One day he was found unresponsive in his cell, at which point he was finally transferred to the hospital, where he died.[223] His autopsy showed that the two swallowed sporks had caused an esophageal perforation, leading directly to his death.[224]

iii. "Leonard"

Leonard, a 75-year-old man who had an amputated leg, sought treatment from a prison infirmary because his prosthesis, which required repair, was causing an ulcer.[225] Seeking to avoid the cost, Wexford initially refused to repair Leonard's

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[217] *Id.*
[218] *Id.*
[219] *Id.*
[220] *Id.*
[221] *Id.*
[222] *Id.*
[223] *Id.*
[224] *Id.*
[225] *Id.*

prosthesis.[226] Wexford then authorized limited repair, but failed to correct the problem that was causing the ulcer.[227] As a result of the worsening ulcer and broken prosthesis, Leonard began using a wheelchair, which in turn caused him to develop a pressure ulcer on his buttock.[228]

Rather than admitting him to the infirmary or sending him to the hospital, Leonard was kept in the general population where his ulcer was not properly monitored.[229] Eventually his untreated ulcer began draining pus and showed clear signs of a bone infection.[230] Nurses reported a "tunneling wound draining pus and at one point even showing bone" but Wexford physicians inexplicably described his wound as "healthy."[231]

At the same time, Leonard was losing weight—42 pounds over the course of several months.[232] After Leonard's cellmate told nurses that he had not eaten in two days, Leonard was finally sent to the infirmary.[233] A nurse called a physician who ordered intravenous antibiotics over the phone without evaluating or diagnosing Leonard.[234] Leonard was found unresponsive later that day and sent to

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[226] *Id.*
[227] *Id.*
[228] *Id.*
[229] *Id.*
[230] *Id.*
[231] *Id.* at 97 (describing the Mortality Review Patient #19).
[232] *Id.*
[233] *Id.*
[234] *Id.*

the hospital, where he died of "overwhelming sepsis."[235] His infected, untreated ulcers were the likely cause of death. [236]

iv. "Patricia"

Patricia had a mass on her pancreas that jail physicians identified as likely pancreatic cancer.[237] She was prescribed 90 mg of morphine to control her severe abdominal pain, with the expectation of additional care following her transfer to prison. [238] But the Wexford physician at the prison took no further diagnostic action, ignored the likely diagnosis of pancreatic cancer, and treated the mass as benign. [239] He subsequently moved Patricia from a pain management regime of morphine to Tylenol. [240] One month later, a blood test positively confirmed that Patricia had pancreatic cancer and the physician referred her for a biopsy. [241] Wexford's corporate office refused to authorize the biopsy, delaying Patricia's formal diagnosis for nearly five months. [242]

After months of failing to monitor or address Patricia's pain and declining to initiate narcotic pain relief, the Wexford physician prescribed palliative sedation

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[235] *Id.*
[236] *Id.*
[237] *Id.* at 86 (describing the Mortality Review Patient #21).
[238] *Id.*
[239] *Id.*
[240] *Id.*
[241] *Id.*
[242] *Id.*

using a combination of morphine and benzodiazepine every two hours.[243] The neutral monitor reviewing Patricia's case noted that her case raised serious ethical concerns as "palliative sedation . . . can be perceived as a form of euthanasia" because it "hastens death," and there was no evidence of a "discussion of palliative sedation with the patient."[244] Patricia died three days later. [245]

v. "Trevor"

Trevor was a 26-year-old man who had been homeless before his incarceration. He suffered from sickle cell anemia and a mental health disorder.[246] When he arrived at prison, a Wexford nurse documented his sickle cell but failed to take his full medical history.[247] Though medical staff ordered a blood count and sickle cell test, those tests were either never done or not documented. [248]

When Trevor was transferred to another correctional facility, he told a Wexford provider that he wanted treatment for his sickle cell but could not afford the $5 co-pay in effect at the time.[249] Trevor's sickle cell anemia went untreated and unmonitored until he died in prison of complications from the disease.[250]

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[243] *Id.*
[244] *Id.*
[245] *Id.*
[246] *Lippert v. Jeffreys*, No. 1:10-cv-04603, N.D. Ill. Health Care Monitor 3rd Report, ECF 1403 at 67 (describing Mortality review patient #1).
[247] *Id.*
[248] *Id.*
[249] *Id.* at 72.
[250] *Id.*

vi. "Liam"

