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[ADDITIONAL COUNSEL LISTED ON SIGNATURE PAGE]

UNITED STATES DISTRICT COURT
DISTRICT OF ALASKA

Rory Vail, Jim Adams, Christopher Nickalaskey, Clarence Shirley, Stephanie Olrun, Nick Ephamka, Jr., Anthony Gilliam, Gavin Christiansen, Jeremy Whitlow, and Naomi Holt, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

Michael Dunleavy, Governor of Alaska; Jennifer Winkelman, Commissioner of the Alaska Department of Corrections; and Travis Welch, Department of Corrections Director of Health and Rehabilitation Services, in their official capacities,

Defendants.

CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

NATURE OF THE CASE

1. Plaintiffs and the putative class they seek to represent are people currently incarcerated in the custody of the Alaska Department of Corrections ("DOC"). The State of Alaska violates the constitutional rights of the approximately 4,400 people incarcerated in its state prisons and jails at any given time. The medical, mental health, and dental care (collectively "health care") provided to people incarcerated in DOC prisons and jails is so inadequate and deficient that it creates a substantial risk of serious harm and endangers the health, safety, and lives of incarcerated people. Plaintiffs are entirely dependent on Defendants for their health care.

2. Constitutionally inadequate health care is systemic at every stage of the health care process -- including inadequate screening of serious health conditions; delaying or denying access to clinicians, medications, medical devices, and medical supplies; delaying or denying access to specialty care; delaying access to emergency care; denying access to necessary medical care for disciplinary reasons and based on criminal case status; understaffing medical positions; maintaining a grossly inadequate medical records system; and failing to provide the full array of services necessary to meet minimum constitutional standards of care.

3. Plaintiffs seek to represent a class of all persons who are now, or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the Alaska DOC. Plaintiffs and the class they seek to represent seek declaratory and injunctive relief to compel Defendants Governor Michael Dunleavy, Alaska DOC Commissioner Jennifer Winkelman, and DOC Director of Health and Rehabilitation Services ("HARS") Travis Welch (collectively "Defendants") to remedy the unconstitutional medical, mental health, and dental care conditions of Alaska's prisons and jails immediately, and to provide incarcerated people with constitutionally adequate health care.

4. For years, Defendants have been aware of, and have failed to remedy, the constitutionally inadequate health care and conditions that place the people incarcerated in their prisons and jails at significant risk of serious harm, including unnecessary pain and suffering, preventable injuries, disfigurement, and death. Among other ways in which Defendants have been on notice of their provision of constitutionally inadequate care:

a. Deaths of people in DOC custody have been at an all-time high in the last few years, many due to lack of adequate medical and mental health care. In February 2023, Defendant Jennifer Winkelman, Commissioner of Alaska DOC, testified before the House Judiciary Committee about the deaths of eighteen incarcerated people in DOC's custody in 2022 and acknowledged that this number was "too many. I absolutely know that."

b. Numerous wrongful death cases have been or are being litigated against Defendants on behalf of people who died in DOC custody as a result of inadequate health care. These include but are not limited to a case resulting in a 2017 verdict that DOC was liable for 24-year-old Mark Bolus's death in custody by suicide; a 2019 settlement with the family of Kellsie Green, who died from malnutrition, dehydration, renal failure and heart dysrhythmia after DOC medical staff failed to follow protocol for detox; a November 2024 jury finding that DOC was negligent in caring for a woman who suffered severe brain injuries in a suicide attempt; a case filed in August 2023 in which an incarcerated man died by suicide, alleging failures of DOC to provide adequate health care for excruciating back pain; a case filed in August 2023 in which an incarcerated man died

by suicide, alleging DOC failed to prevent the suicide; and a case filed in March 2025 alleging a man died from meningitis following DOC's failure to treat an ear infection.

c. In 2015, an administrative review of DOC by a Special Assistant appointed by then-Governor Walker after a number of deaths in custody identified multiple failures of medical and mental health care in DOC and detailed multiple deaths that were attributed to lack of medical or mental health care. The review concluded, among other inadequacies, that there was a "lack of ownership by superintendents regarding provision and quality of medical and mental health care to inmates," stating that "[t]he provision of mental health care must be comprehensively reviewed and improved," and recommending increased staff training and evaluation. The review recommended creation of an independent team within DOC to investigate deaths in custody, but this was never done.

d. Defendants routinely receive grievances about health care from incarcerated people in DOC's custody and, through this process, have received hundreds of complaints about DOC's failure to provide adequate health care.

e. The Alaska State Ombudsman investigated and reported on inadequacies in access to treatment and medication for chronic illnesses for people incarcerated at DOC facilities in 2008. Many of the same systemic problems continue today.

f. The State Ombudsman has investigated and published two public reports on their findings of inadequate dental care. In February 2024, the DOC did not refute the most recent findings related to inadequate dental care and stated these deficiencies are "due to lack of critical staff."

g. In 2010, DOC officials worked with the ACLU of Alaska to complete a report reviewing conditions inside Alaska prisons. After interviewing state officials, staff, and more than 150 incarcerated people, the report concluded that DOC had serious deficiencies in medical care, including inadequate staffing, lack of prompt or adequate treatment, suicide prevention protocols at odds with national standards, and under-treatment of mental illness.

JURISDICTION

5. This action arises under the United States Constitution and 42 U.S.C. § 1983. Jurisdiction is proper in this Court pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3). This Court has jurisdiction over Plaintiffs' claims for declaratory and injunctive relief pursuant to 28 U.S.C. §§ 2201 and 2202.

VENUE

6. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) because Defendants reside in the District of Alaska and because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in the District of Alaska.

PARTIES

Plaintiffs

Rory Vail

7. Rory Vail is a 35-year-old man in custody at DOC's Anchorage facility. He is a pre-trial detainee who has been continuously incarcerated in DOC custody since February 2023.

8. In May 2022, Mr. Vail developed a left inguinal hernia, a defect in the abdominopelvic wall that allows the bowel to protrude outside the body. He also has ongoing dental disease including tooth decay and cavities, gum disease, and missing teeth.

9. He has suffered from testicular pain as a result of hernia bulging. DOC medical staff told Mr. Vail in February 2023 that he did not qualify for surgery and instead issued Mr. Vail a hernia belt.

10. In March and early April 2023, DOC denied Mr. Vail's requests for a bottom bunk and to use the shower on the ground floor (also known as the "bottom tier") to accommodate his impaired mobility and difficulty climbing stairs or ladders due to the hernia, and it denied another request for hernia repair surgery.

11. Mr. Vail complained in April 2023 to DOC medical staff that his hernia pain was constant, the hernia had descended into his right testicle, and his stool had been black for two weeks. He reported that when he self-reduced the hernia, it would fall out of place again with any movement. His stool tested positive for microscopic blood, an indicator of upper intestinal bleeding. The provider ordered colonoscopy evaluation, bloodwork, bottom bunk and shower tier, and another hernia belt, but denied surgery. The colonoscopy was not scheduled until June 27, 2023, however, at which point Mr. Vail declined the colonoscopy because he had not had black stool in two months.

12. By September 2023, Mr. Vail complained of daily pain and the hernia not being completely reducible. He could no longer exercise without pain. The DOC provider acknowledged the "moderately large left inguinal hernia" that descended into the testicle and was only "slightly reducible" and "immediately slides back out." Although Mr. Vail's physician ordered a surgery consultation on September 22, 2023, as of the date of this complaint he has not been seen for a surgery consultation.

13. DOC medical staff saw Mr. Vail again in November and December 2023 for worsening hernia symptoms, and he filed another grievance after the provider noted that Mr. Vail should "follow up with medical following sentencing."

14. Defendants have denied Mr. Vail needed medical care for his hernia on the ground that the criminal case against him is not yet resolved.

15. Defendants have also failed to provide appropriate dental care to Mr. Vail, who has presented to DOC with dental pain, difficulty eating, avulsion of a tooth (dislodged from the tooth socket) with swelling, necrotic (dead) tooth, decay, and gum inflammation. Despite DOC health care staff identifying his dental needs as requiring emergent or urgent treatment, Defendants have delayed needed timely care, and have not provided fillings for cavities, nor care for his periodontitis. Untreated cavities and periodontal disease increase the risk of severe complications including infection, sepsis, and death.

Jim Adams

16. Jim Adams is a 46-year-old man in custody at DOC's Spring Creek facility. He is a post-conviction prisoner who has been continuously incarcerated in DOC custody since June 2020.

17. Mr. Adams suffers from chronic back and hip pain following a machine accident that resulted in crushed vertebrae. He also has been diagnosed with H. pylori, the bacteria most

commonly responsible for peptic ulcer disease, chronic gastritis, gastric cancer, and other upper gastrointestinal (GI) disorders. Despite knowledge of his medical diagnoses, Defendants have failed to provide appropriate medical care.

18. Despite Mr. Adams's history of vertebral trauma and worsening chronic neurological pain, which together suggest disc herniation, DOC has denied Mr. Adams physical therapy for more than a year after initially presenting with back and hip pain. Defendants have further denied Mr. Adams MRI or CT imaging to assess his current condition. Nor has DOC provided him with spinal steroid injections, or appropriate pain medication. Health care staff only told Mr. Adams to purchase Tylenol and Motrin from the commissary, and offered him a printed list of exercises. As a result of DOC's inadequate and ineffective treatment, Mr. Adams remains in chronic and worsening pain.

19. Mr. Adams has notified DOC of his gastrointestinal illnesses, including acid reflux and the bacteria, H. pylori. After a long delay in testing for H. pylori, prison health care staff initiated treatment to eradicate the H. pylori after he tested positive for it. Nevertheless, they denied approval for the medically indicated follow-up test to confirm whether the treatment fully eradicated the bacteria. Consequently, Mr. Adams remains at risk of gastric cancer and other gastrointestinal disease caused by H. pylori if it remains present in his gastrointestinal tract.

20. Mr. Adams has no remaining teeth, yet he has not been provided with dentures. In 2023 and again in June 2024, DOC determined Mr. Adams to be a "likely candidate" for dentures because he is "fully edentulous," meaning that he has no remaining teeth. DOC, however, informed Mr. Adams that the process to obtain dentures is "long" with "no guarantee[d] wait time." Due to his condition and DOC's failure to provide adequate dental care,

Mr. Adams cannot consume or chew food properly, presenting a risk of malnutrition or choking while eating.

Christopher Nickalaskey

21. Christopher Nickalaskey is a 33-year-old man in custody at DOC's Anchorage facility. He is a pre-trial detainee who has been remanded to DOC custody for probation violations related to his mental illness and substance use disorder ("SUD") in December 2022 and again in September 2023. Since September 2023, he has been continuously in DOC custody.

22. DOC assessed him in January 2023 as having "a profound drug problem" for which "help obtaining appropriate treatment is absolutely necessary." Reassessment in late 2023 when he was reincarcerated recommended "high intensity residential treatment." Despite his request to receive medication-assisted therapy ("MAT") from DOC in 2023, DOC did not provide it. MAT in combination with behavioral health treatment is the standard of care, both inside and outside carceral facilities, for nearly all patients with SUD.

23. Despite Defendants' knowledge since 2022 that Mr. Nickalaskey had a serious SUD, and a history of multiple overdoses, Defendants failed to provide MAT or any other treatment and told him in 2023 that DOC does not provide suboxone or other MAT options. In December 2024, while incarcerated in DOC custody, DOC wrote to him, "The drug assessment you received can assist you with getting on treatment programs upon your release [but] not in custody."

Clarence Shirley

24. Clarence Shirley is a 40-year-old man held as a pre-trial detainee at DOC's Goose Creek facility. He has been incarcerated since 2020. He is a military veteran, diagnosed with post-traumatic stress disorder ("PTSD") and traumatic brain injury ("TBI") related to his years of

military service. Mr. Shirley also suffers from chronic right knee pain and a torn meniscus, chronic hip pain, and dental disease.

25. Mr. Shirley suffers from insomnia and nightmares related to his PTSD and TBI. Defendants denied his request for medication for insomnia, telling him DOC does not prescribe sleep aids. Although DOC started him on Prazosin, a medication used to treat PTSD with nightmares, his symptoms of visual and auditory hallucinations, racing thoughts, and nightmares were not well controlled, and Mr. Shirley brought this to the attention of medical staff. Despite their knowledge that Mr. Shirley's current treatment is ineffective, Defendants have not adjusted or modified his treatment.

26. Defendants failed to provide chronic disease management and necessary medication for Mr. Shirley's chronic right knee pain. In addition, 15 months passed between the time he originally requested treatment for persistent pain in May 2022, and the time he received effective diagnosis and treatment, including a scan revealing a complex tear of his meniscus which required surgery to remove part of the ligament. During that time period, his chronic pain was not treated effectively. Had he received timely and proper treatment at the time he reported the symptoms, the injury would not have progressed to become so severe as to require a partial removal rather than a repair.

27. Mr. Shirley has suffered chronic and worsening right hip pain from a prior injury, which was worsened by favoring the hip rather than placing weight on his injured knee. Defendants have failed to manage the hip pain even with a simple modification such as giving him a bottom bunk. Mr. Shirley requested a bottom bunk multiple times because of difficulty getting in and out of a top bunk due to his lack of mobility from the knee and hip damage, and worsening hip pain as a result of having to climb up and down to the top bunk. DOC has denied

all of his requests for a bottom bunk. Moreover, in March 2024, Defendants told Mr. Shirley that DOC would not address his hip pain until after he was convicted and sentenced.

28. In 2020, Mr. Shirley had a fractured front tooth. DOC clinic staff informed him that he could only have the tooth pulled and that he could not receive care to restore the tooth, although less invasive and extreme treatment is an available alternative that would preserve his tooth. He declined extraction then, and again in 2021, when he was again not offered restoration.

29. While incarcerated, Mr. Shirley suffered two more fractured teeth including one partial avulsion (loose in the socket), and an avulsed (knocked out) tooth. Despite requesting dental care in September 2021, he did not receive an appointment for four months, by which time he had pain and "gross decay." DOC dental staff extracted two teeth and Mr. Shirley required sutures to repair wounds in his mouth caused by the fractured teeth cutting his lips.

30. In 2023, although he experienced a dental emergency with an avulsed tooth, requiring immediate care, Defendants did not provide care for nearly three weeks, at which point it was far too late to save the tooth, and the tooth was pulled. Mr. Shirley suffered severe pain before and after treatment, but DOC denied him a follow-up appointment, responding to his filed grievance by saying he had already been treated sufficiently and would be placed again on a "waitlist" for dental care. By May 2024, despite continued severe pain and another request, Mr. Shirley still had not been provided a dental appointment. DOC medical staff informed him at that time that the dental waiting list was extremely long, and that he needed to be patient. By this point, Mr. Shirley had been waiting for adequate dental care for four years.

31. In or about June 2024, as a result of the independent Ombudsman's report detailing inadequate dental care (*see* Paragraph 4.f, *supra* and Paragraphs 223-232, *infra*), DOC temporarily hired outside dental contractors to help remedy the years-long waiting list for dental

care. The contractors gave Mr. Shirley several temporary fillings, telling him he could get permanent fillings once he left DOC custody. DOC's dental contractor also pulled two more of Mr. Shirley's teeth. The contractors left DOC two months after they were brought in by Defendants. As of the date of this Complaint, Mr. Shirley is back on the dental waiting list because one of the teeth with a temporary filling broke while he was eating. He is awaiting care for the broken tooth.

Stephanie Olrun

32. Stephanie Olrun is a 37-year-old woman, in custody at DOC's Hiland Mountain facility. She is convicted but unsentenced and has been continuously incarcerated in DOC custody since March 2021.

33. Ms. Olrun has hyperlipidemia ("HLD" or "high cholesterol") and diabetes mellitus type 2, along with a mental health diagnosis of postpartum depression. Defendants have failed to ensure that her chronic disease is managed properly, resulting in a life-threatening outcome.

34. Ms. Olrun suffered a diabetic complication in March 2022, after which she made diet and exercise changes with the goal of weaning herself off insulin therapy while continuing her other diabetes and HLD medications. In May 2023, she presented to the DOC clinic with blurry vision, heartburn, numbness and stabbing pain to her right knee, and bilateral calf cramping. Her blood sugar was very high (567 mg/dL), leading her to restart insulin. However, despite her dangerously elevated blood sugar, medical staff failed to provide blood sugar checks until a few weeks later, with the stated reason being higher-priority medical activity in the prison.

35. In July 2023, Ms. Olrun complained of severe low back pain and was diagnosed with muscle spasms. Her pain did not improve and became so excruciating that she could not

walk to receive medical attention, eat meals, or use the bathroom without the assistance of other incarcerated people. Medical staff did not check her blood sugar levels even while she remained in her cell incapacitated by pain.

36. Approximately one week later, an officer noted that Ms. Olrun had fallen out of bed and was unresponsive. Medical staff gave her Narcan (naloxone), an opioid reversal agent, suspecting without evidence that she had overdosed on drugs. The Narcan did nothing to help her, as testing revealed an extremely elevated blood sugar legal of 413 mg/dL—almost four times the upper limits of a normal range. At the hospital emergency room, she was in a diabetic coma and suffering from acute renal injury, brought on by diabetic ketoacidosis, a life-threatening complication of poorly controlled diabetes. Ms. Olrun was admitted to the Intensive Care Unit and was treated there for severe ketoacidosis, kidney malfunction, and significant heart strain due to both. She spent six days in the hospital.

37. Since the hospitalization, Ms. Olrun's A1C levels, which measure average blood sugar levels, have remained elevated. When she asked DOC for help managing her diabetes, DOC told her to exercise more. This has been impossible because the prison where Ms. Olrun was in custody at times failed to provide access to indoor or outdoor exercise for 14 days or more in a row.

38. Ms. Olrun requested mental health care but Defendants delayed providing care for months. In January 2024, she felt high levels of stress and "a disconnect" after a facility transfer, and requested mental health care. DOC staff told her that DOC does not provide individual counseling, and offered her remote, group therapy. Reiterating her need for care in February and again in June 2024, Ms. Olrun expressed feeling like she was "going to break."

Nick Ephamka, Jr.

39. Nick Ephamka, Jr. is a 55-year-old man in custody at DOC's Goose Creek facility. He is a pre-trial detainee who has been continuously incarcerated in DOC custody since 2018.

40. Mr. Ephamka has a history of myopia (nearsightedness) and worsening cataracts that have advanced to require surgery. Because Defendants have failed to provide him with the needed ophthalmology and chronic care, his vision has become so impaired that he cannot clearly see the food on his plate, let alone safely navigate the prison environment.

41. In August 2022, DOC confiscated his prescription eyeglasses because they had metal frames. When he requested replacement glasses in the fall of 2022, Defendants' nurse practitioner told him that "[t]here are different criteria for glasses for sentenced and unsentenced inmates." At that time, he had been incarcerated without his criminal case being resolved for nearly four years, so the practitioner said she would try to get him scheduled for an optometry evaluation.