Liam, a 46-year-old incarcerated man, saw a Wexford doctor because he had severe pain in his left hip.[251] An x-ray and accompanying tests suggested he had metastatic bone cancer.[252] No follow-up tests were done.[253]

Over the next two months, Liam saw health care providers almost twenty times complaining about severe weight loss, pain, and inability to walk. [254] Eventually, he was admitted to the jail infirmary, by which point he had lost 30 pounds and could no longer walk any meaningful distance.[255] It took another four days for a physician to see him.[256] When the Wexford physician did come, he did not perform an examination. He simply noted that Liam was "ambulatory" and discharged him.[257]

Liam continued to lose weight and placed two more health care requests.[258] A nurse finally noticed his extreme weight loss and put in an urgent referral to escalate his care, but nothing came of it.[259] Two weeks later, Liam's scheduled sick

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[251] *Id.* at 190.
[252] *Id.* at n.8.
[253] *Id.*
[254] *Id.* at 190-92.
[255] *Id.* at 191.
[256] *Id.*
[257] *Id.* The neutral monitor reviewing Trevor's case stated: "This was an extremely cynical note warranting peer review. It was callous professional behavior." *Id.*
[258] *Id.*
[259] *Id.*

call with a physician was cancelled due to "time constraints."[260] Four days after that, Liam was found vomiting and with abnormal vital signs and dizziness, having lost a total of 50 pounds. He was finally hospitalized and diagnosed with metastatic bone cancer.[261]

Liam returned to the jail infirmary, but due to further delays by Wexford he did not receive necessary tests and oncology care for another two months. [262] In all, Wexford physician's consistent failures to properly evaluate and treat Liam delayed his diagnosis by 10 months.[263] He died shortly after his formal diagnosis.[264]

vii. "Elijah"

Elijah was a 69-year-old patient who suffered from multiple health problems that went untreated by Wexford providers, despite frequent evaluations.[265] For example, he was evaluated twenty times in a two-year period for high blood pressure, but no one took action to treat the problem.[266] Nor was he was treated for an abnormally rapid heart rate.[267] Because he frequently fell from his top bunk, a

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[260] *Id.*
[261] *Id.* at 191-92.
[262] *Id.* at 192, 193.
[263] *Id.* at 192.
[264] *Id.*
[265] *Id.* at 239.
[266] *Id.*
[267] *Id.*

Wexford doctor suspected he had a seizure disorder, but declined to order any diagnostic testing.[268] When an x-ray showed a knee fracture following a fall from his bunk, he was not referred to an orthopedic surgeon or treated for the fracture.[269]

In 2020, Elijah became extremely dizzy, and a nurse noted that his left side was slow to move—symptoms that suggested a stroke.[270] Rather than do an EKG to detect whether Elijah was in fact having a stroke, the nurse attributed his symptoms to having not eaten breakfast or lunch.[271] Two days later Elijah began seizing, went into cardiac arrest, and died.[272]

III. LEGAL ACCOUNTABILITYS IS A NECESSARY ANTIDOTE TO AN INCENTIVE STRUCTURE THAT PUTS PROFITS OVER PATIENTS.

Many of the people at the centers of the stories in Part II have something in common besides their horrific treatment at the hands of private correctional healthcare companies: They suffered from a pre-existing disability. Incarcerated people with disabilities have few avenues for protecting their rights. For starters, the U.S. Supreme Court's "restrictive reading of the constitutional provisions governing treatment of prisoners . . . has radically undermined prison officials' accountability for tragedies behind bars—allowing, even encouraging, them to

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[268] *Id.*
[269] *Id.*
[270] *Id.* at 241.
[271] *Id.*
[272] *Id.*

avoid constitutional accountability."[273] This restrictive reading of the relevant constitutional provisions is in addition to severe, judicially imposed, limits on the remedies available against private entities, such as the bar on *respondeat superior* liability.[274] The U.S. Congress has likewise taken drastic steps to shut the courthouse doors to incarcerated people, including those with disabilities. With the passage of the Prison Litigation Reform Act, a daunting collection of barriers to obtaining redress, the success-rate of lawsuits brought by incarcerated people has plummeted.[275] These formidable obstacles render civil rights lawsuits—whether brought in federal or state court—inadequate to protect the rights of incarcerated people with disabilities.