42. In December 2022, DOC optometry gave Mr. Ephamka a diagnosis of bilateral "dense" cataracts and myopia (with a visual acuity of 20/400 in both eyes). Glasses were not prescribed, because DOC decided that cataracts were the source of his severe visual impairment. DOC's provider recommended evaluation for cataract surgery.

43. Around the spring of 2023, Mr. Ephamka had also repeatedly asked the prison clinic for assistance, as he could not see well enough to care for his severe facial acne. He often bled from his face, at times soaking a napkin with blood. Records show that on April 27, 2023, Mr. Ephamka had acne vulgaris that was seeded with bacteria that then culminated in cellulitis. He received an antibiotic cream.

44. In July 2023, presenting with another flare-up of the acne, DOC's medical provider denied another antibiotic prescription on the ground that the medication is not "preventative treatment of acne." Mr. Ephamka's visual impairment throughout this period has made managing his severe skin condition difficult and has exacerbated its effects.

45. In December 2023, still without eyeglasses or cataract surgery, Mr. Ephamka again complained of severe visual impairment. He continued to raise these problems throughout the spring of 2024. In June 2024, DOC granted him another eye exam and acknowledged his "dense cataracts" that were observed in 2022 and acknowledged that eyeglasses were not prescribed previously because it was determined they would "do little good" without cataract surgery. The new eye exam did not take place until August 2024. At that August appointment, cataract surgery was recommended for both eyes. Yet Mr. Ephamka was again told by DOC in October 2024 that he was not eligible for cataract surgery because he was pre-trial.

46. Defendants did not provide appropriate vision care to Mr. Ephamka for years, despite their awareness of the need, and continued to deny him needed cataract surgery. In December 2024—after approximately two and a half years attempting to navigate Goose Creek with severely impaired vision and two years since DOC's provider had recommended cataract evaluation—DOC finally informed him that the surgery was approved, but as a stated exception to their policy of not providing it for "unsentenced" people in custody. As of the date of this Complaint, however, the surgery has not taken place.

47. Throughout this ordeal, Defendants repeatedly denied Mr. Ephamka necessary medical care for his impaired vision for the stated reason that he is pre-trial and has not yet been convicted or sentenced.

Anthony Gilliam

48. Anthony Gilliam is a 63-year-old man who is post-conviction and has been in DOC custody since 2014. He is incarcerated at the Goose Creek prison.

49. Mr. Gilliam has a history of multiple psychiatric disorders including diagnosed depressive disorder and anxiety disorder, as well as multiple suicide attempts and abuse in childhood.

50. Prior to incarceration, he was treated effectively for his psychiatric disorders with counseling and medications. While in DOC custody, his mental health has declined significantly, culminating in four suicide attempts

51. DOC has delayed or denied multiple requests by Mr. Gilliam for mental health care. He has had to submit requests multiple times to receive any response, and has experienced delays of several weeks to receive an assessment. Physician-level mental health providers are only available through brief "telemedicine" encounters, and the facility does not provide any group therapy.

52. DOC has not managed Mr. Gilliam's illness adequately, providing only intermittent and inadequate care. In one instance, Mr. Gilliam told a mental health staff person that his psychiatric medications were not working and causing adverse side effects. The clinician discontinued his medications abruptly instead of tapering them, and did so without authorization from a qualified provider. Mr. Gilliam then experienced insomnia and headaches, and became very depressed, irritable, and unable to function.

53. In another episode, Mr. Gilliam truthfully admitted that he was thinking about hurting himself. DOC staff abruptly ended the interview, and Mr. Gilliam was handcuffed and placed in segregation, where he was stripped naked, given only a blanket to serve as clothing, and placed in a cell with no bed so that he was forced to sleep on the cement floor. In isolation,

mental health personnel did not evaluate or monitor Mr. Gilliam. His only human interaction was with an officer who pushed meals through a door slot and provided requested toilet paper, sparingly and after long delays. He was kept in isolation for four days and then allowed to return to a cell only when he stated he was "feeling better," which he did in order to be freed from the harsh conditions of the isolation cell.

54. DOC has provided inadequate psychiatric care to Mr. Gilliam, including failing to follow him therapeutically after suicide attempts; failing to reevaluate him; failing to monitor, regulate, and adjust his psychiatric medications appropriately; and failure to provide adequate counseling and therapy.

55. Mr. Gilliam has also not received adequate care for orthopedic pain, including elbow, wrist, back and knee pain, swelling and spasms. As a result he continues to suffer chronic pain. DOC medical personnel failed to order indicated diagnostic testing and failed to provide proper care when current treatment is ineffective. For example, although braces were prescribed, DOC confiscated them while Mr. Gilliam was in segregation. When his multiple joint pains did not improve despite anti-inflammatory medication, he deteriorated to the point of needing a wheelchair (which he later returned, trying to strengthen himself to be able to ambulate without assistance). In December 2024, after Mr. Gilliam complained of knee pain for a year, DOC ordered an x-ray that showed a meniscal tear. Meniscal tear typically requires surgical repair but DOC has not provided specialty care, further imaging via MRI, or repair.

56. For his wrist, with a diagnosis of carpal tunnel syndrome and continuing pain, DOC failed to treat Mr. Gilliam adequately when bracing was inadequate.

57. For his elbow tendinitis, DOC is aware that treatment via bracing and pain medication have failed, yet has provided no additional imaging, diagnosis, physical therapy or other intervention.

Gavin Christiansen

58. Gavin Christiansen is a 43-year-old man in custody at DOC's Goose Creek facility. He is a post-conviction detainee who has been continuously incarcerated in DOC custody since October 2020.

59. Mr. Christiansen has mental health diagnoses including PTSD, bipolar disorder, antisocial personality disorder, mood disorder, schizophrenia, depression, and anxiety. Mr. Christiansen also suffers from prostate hyperplasia which requires medication to control urinary frequency; the possible long-term consequences of not treating this condition include kidney failure.

60. Defendants have failed to provide adequate treatment for Mr. Christiansen's PTSD, which should be treated with trauma-focused psychotherapy and/or medication. Defendants prescribed him Cymbalta, a dual selective serotonin reuptake inhibitor/ serotonin and norepinephrine reuptake inhibitor ("SSRI/SNRI") for depression and anxiety, along with Prazosin for nightmares and sleep disturbances. When his symptoms persisted and worsened, the medication was not adjusted or switched to another medication, and no alternative medication was added to his regimen.

61. Defendants have not made psychotherapy available to Mr. Christiansen.

62. Mr. Christiansen continued to have urinary tract symptoms and was recommended to start the medication Flomax. Because Flomax cannot be taken with Prazosin, which he takes to treat nightmares associated with his PTSD, Mr. Christiansen cannot take both. Concerned about the risk of kidney failure, he stopped the Prazosin in August 2024, and his

nightmares became more frequent and distressing. When he asked about an alternative to Prazosin, medical staff informed him that this was the only medication available through DOC to treat nightmares associated with PTSD. To date, DOC has not prescribed an alternative, although multiple alternative medications exist.

63. Defendants have also provided deficient care for Mr. Christiansen's gastrointestinal disorders. After reporting chronic diarrhea beginning in January 2024, he did not receive wipes or medication for several months. Even after medication was started, the diarrhea continued, and progressed to include lower abdominal pain. The DOC provider discontinued the first medication based on negative interaction with mental health medications, "abuse potential. and short term usage indications." Not until October 2024 did DOC order stool testing for infection or bleeding. DOC did not order testing for anemia, nutritional deficits, or colonoscopy, which are indicated for diarrhea lasting more than four weeks.

Jeremy Whitlow

64. Jeremy Whitlow is a 42-year-old man detained pre-trial at DOC's Wildwood facility. He has been incarcerated since 2020.

65. Mr. Whitlow has been diagnosed with ulcerative colitis ("UC"), a chronic inflammatory colon condition in which abnormal reactions of the immune system cause inflammation and ulcers in the rectum and large intestine. If not treated properly, the disease can progress to colon cancer. Because of DOC's failure to treat his disease appropriately during a previous incarceration, Mr. Whitlow's colitis progressed to the advanced pre-stages of colon cancer.

66. In 2009, Mr. Whitlow underwent surgery during a previous incarceration to remove the majority of his colon and create an ileostomy which allows stool to drain into a collection bag affixed to the external abdominal wall. The surgery included removing adhesions

(scar tissue) as well. Medical records and testing done during the surgery showed that he had malignant cells present. After his release, in 2017, an outside surgeon conducted ileostomy reversal surgery to reconnect his upper bowel to the rectum and allow normal bowel movements.

67. While in DOC custody in 2017-18, despite needing a low-fiber diet due to his medical condition, DOC denied Mr. Whitlow a medical diet. He suffered a bowel obstruction, possibly due to the presence of adhesions, which perforated his small intestine. Mr. Whitlow had emergency surgery to have another ileostomy bag reattached to his stoma.

68. In early 2021, during his current period of incarceration, Mr. Whitlow's ileostomy bag was ripped off during an altercation with another incarcerated person. DOC then moved him to solitary confinement for approximately *two years*, for the stated reason of protecting him from medical harm. In solitary confinement, the wound on his abdomen kept bleeding, and Mr. Whitlow repeatedly requested treatment which he did not receive.

69. After much delay, DOC provided wound care via an outside wound clinic, but this did not address the problem. Finally, in September 2022 DOC allowed Mr. Whitlow to see the outside doctor who performed surgery to once again reverse the ileostomy and reconnect his bowels.

70. DOC mismanaged Mr. Whitlow's serious medical condition for years. He is at risk of serious complications, including but not limited to cancer, based on the age at which he was diagnosed.

Naomi Holt

71. Naomi Holt is a 42-year-old woman in custody at DOC's Hiland Mountain facility. She is a post-conviction prisoner who has been continuously incarcerated in DOC custody since 2015.

72. Ms. Holt suffers from abscesses and cellulitis caused by infectious disease, yet DOC has failed to provide appropriate wound care. Ms. Holt also has multiple psychiatric diagnoses: major depression with psychotic features, anxiety, PTSD with nightmares, and borderline personality disorder. DOC has not provided appropriate mental health care. DOC also has not provided her with adequate dental care.

73. In April 2023, Ms. Holt developed an infection around a spider bite requiring incision and drainage. Another infection later developed around her toe. Ms. Holt developed abscesses beginning in August 2023. Abscesses are isolated collections of pus due to bacteria seeding through the skin barrier. Some of the abscesses progressed to cellulitis, a progression of infection to the skin. Despite more and more abscesses, some of which did not heal, DOC only recommended wound care. By April 2024, one wound was so large that a nurse referred Ms. Holt to a physician assistant who prescribed antibiotics and drained the abscess. Yet almost three months later, the larger abscess had not healed completely. She then developed two more abscesses.

74. Because of her abscesses and cellulitis, her younger age, and status as a prisoner confined in close quarters with others in a large communal population, Ms. Holt was at higher risk for exposure to aggressive, drug-resistant bacteria that cause skin infections, of which methicillin-resistant staph aureus ("MRSA") is a concerning possibility. MRSA often leads to recurrent skin infections, with the risk of severe complications including bacteremia, endocarditis, and deep joint or bone infections.

75. Despite this risk of harm from serious infections, DOC failed for nearly a year to prescribe antibiotics for Ms. Holt's chronic, poorly healing abscesses and never cultured their drainage, both of which were medically indicated. When Ms. Holt was finally treated with

doxycycline, a broad-spectrum antibiotic typically effective against MRSA, her history of persistent recurrence of abscesses and cellulitis should have alerted providers that her body was likely colonized, which would have required a prolonged course of antibiotics and repeat testing to evaluate effectiveness of treatment.

76. Defendants' failure to provide appropriate medical care led to Ms. Holt suffering longer than necessary from the painful abscesses, and prolonged her wound care.

77. Ms. Holt's psychiatric conditions are chronic and susceptible to significant fluctuations, some of which may be completely debilitating. These lifelong conditions must be treated by controlling symptoms and maximizing functionality for better quality of life.

78. During her time in DOC custody, Ms. Holt has not received regular or timely mental health services despite providers' recommendations for such care. She also has been denied timely evaluation after medication adjustment. Although her symptoms persist, DOC has not initiated a trial of different medication.

79. Ms. Holt's symptoms have included chronic fatigue, depression, ruminating thoughts, intermittent hallucinations, insomnia, and fear of other people. Although Ms. Holt's symptoms have been persistently active and cause great distress, Defendants' mental health care for her has been irregular and ineffective.

80. Months-long dental care delays have caused Ms. Holt to suffer chronic pain without assessment or treatment. Despite chronic pain, she was made to wait four months for a dental hygienist appointment, and the hygienist then placed her on a wait list to see a dentist for evaluation of a painful denture, noting that "waiting times" were discussed with Ms. Holt. Inadequate dental assessment risks the failure to identify dental or gum infection that can progress to serious complications, including death.

CLASS ACTION ALLEGATIONS

I. The DOC Class

81. All Plaintiffs bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a class defined as "all prisoners who are now, or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the Alaska DOC" (the "Plaintiff Class").

A. Numerosity/Impracticability of Joinder: Fed. R. Civ. P. 23(a)(1)

82. The class is so numerous that joinder of all members is impracticable. Fed. R. Civ. P. 23(a)(1). At any given time, DOC confines approximately 4,400 people, all of whom are dependent entirely on Defendants for the provision of health care. All people in DOC custody are at risk of developing serious medical, mental health, or dental conditions while confined. There are hundreds, if not thousands, of prisoners at any given time who already have such conditions. Due to Defendants' policies and practices, all current and future DOC prisoners, numbering many thousands annually, receive or are at risk of receiving inadequate health care while in DOC custody.

83. The Plaintiff Class members are identifiable using records maintained in the ordinary course of business by DOC.

B. Commonality: Fed. R. Civ. P. 23(a)(2)

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

a. Whether Defendants fail to have adequate numbers of health care staff and fail to provide adequate training to staff;

b. Whether Defendants fail to provide adequate clinical space for health care encounters;

c. Whether Defendants fail to provide appropriate and timely intake screening and assessment of medical, dental, and mental health conditions;

d. Whether Defendants fail to provide continuity of health care;

e. Whether Defendants fail to provide timely and adequate access to health care;

f. Whether Defendants fail to provide adequate emergency health care;

g. Whether Defendants fail to provide an adequate and secure medical records system;

h. Whether Defendants fail to provide necessary medications;

i. Whether Defendants fail to provide adequate dental care;

j. Whether Defendants fail to provide adequate mental health care;

k. Whether Defendants deny health care to pre-trial detainees, many of whom are in DOC custody for years awaiting case resolution, because of their pre-trial status;

l. whether Defendants' failure to operate a health care system providing minimally adequate health care violates the Cruel and Unusual Punishments Clause of the Eighth Amendment; and

m. whether Defendants have been deliberately indifferent to the serious health care needs of class members and to the risk posed by their failure to maintain an adequate health care system.

85. Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

C. Typicality: Fed. R. Civ. P. 23(a)(3)

86. The claims of the Plaintiffs are typical of those of the Plaintiff Class, as their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the class's claims.

D. Adequacy of Representation: Fed. R. Civ. P. 23(a)(4)

87. Plaintiffs are capable of fairly and adequately protecting the interests of the Plaintiff Class because Plaintiffs do not have any interests antagonistic to the class; their interests are aligned with and co-extensive with those of the class. Plaintiffs, as well as the Plaintiff Class members, seek to enjoin the unlawful acts and omissions of Defendants.

88. Plaintiffs are represented by counsel experienced in civil rights litigation, prisoners' rights litigation, and complex class action litigation.

E. Fed R. Civ. P. 23(b)(1)(A) and (B)

89. This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(1) because the number of class members is approximately 4,400, and the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants. Additionally, the prosecution of separate actions by individual members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

F. Fed. R. Civ. P. 23(b)(2)

90. This action is also maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(2) because Defendants' policies, practices, actions, and omissions that form the basis of this Complaint are common to and apply generally to all members of the class, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the class. All

statewide health care policies are centrally promulgated, disseminated, and enforced by the central headquarters of DOC under the auspices of Defendants Dunleavy, Winkelman, and Welch. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Plaintiff Class.

II. The Pre-Trial Subclass

91. Plaintiffs Vail, Nickalaskey, Shirley, Ephamka, and Whitlow bring this action on their own behalf and, pursuant to Rules 23(a), 23(b)(1), and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a subclass defined as: "all pre-trial prisoners who are now, or will in the future be, subjected to the medical, mental health, and dental care policies and practices of the Alaska DOC" (the "Pre-Trial Subclass").

A. Numerosity/Impracticability of Joinder: Fed. R. Civ. P. 23(a)(1)

92. The subclass is so numerous that joinder of all members is impracticable. Fed. R. Civ. P. 23(a)(1). DOC confines approximately 2,200 people at a given time whose criminal charges have not yet been adjudicated, all of whom are dependent entirely on Defendants for the provision of health care. All subclass members are at risk of developing serious medical, mental health, or dental conditions while confined. There are at least hundreds of subclass members at any given time who already have such conditions and the population of the subclass is constantly shifting as new people enter the subclass and others leave as their cases progress. Due to Defendants' policies and practices, all subclass members receive or are at risk of receiving inadequate health care while in DOC prisons.

93. The subclass members are identifiable using records maintained in the ordinary course of business by the DOC.

B. Commonality: Fed. R. Civ. P. 23(a)(2)

94. There are questions of law and fact common to the members of the subclass. In addition to the questions common to the class (see Paragraph 84 above), such questions include, but are not limited to:

a. whether Defendants deny health care to members of the subclass because they are incarcerated awaiting trial;

b. whether Defendants' failure to operate a health care system providing minimally adequate health care to the Pre-Trial Subclass violates the Due Process Clause of the Fourteenth Amendment; and

c. whether Defendants have been deliberately indifferent to the serious health care needs of subclass members and to the risk posed by Defendants' failure to maintain an adequate health care system.

95. Defendants are expected to raise common defenses to these claims, including denying that their actions violated the law.

C. Typicality: Fed. R. Civ. P. 23(a)(3)

96. The claims of the subclass Plaintiffs are typical of those of the Pre-Trial Subclass, as their claims arise from the same policies, practices, or courses of conduct; and their claims are based on the same theory of law as the subclass's claims.

D. Adequacy of Representation: Fed. R. Civ. P. 23(a)(4)

97. Subclass Plaintiffs are capable of fairly and adequately protecting the interests of the subclass because they have no interests antagonistic to the subclass; their interests are aligned with and coextensive with those of the Subclass. Subclass Plaintiffs, as well as the subclass members, seek to enjoin the unlawful acts and omissions of Defendants.

98. Subclass Plaintiffs are represented by counsel experienced in civil rights litigation, prisoners' rights litigation, and complex class action litigation.

E. Fed R. Civ. P. 23(b)(1)(A) and (B)

99. This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(1) because the number of subclass members is approximately 2,200, and the prosecution of separate actions by individuals would create a risk of inconsistent and varying adjudications, which in turn would establish incompatible standards of conduct for Defendants. Additionally, the prosecution of separate actions by individual subclass members could result in adjudications with respect to individual members that, as a practical matter, would substantially impair the ability of other members to protect their interests.