In light of this doctrinal landscape, it is no exaggeration to state that public accommodations and disability discrimination laws are the last best hope for protection for the more than 50% of incarcerated people who have some form of disability.[276] Yet today, Corizon and its peers, which have long profited on the backs of a vulnerable and captive populace, ask to be further immunized from the

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[273] Margo Schlanger, *The Constitutional Law of Incarceration, Reconfigured*, 103 CORNELL L. REV. 357, 359 (2018).
[274] *Tsao v. Desert Palace*, 698 F.3d 1128, 1138-39 (9th Cir. 2012) (misapplying *Monell* to private entity defendants).
[275] *See* Margo Schlanger, *Trend in Prisoner Litigation as the PLRA Approaches 20*, 5 CORRECTIONAL LAW REP. 69–88 (2017).
[276] *See* Margo Schlanger, *Prisoners with Disabilities: Individualization and Integration*, Academy for Justice, A Report on Scholarship and Criminal Justice Reform 295, 296 tbl. 1 (Erik Luna ed., Oct. 2017).

death and destruction they leave behind. This Court should decline that invitation and hold that these mega-corporations are bound by Oregon's laws prohibiting discrimination on the basis of disability.

CONCLUSION

For the aforementioned reasons, this Court should find that Or. Rev. Stat. § 659A.142 does not exempt private contractors that provide medical care to people in Oregon's jails from liability for failure to accommodate people with disabilities.

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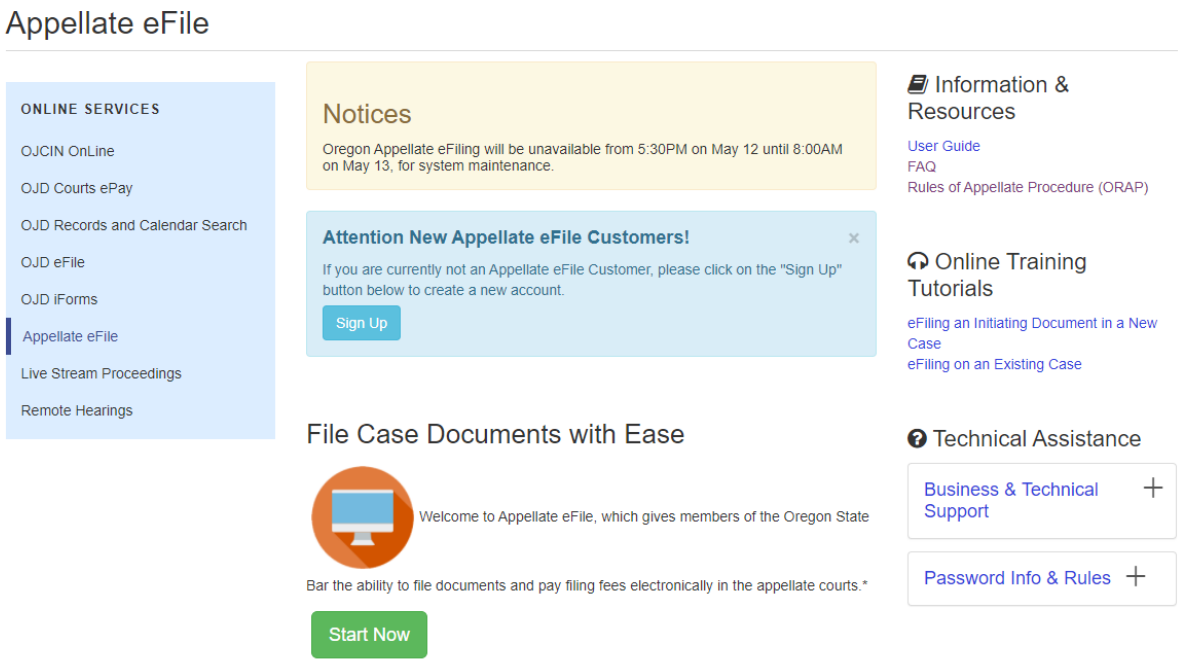

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I certify that I electronically filed the foregoing BRIEF OF *AMICI CURIAE* with the State Court Administrator, Records Section, by using the appellate electronic filing system on May 13, 2021.

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