F. Fed. R. Civ. P. 23(b)(2)

100. This action is also maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(2) because Defendants' policies, practices, actions, and omissions that form the basis of this complaint are common to and apply generally to all members of the subclass, and the injunctive and declaratory relief sought is appropriate and will apply to all members of the subclass. All statewide health care policies are centrally promulgated, disseminated, and enforced by the central headquarters of DOC under the auspices of Defendants Dunleavy, Winkelman, and Welch. The injunctive and declaratory relief sought is appropriate and will apply to all members of the Subclass.

Defendants

101. Defendant Michael Dunleavy is the Governor of Alaska. As Governor, he is responsible for the oversight and operation of DOC, including appointing the Commissioner of DOC, and proposing the budget for DOC. Alaska Const. art. III, § 25, AS 37.07, 44.19. As Governor, Defendant Dunleavy bears ultimate responsibility for providing all people in DOC

custody with constitutional conditions of confinement, including adequate health care. At all times relevant hereto, he has acted under color of state law. He is sued in his official capacity.

102. Defendant Jennifer Winkelman is the Commissioner of DOC. As Commissioner, Defendant Winkelman is responsible for establishing, monitoring, and enforcing overall operations, policies, and practices of DOC, which includes the provision of constitutionally adequate health care for all people committed to its custody, whether they are pre-trial or post-conviction. AS 33.30.01. As Commissioner, Defendant Winkelman is responsible for decisions concerning staff hiring, supervision, deployment, and training that directly affect incarcerated people's abilities to obtain adequate and necessary health services. She is responsible for establishing programs to "maintain health" and to provide "necessary medical services for prisoners in correctional facilities . . . includ[ing] medical, psychological, and psychiatric care that is necessary to enable a prisoner to participate in or benefit from rehabilitative services made available by the department." 22 AAC 05.121. She is responsible for providing constitutional conditions of confinement in all facilities and units. At all times relevant hereto, she has acted under color of state law. She is sued in her official capacity.

103. Defendant Travis Welch is the Director of DOC's Health and Rehabilitation Services (HARS). As Director of HARS, Defendant Welch is responsible for establishing, monitoring, and enforcing system-wide health care policies and practices for all DOC facilities. He is responsible for supervising and ensuring the provision of "quality, accessible, and timely health care services" for all people within DOC custody. Alaska DOC Policy 807.01. At all times relevant hereto, he has acted under color of state law. He is sued in his official capacity.

FACTUAL ALLEGATIONS

104. Defendants subject all people confined in Alaska prisons and jails, including Plaintiffs and the class and subclass they seek to represent, to a substantial risk of serious harm

by failing to provide adequate health care. At numerous stages at which confined persons interact with the health care system maintained by Defendants, the health care system fails to provide constitutionally adequate care.

105. In particular, Defendants have policies and practices of understaffing health care positions; inadequately screening for serious health conditions; delaying or denying access to clinicians, medications, medical devices, and medical supplies; delaying or denying access to specialty care; delaying access to emergency care; denying access to necessary medical care for disciplinary reasons; and failing to provide the full array of services necessary to meet minimum constitutional standards of care.

106. Defendants' medical records system is grossly inadequate for purposes of providing continuity of health care, accountability, monitoring, quality assurance, and oversight of the system.

107. Defendants are deliberately indifferent to the substantial risk of serious harm caused by these systemic health care deficiencies.

I. The DOC System and Its Health Care

108. Defendants are responsible for the operation of all prison and jail facilities within the State of Alaska, which incarcerate approximately 4,400 people as of July 2024. Alaska DOC is a unified system that operates and manages both jails and prisons statewide. The jail population of approximately 2,200 includes pre-trial detainees, and people convicted of and serving misdemeanor sentences of less than one year. The prison population of approximately 2,200 consists of people convicted of and serving felony sentences longer than one year.

109. DOC operates 13 facilities: Anchorage Correctional Complex (ACC), Anvil Mountain Correctional Center (AMCC), Fairbanks Correctional Center (FCC), Goose Creek Correctional Center (GCCC), Hiland Mountain Correctional Center (HMCC), Ketchikan

Correctional Center (KCC), Lemon Creek Correctional Center (LCCC), Mat-Su Pretrial (MSPT), Palmer Correctional Center (PCC), Point Mackenzie Correctional Farm (PMCF), Spring Creek Correctional Center (SCCC), Wildwood Correctional Center (WCC), and Yukon Kuskokwim Correctional Center (YKCC). HMCC is the only all-women facility in the state, incarcerating both women who are pre-trial and those who are post-conviction. AMCC, FCC, KCC, LCCC, WCC, and YKCC primarily incarcerate men, but have small populations of women who are pre-trial or serving sentences of less than a year. All other facilities house incarcerated men.

110. Defendants' health care policies and practices are deficient and inadequate, subjecting all incarcerated people to a substantial risk of unnecessary suffering, serious injury, clinical deterioration, and death.

111. Defendants have actual knowledge of the deficient and inadequate policies and practices and the resulting substantial risk of serious, avoidable, and unnecessary harm and suffering to Plaintiffs and class members, but have failed to take reasonable steps to remedy these deficiencies.

112. Defendants commit through written policies that incarcerated people will have access to "medical, dental, and mental health care services comparable in quality to those available to the general public." DOC Policy 807.02(IV)(A). However, this policy is not honored, as shown by the systemic deficiencies detailed in this Complaint, and by the preventable injuries and deaths that have occurred in DOC facilities.

113. Defendants also state in the same written policy that "the same quality of care will be provided to sentenced and unsentenced prisoners" and that, "[r]egardless of the prisoner's [sentenced] status, all essential and medically necessary care will be approved and delivered in a

timely manner." DOC Policy 807.02. But this policy is consistently ignored by Defendants: people awaiting trial are regularly denied necessary health care services solely due to their pre-trial status. DOC staff consistently tell people to wait until they are sentenced to receive health care, a waiting period that can stretch for months or years as their criminal cases linger in the court system.

114. DOC is responsible for providing mental health services to the largest population of people with mental illness in the State of Alaska. By DOC's own estimate, given in legislative testimony, 65% of the incarcerated population have a diagnosed mental health disorder. More than one in five (22%) people in DOC custody have a persistent and serious mental illness, like schizophrenia or bipolar disorder.

115. Defendants fully control all aspects of health care services available to incarcerated people, including "dental, psychological, psychiatric, [and] medical services." DOC Policy 807.02.

II. Systemic Deficiencies in the Provision of Adequate Health Care

A. Defendants Lack Adequate Numbers of Health Care Staff and Fail to Provide Adequate Training

116. Defendants' policy and practice of chronically and consistently understaffing health care positions results in multiple deficiencies and inadequate health care: there is insufficient staffing to timely respond to requests for health care and to emergencies, to provide uninterrupted medication delivery, or to adequately screen, monitor, and provide follow-up care to people with serious and chronic illnesses. The inadequate health care staffing is caused by Defendants' failure to actively recruit, hire, train, supervise, and retain sufficient and competent health care staff.

117. DOC's own policies require it to provide "essential health care in a timely manner by qualified practitioners and/or allied health care personnel." DOC Policy 807.01. In practice, however, DOC does not maintain the health care professional staffing necessary to provide minimally adequate and timely care to the more than 4,400 prisoners in its custody.

118. For example, Defendants' mental health staffing is grossly inadequate to serve the needs of the incarcerated population. According to DOC's public information, only four psychiatric providers (a term of art that means either psychiatrists or advanced practice psychiatry nurse practitioners who are qualified to prescribe and manage psychotropic medications) serve the entire state prison population; as of October 2024, DOC staffing for all mental health-related positions had a 50 percent vacancy rate.

119. DOC also does not have enough custody staff to escort and transport incarcerated people to health care encounters, both within facilities and at community medical facilities.

120. The health care staff that Defendants employ (in addition to being insufficient in number) are also not adequately trained or qualified to meet incarcerated people's health care needs, and they lack essential knowledge on clinical guidelines. Defendants rely on lower-level health care staff to make diagnostic and treatment decisions that greatly exceed their training, qualifications, and/or licensure. Defendants' failure to maintain adequate numbers of sufficiently trained health care staff exacerbates the substantial risk of serious harm to Plaintiffs and class members.

121. When class members do receive care, it is often compromised by the inadequate training and supervision of overextended medical staff. For example, DOC medical staff failed to recognize that Plaintiff Christiansen's prolonged diarrhea required particularized care. DOC did

not order stool testing for 10 months, and never ordered testing for anemia, nutritional deficits, or colonoscopy, which are indicated for diarrhea lasting more than four weeks.

122. Plaintiff Holt repeatedly presented with recurrent abscesses, but DOC medical staff failed to order the culture of the abscesses nor recognize that she was likely colonized by MRSA, which requires a prolonged course of antibiotics and repeat testing.

123. Similarly, medical staff at a different DOC facility never cultured the abscess fluid of an incarcerated man that presented with recurrent abscesses, as is recommended for all abscess patients.

124. Another incarcerated man presented with severe pain less than a year after having surgery for a bimalleolar fracture, in which both the tibia and fibula (the large bones in the lower leg) are broken. DOC staff failed to order a physical exam or imaging, even though one-fifth of patients who undergo this surgery develop major post-surgical complications and one-third require reoperation. The man was not seen by an orthopedist for another fifteen months, at which time surgery was recommended to remove hardware inside the ankle and fuse the bones.

125. The same man is diabetic and required injections to control his insulin levels. He expressed reluctance to medical staff to start daily injections, and requested a weekly injection. The DOC provider told him there were no weekly injectable medications that could help him. This is untrue — Ozempic has been used in the United States for this purpose since 2017, and is on the formulary at the facility.

126. As another example, after one man injured the big toes on both his feet, a DOC nurse provided wound care, but medical staff failed to prescribe antibiotics for six weeks, despite signs of infection, because the lower-level medical staff person dismissed it as a "foot fungus."

Left untreated, the infection quickly progressed and, days after his release from DOC custody, the man required emergency care and had to have the big toes on both of his feet amputated.

B. Defendants Provide Inadequate Clinical Space for Health Care Encounters

127. Defendants provide insufficient clinical space to address the health care needs of Plaintiffs and class members. ACC, for example, only has twelve (12) infirmary beds for the approximately 800 people confined there. DOC officials reported in 2022 that "[t]he infirmary at the Anchorage Correctional Complex is full every day and there is a waiting list."

128. Ten of the thirteen DOC facilities do not have an infirmary at all.

129. The Department reported to the state Office of Management and Budget in 2022 that "Both the men's and women's mental health units are always at capacity and often over capacity. Treatment units have become stabilization units due to statewide needs and offenders are often discharged from those units with minimal interventions other than stabilization in order to make room for new, more acute cases."

130. Eight of the thirteen DOC facilities do not have any mental health units.

131. In legislative testimony, former DOC HARS Director Laura Brooks estimated in 2022 that every day there are ten to fifteen men waiting for a bed at the acute mental health unit in ACC and four to five women waiting for acute care at HMCC. While these patients wait for mental health care, they typically languish in harsh isolation cells with no meaningful mental health treatment, while experiencing serious and worsening psychiatric symptoms.

132. Medical screening procedures and appointments are routinely conducted in non-confidential and unsanitary treatment spaces and hallways. People incarcerated in isolation units who receive mental health "check-ins" typically receive them through the locked door of their cell, within earshot of other incarcerated people and correctional staff, compromising confidentiality and quality of care.

133. The lack of adequate physical space in which to conduct private health care screenings and appointments results in widespread breaches of patients' confidentiality.

134. The lack of adequate physical space in which to conduct private health screenings and appointments results in dangerous and unsanitary conditions for medical care.

C. Defendants Fail to Provide Appropriate and Timely Intake Screening and Assessment

135. The failure to provide adequate health care, including mental health, medical, and dental care, begins at intake. When incarcerated people are newly admitted to DOC, the Defendants send most people to ACC. There, people are ostensibly evaluated for medical, dental, and mental health conditions. During the intake process, Defendants often fail to perform diagnostic testing, or fail to identify chronic illnesses and other serious conditions and disabilities.

136. DOC does not track or provide periodic dental, physical, mental health, and other medical testing and screening, based on factors such as age and gender, that are necessary to timely identify medical problems and to prevent otherwise avoidable pain, suffering, and death. Defendants do not properly screen incarcerated people entering the system for psychiatric, intellectual, sensory and physical disabilities, substance use disorder, or other health needs. This causes significant risk of harm by exacerbating patients' health conditions and disabilities; causing harm and injury to incarcerated people with chronic illnesses and disabilities; and placing them in inappropriate settings, which puts them at risk of deteriorating health, violence, and exploitation.

137. Because the DOC intake screening process is inadequate to identify incarcerated people with disabilities or serious or chronic health care problems, incarcerated people are at a significant risk of serious harm. For example, Plaintiff Nickalaskey entered DOC custody most

recently in September 2023. When he was previously in DOC custody, in January 2023 he was assessed with a "profound drug problem, and help obtaining appropriate treatment is absolutely necessary and should be prioritized." Despite this prior assessment of polysubstance abuse disorders, when Plaintiff Nickalaskey re-entered custody in September 2023 he was not referred to substance use disorder treatment.

138. As another example, a woman entered the DOC system with a torn meniscus, which an outside provider had told her could be treated with minor surgery. DOC did not properly evaluate her and refused to authorize surgery. Her knee pain worsened, and an MRI from February 2024 indicated that she now needs a full knee replacement. As a result of DOC's inadequate evaluation and delayed medical care, she now requires a cane to walk, has gained significant weight, and suffers from mental health problems. After she submitted a request for interview ("RFI") regarding her much-needed knee surgery, she received a non-substantive response from DOC. She was subsequently released from prison, permanently disabled from the failure to treat her knee injury, despite that it was initially a minor and repairable injury.

D. Defendants Fail to Provide Continuity of Care

139. DOC health care staff fail to evaluate and treat patients who were undergoing care for chronic or serious conditions prior to being incarcerated at DOC, or who develop such conditions while incarcerated in DOC.

140. For example, Plaintiff Gilliam was receiving medications and counseling for his serious mental health conditions prior to entering custody, which effectively managed his symptoms. But Defendants refused to continue that care, denying him any form of counseling and mismanaging his psychiatric medications. As a result, he has made several suicide attempts.

141. Plaintiff Adams complained of worsening acid reflux for years before finally receiving an endoscopy to investigate the cause. The procedure revealed H. pylori, the bacteria

most commonly responsible for upper gastrointestinal disease. Prison medical staff initiated appropriate treatment to eradicate the bacteria, but failed to order follow-up testing even though such testing is universally recognized as necessary because of H. pylori's known resistance to antibiotics.

142. DOC health care staff fail to effectively treat incarcerated people after their discharge from the hospital or infirmary and return to DOC facilities.

143. Defendants also delayed providing wound care and post-operative care to an incarcerated person who received emergency surgery for gallstone pancreatitis and ascending cholangitis (inflammation of the bile ducts). The offsite medical provider instructed Defendants to wash the incision sites with soap and water, leave wounds open to air, start Augmentin for five days, and follow up in 14 days. Defendants failed to provide further evaluation of the wound or change the dressing. Both diagnoses have high mortality rates related to complications following the procedure. The incarcerated person's wound was not assessed and his bandages were not changed until almost three weeks after the procedure.

E. Defendants Fail to Provide Timely or Adequate Access to Health Care and Specialty Health Care

144. Plaintiffs and class members often experience substantial delays in seeing DOC health care staff. When an incarcerated person brings a medical concern to DOC health care staff, it often takes months—and sometimes, years—for health care staff to see the patient for comprehensive care.

145. Incarcerated people also experience long delays before they are seen and treated by outside specialists, or are denied specialty care altogether.

146. When incarcerated people complain of symptoms that indicate severe health conditions, they are often not evaluated by a specialist in a timely manner, leading to missed diagnoses, deteriorating health, and life-threatening complications.

147. Incarcerated people experience long delays before DOC arranges for them to receive surgery at outside facilities.

148. Defendants' delays in care result in needless suffering, prolonged agony, and worsening medical conditions.

149. Incarcerated people have died because of these delays in care. One incarcerated man notified DOC medical staff when he started urinating blood. He was told to drink more water. A few days later, he was rushed to an Anchorage hospital where he died in January 2024 due to an untreated blood clotting disorder.

150. Another incarcerated person had an ear infection, about which he repeatedly notified DOC medical staff. The infection went untreated and the man developed spinal meningitis and died.

151. Defendants also fail to timely review and act on laboratory and testing results, which in turn delays patients' receipt of critical care, or it means that they receive no care at all. As a result of these deficiencies, incarcerated people with disabilities or serious or life-threatening conditions unnecessarily suffer and are put at substantial risk of serious harm.

152. Defendants failed to provide timely diagnosis and care to Plaintiff Whitlow, who is diagnosed with ulcerative colitis. As a result, his illness was exacerbated and advanced to the pre-stages of colon cancer.

153. Defendants delayed for at least two years providing Plaintiff Ephamka, who has severe cataracts in both eyes and 20/400 vision, with cataract surgery and glasses, despite their

own recommendation in 2022 that treatment be provided. This led him to significant limits on his activities of daily living, as well as significant risks to his safety, as a result of his impaired vision.

154. Defendants failed to diagnose Plaintiff Shirley's severely torn meniscus for over three months. After even further delays and months of debilitating knee pain, Mr. Shirley finally underwent surgery, more than a year after he first informed DOC medical staff of pain. Because of the lengthy delay and his worsening condition, his meniscus could not be repaired, ultimately requiring a partial removal.

155. Defendants delayed at least six months in providing cancer treatment to an incarcerated person who was diagnosed with prostate cancer.

156. Defendants delayed testing Plaintiff Adams for H. pylori, during which time he experienced stomach pains, was unable to keep food down, and consequently, lost substantial weight in a short period of time.

157. After another incarcerated man who is elderly went into heart failure, responding staff used a defibrillator to revive him. The shock of the defibrillator exacerbated and enlarged his existing abdominal hernia, causing it to begin frequently bulging out of his abdomen. DOC medical staff failed for months to address this condition, causing pain and discomfort as the man was forced to repeatedly push his protruding hernia back into his abdominal cavity. While he eventually did get the hernia repaired after almost a full year of requesting care, he suffered pain and restriction of movement for months, which exacerbated his already extensive history of medical complications.

158. This same man experienced long delays and failure to care for, or refer him out for specialty care for, his cardiac and pulmonary disease—including heart failure and blockages,

chest pain, chronic obstructive pulmonary disorder, fainting, dizziness, uncontrolled hypertension, and chronic fatigue. This has caused him continuing harm and puts him at risk of injury and death.

159. Defendants delayed transporting an incarcerated person with in-remission stage three colon cancer to have his chest port flushed. The chest port, which was implanted for his previous cancer treatment, must be flushed monthly to avoid infection.

160. Defendants delayed diagnosing an incarcerated person with tuberculosis, pneumonia, and COVID-19 for an entire year even though he was exhibiting fever, weight loss, headaches, shortness of breath, and coughing up blood. He has since died.

161. Defendants delayed scheduling an ostomy reversal surgery for an incarcerated woman for 11 months, even though a surgeon at Alaska Regional Hospital stated the surgery was necessary within one to two weeks. During these 11 months, the woman was admitted to an emergency room on multiple occasions and nearly died from septic shock due to complications with her ostomy.

162. Defendants failed to refer an incarcerated person for surgery for seven months, even though he presented with an abscess near his anus that was extremely painful and recurring. The man's presentation suggested a fistula, which was confirmed by the eventual surgery, but the providers failed to refer him for CT imaging. Prior to the surgery, medical staff treated him with repeated incision and drainage of the abscess without administering a local anesthetic. This was an extreme departure from the standard of care and subjected the man to severe, unnecessary pain.

163. For years, Defendants failed to refer a woman with severe degeneration in her hip to be seen by a specialist. During this time, she reported extreme pain, began using a walker, and

requested a wheelchair. After a year and a half of unnecessary pain and suffering, she was finally referred to a physical therapist to start treatment and strength training.

F. Defendants Fail to Provide Adequate Treatment For Chronic Disease

164. Defendants do not adequately provide care for incarcerated people with chronic conditions.

165. DOC medical staff fail to provide adequate monitoring and follow-up appointments for people with chronic health conditions, who require regular monitoring of blood pressure, blood sugar levels, cholesterol, and more. Medical staff's failure to schedule regular check-ups and provide and monitor necessary treatment plans has led to dangerously unmanaged and mismanaged chronic conditions.

166. For example, DOC failed to provide regular and routine care to Plaintiff Olrun, who has type 2 diabetes, including consistent blood sugar testing. This failure to manage her chronic disease caused her to enter a diabetic coma and be hospitalized for six days.

167. Defendants failed to treat Plaintiff Holt's painful recurrent abscesses effectively, causing numerous infections that, if left untreated, can progress into life-threatening complications like endocarditis (infection of the heart valves), bacteremia (infection of the blood), and osteomyelitis (infection of the bone).

168. Defendants failed to provide appropriate care to an incarcerated person with early onset dementia and a traumatic brain injury, putting him in a vulnerable position and at risk of substantial harm.

169. Defendants provided inadequate treatment to an elderly incarcerated man who has chronic heart disease, which exacerbated his medical condition, including going into cardiac arrest and suffering a hernia from use of a defibrillator after he went into cardiac arrest.

170. Defendants improperly incarcerated the same man in an isolation unit after he fainted instead of sending him to be evaluated and treated by medical staff, causing him to suffer broken ribs and a worsening hernia from a fall he experienced after fainting, as well as the suffering and harm caused by isolated confinement.

171. Defendants repeatedly advised a woman with a history of kidney failure to take non-steroidal anti-inflammatory drugs ("NSAIDs") for her osteoarthritis, even though NSAIDs are contraindicated because of her history of renal disease.

172. Defendants similarly provided inadequate care to an incarcerated man who had contracted tuberculosis and later died. Although the man received initial medication, he repeatedly asked for additional care because of his difficulties breathing and rapidly diminishing weight, yet DOC medical staff only offered him inhalers and a nebulizer. The man died in November 2024 of complications related to tuberculosis.

173. For years, Defendants have failed to diagnose and treat Plaintiff Adams's chronic neurological pain caused by a prior injury to his vertebrae. Specifically, they prescribed Tylenol and Motrin (which he had to purchase from the commissary) and offered a list of physical therapy exercises for worsening pain and numbness, but failed to provide MRI or CT imaging, spinal injection, or other appropriate evaluation and treatment to properly diagnose and treat neuropathy, herniated discs and "severe limitation" in his lumbar function. He remains in chronic, worsening pain.

174. Defendants have failed to provide Plaintiff Ephamka with treatment as his cataracts worsened. Over the course of at least two years, Defendants delayed providing surgical evaluation and surgery despite acknowledging that surgery is needed and that eyeglasses will not correct his lack of vision.

175. Defendants have failed to provide adequate care for Plaintiff Vail's chronic inguinal hernia. Over several years, despite worsening testicular pain, enlargement of the hernia, and interference with his ability to climb to a top bunk or exercise, Defendants repeatedly denied surgical evaluation, despite the chronic hernia having progressed to require it.

G. Defendants Fail to Provide Adequate Emergency Health Care

176. DOC medical staff fail to timely and appropriately respond to emergency medical situations and requests for emergency medical treatment from incarcerated people.

177. DOC medical staff regularly misdiagnose or minimize life-threatening emergencies, which has led to suicide attempts, seizures, diabetic shock, heart failure, and more.

178. In May 2023, for example, Defendants failed to recognize that Plaintiff Olrun should have been transferred to emergency care immediately when she presented with an extremely high blood sugar reading, blurry vision, heartburn, numbness and stabbing pain to her right knee, and bilateral calf cramping. Instead, medical staff simply restarted insulin therapy. They did not order blood tests nor refer her for evaluation of her dangerously high blood sugar levels.

179. As described above, DOC failed to provide adequate emergency care for Plaintiff Shirley's dental emergency.

180. As described above, DOC failed to provide adequate emergency care for Plaintiff Whitlow's medical emergency after his ileostomy bag was ripped off.

181. In April 2024, an incarcerated man began complaining of stomach pain and started vomiting. One custody officer, who is a former emergency medical technician, insisted that an ambulance be called for the man. DOC medical staff refused the custody officer's request to call an ambulance, stating their belief that the man was faking his symptoms. The man died a few hours later.

182. DOC custody staff are not adequately trained to respond to medical or mental health emergencies. DOC custody staff often fail to adequately respond or call for medical help promptly when there are medical emergencies, when timely medical intervention is most critical. DOC does not provide adequate training, policies, or procedures for custody staff who respond to health care emergencies.

183. For example, custodial staff routinely respond to individuals having seizures with physical force, including by putting them in handcuffs. This has occurred even when incarcerated individuals repeatedly provided documentation of their seizure disorder to health and custodial staff.

184. One incarcerated person, for example, had a burst appendix in 2024, and repeatedly notified custodial staff of his pain and need for care. Custodial staff refused to call for medical care, accusing him of faking his condition. He had to wait over eight hours until a new shift of custodial staff arrived and agreed to call for medical care.

185. Another incarcerated man, who had mental illness, tried to castrate himself in late 2023 while he was held in solitary confinement by tying a rubber band around his testicles. Several people in nearby cells reported the situation to custodial staff, including the smell of rotting flesh. DOC staff waited three days before taking the man to the emergency room.

H. Defendants Fail to Maintain an Adequate and Secure Medical Records System

186. An adequate medical records system is an essential element of correctional health care. Defendants fail to maintain an adequate medical records system.

187. Defendants' system for tracking medical information for class members routinely omits vital information, including records and communications from outside medical providers.

This has resulted in DOC health care staff failing to know the medical history, diagnoses, and treatment status of their patients.

188. Defendants fail to properly track requests for medical care, resulting in Defendants' failure to provide diagnosis or care in response to patient requests.

189. Defendants fail to properly protect the Personal Health Information ("PHI") of class members, including failing to adequately supervise entities contracted to provide health care services, in violation of federal and state medical privacy laws. For example, the PHI of more than 70 individuals currently or formerly incarcerated at DOC was published online by NaphCare, the company with which DOC contracts to administer DOC's medical records system. This information remained online and publicly accessible for months, and possibly years. In November 2024, in response to a complaint filed by Plaintiffs' counsel, the U.S. Department of Health & Human Services opened an investigation into DOC and NaphCare to determine whether they had violated the Health Insurance Portability and Accountability Act (HIPAA), and if so, what penalties should be assessed against the State and NaphCare.

190. Defendants restrict the ability of class members to access their own medical records. To obtain their medical records (which are kept electronically and therefore any production involves printing from a computer record, rather than copying a physical file), an incarcerated individual must submit a request and pay a fee — $20 for the first ten pages, and $0.25 for each page thereafter. Upon information and belief, this rate is one of the highest costs for medical records of any state correctional system in the U.S. To the extent that incarcerated people in DOC are employed in prison jobs, they are paid between 30 to 90 cents per hour. DOC Policy 812.02. Therefore, at the average hourly pay rate of 60 cents per hour, it would take a person incarcerated in DOC more than 33 hours of work to purchase ten pages of documents

from their medical record. Even when incarcerated people are able to pay for records, they must often wait months to receive them.

I. Defendants Do Not Allow Class Members to Grieve Health Care Issues Properly

191. DOC does not provide a reliable way for incarcerated people to file a grievance when health care is denied. DOC routinely fails to respond to grievances, or responds days or weeks after their submission, even when the grievance indicates an urgent need for health care.

192. DOC dissuades individuals from filing grievances. At one facility, when incarcerated people asked for grievance forms, corrections officers instead have distributed a fake document entitled "Hurt Feelings Report." The fake Report asks the name of the "Whiner", asks whether they want their "mommy", and requests them to "tell us in your own sissy words how your feelings were hurt."

J. Defendants Fail to Provide Necessary Medications

193. DOC fails to maintain an appropriate or adequate formulary of medications and to establish and implement appropriate policies and procedures for medication management and distribution to incarcerated patients. As a result, patients are prescribed inappropriate medications that are ineffective to treat their illness, or may present side effects that cause complications or dangerous interactions.

194. DOC health care staff regularly provide incarcerated people with incorrect dosages and improper titration of medication for serious health conditions.

195. DOC regularly discontinues medications abruptly and without notice to the incarcerated person, and without supervision by appropriate health care staff, leading to dangerous episodes, including seizures and psychiatric decompensation, that could harm the incarcerated person.

196. For example, DOC staff abruptly cut off Plaintiff Gilliam's mental health medications after he told the clinician they were not working and that he was experiencing side effects. He was not provided follow-up to start other medications, became depressed, and began experiencing insomnia and nightmares.

197. Plaintiff Christiansen elected to stop taking Prazosin, a medication he was prescribed for nightmares related to his PTSD, because it risked dangerous interaction with a medication he was prescribed for improved kidney function. When he complained that his nightmares were worsening and requested a new medication, DOC refused to prescribe one of the many alternatives that exist.

198. One man was not given his seizure medication at the appropriate intervals because he was in punitive segregation. He had multiple seizures in one week and had to be transported to a hospital emergency room.

199. DOC improperly reduced the medications prescribed by the U.S. Department of Veterans Affairs ("VA") to an incarcerated military veteran that help stabilize his serious psychiatric disorders, and discontinued a number of his medications altogether.

200. For the same patient, Defendants improperly changed medications, resulting in him decompensating and suffering from schizophrenic episodes.

201. DOC also improperly reduced the medications prescribed by the VA for another incarcerated military veteran who suffers from PTSD and anxiety.

202. Another incarcerated man with schizophrenia had his psychotropic medication abruptly stopped because DOC medical providers failed to renew it. He began experiencing mental health symptoms and kicking the door of his cell. He was pepper-sprayed multiple times by correctional staff. Following this incident, DOC put him back on his psychotropic medication

at twice the dosage he received previously. After a few weeks, the man asked to have his dosage adjusted because he was sleeping all day. He submitted the request to lower the dosage in December 2024, but DOC told him he could not discuss medication changes until seeing the provider three months later, in March 2025.

203. Defendants denied keep on person ("KOP") medication so that an incarcerated person with a seizure disorder could take the medication as needed to prevent seizures, thus placing him at risk of harmful seizures and of being subjected to uses of force by DOC custodial staff, who often respond to seizures with uses of force.

204. Defendants refused to provide answers to questions about interactions and side effects of psychotropic medication to an incarcerated person diagnosed with PTSD and depression, making it impossible for him to meaningfully consent to treatment. As a result, he/she is not receiving any medication for his/her psychiatric disorders.

K. Defendants Fail to Provide Evidence-Based Treatment for Substance Use Disorder

205. Defendants fail to provide necessary medication-assisted treatment (MAT) for incarcerated people with substance use disorders, including medications for opioid use disorder (MOUD) such as methadone and buprenorphine (brand name Suboxone). Despite MOUD being the only effective treatment for OUD and dramatically reducing the risk of relapse, overdose, and death, Defendants' written policy only provides MOUD for a short time to people who enter custody with an active prescription from a community provider. DOC does not provide MOUD treatment for anyone else, even those with a diagnosed OUD, who require the treatment.

206. Plaintiff Nickalaskey, who suffers from polysubstance use disorder and has acknowledged using opioids and experiencing several overdoses, has been denied MOUD and any other MAT by DOC.

207. People who received MOUD treatment in the community before entering DOC are routinely placed in segregation and incur disciplinary infractions for having opiates in their urine during DOC drug tests, although these opiates are the result of their prescribed medication. When community MOUD providers have contacted DOC to explain that their patients' treatment will result in urine tests that are positive for opioids, the DOC facility staff often refuse to speak with them or to change disciplinary write-ups.

208. The National Commission on Correctional Health Care and the National Sheriffs' Association strongly support MOUD in jails and prisons, calling MOUD "a central component of the contemporary standard of care for the treatment of individuals with [OUD]." Many local jails and state prisons throughout the country routinely provide MOUD to people in their custody throughout the duration of their incarceration.

209. Even for people who enter DOC with an active MOUD prescription, DOC often inappropriately changes the medication they are given.

210. Under Defendants' policy, DOC arbitrarily cuts off the medication for those with an active MOUD prescription after 30 days, with no individualized assessment of the person's medical need, and despite evidence that for many people, MOUD is necessary for years or even a lifetime. In one instance, this sudden, arbitrary, and forcible termination of MOUD resulted in an incarcerated woman going through withdrawal just as her criminal trial was starting. She vomited and fainted at the courthouse, and her trial had to be postponed.

211. Because of Defendants' failure to provide necessary MOUD, incarcerated people have experienced painful and unnecessary withdrawal. When one man receiving MOUD treatment in the community was remanded to custody, DOC took him to an outside MOUD

clinic only one time. He was never provided MOUD again, and was thus forced to go through excruciating withdrawal symptoms, which caused him to be hospitalized for several days.

212. These withdrawal symptoms and opioid cravings are especially dangerous for people in a jail or prison setting. As described above, Plaintiff Nickalaskey had overdosed five times before entering DOC custody. Additionally, for those who are about to be released, denial of MOUD not only violates the standard of care, but it also makes these people many times more likely than the general population to die of an overdose in the weeks following release.

L. Defendants Deny Access to Assistive Devices, Medical Supplies and Appliances

213. Defendants control whether incarcerated people are authorized to have medically essential devices, including but not limited to: artificial limbs, eyeglasses, contact lenses, dentures, hearing aids, and orthopedic shoes. DOC Policy 807.15.

214. Defendants control whether incarcerated people are authorized to have durable medical equipment, including but not limited to: CPAP/BiPAP machines, oxygen equipment, breast pumps, wheelchairs, walkers, crutches, and canes. DOC Policy 807.15.

215. On at least two occasions DOC staff took away Plaintiff Vail's hernia belt. Mr. Vail was forced to go without a hernia belt until in one instance a DOC provider ordered a new belt and in another instance a DOC provider ordered that his belt be retrieved from Property and returned to him.

216. Numerous incarcerated people, including Plaintiff Ephamka, have had eyeglasses taken away at intake to custody, because the glasses had metal frames. DOC has sometimes not provided any replacement eyeglasses for these people.

217. One man with severe hemorrhoids was seen in the emergency room and given a medical cushion because he experienced extreme discomfort when sitting on hard surfaces. Upon being transported back to DOC, staff took the cushion away and never returned it.

218. One man has had two surgeries to repair a detached retina, and his outside ophthalmic surgeon submitted multiple requests to DOC for the man to be given sunglasses. DOC continues to deny the sunglasses.

219. Defendants refused to provide hearing aids to a man with hearing loss, saying the denial was because of his pre-trial status.

220. An incarcerated man was denied a CPAP machine—necessary to treat his severe obstructive sleep apnea—for weeks after his machine broke in October 2024. Defendants first told him it would take weeks to repair the machine, although DOC medical staff knew the man needed the CPAP to breathe at night, then informed him he must undergo a sleep study before they would authorize a replacement machine. Without the CPAP, this man had great difficulty breathing at night for weeks and indeed, stopped breathing completely several times while sleeping. DOC staff finally provided a working CPAP machine in January 2025.

221. When incarcerated people are transferred between facilities, their medical devices --- including hearing aids, dentures, and medical shoes --- are routinely lost or misplaced. Even if they do eventually receive their medical device, individuals often go without the device for a month or more.

M. Defendants Fail to Provide Adequate Dental Care

222. Defendants' policy and practice of failing to provide adequate care and having insufficient staffing and resources extends to dental care. Defendants' policies and practices for dental care are inadequate, subjecting Plaintiffs and class members to a substantial risk of tooth loss, unnecessary infections, suffering, serious injury, clinical deterioration, or death. Defendants

have knowledge of these inadequate policies and practices and the resulting substantial risk of serious harm and suffering to Plaintiffs and class members, but they have failed to remedy these deficiencies.

223. In 2019, the Alaska State Ombudsman opened an investigation into dental care at DOC. In their 2021 report about the investigation, the Ombudsman found that "[e]vidence reviewed during the investigation showed that DOC did not meet its obligation to provide the complainant with timely access to necessary dental health care services and failed to meet the service delivery standards established in departmental policies for the treatment of painful and emergent dental conditions. On a broader scale, this investigation found systemic deficiencies in DOC's Dental Services Program preventing the Department from providing dental health care services across all facilities adequate to meet the level of need that exists among the prison population."

224. To remedy deficiencies in dental care, in 2021 the Ombudsman recommended an internal audit of DOC dental services, the creation of an action plan to reduce the number of patients waitlisted and reduce wait times, the revision of departmental policy to include specific timeframes for dental services, and other recommendations related to staffing and funding new positions. Upon information and belief, none of these recommendations were implemented.

225. The Alaska State Ombudsman initiated another investigation into dental care at DOC in 2023, following further complaints from incarcerated people that they were not receiving dental care. In the 2024 report outlining their second investigation and findings, the Ombudsman again found that DOC was not meeting its legal obligation to "maintain health" and "provide necessary medical services for prisoners in correctional facilities or who are committed by a court to the custody of the commissioner."

226. The 2024 Ombudsman Report looked closely at the dental care being provided at the largest DOC facility, Goose Creek Correctional Center (GCCC).

227. The 2024 report found that "[c]urrent resources only allow the GCCC Dental Program to extract teeth and fight infection. Routine exams, cleanings, fillings, and making dentures are not currently performed."

228. Defendants' policies, procedures, and practices do not provide for routine dental screening nor annual and other periodic dental examinations and treatment necessary for dental health and to avoid pain, suffering, and dental disease.

229. The 2024 Ombudsman Report also investigated the provision of dentures by DOC, finding that "while a denture waitlist is maintained, the wait time is now years long, and progress is not being made on the list because of limited staff and prioritizing more urgent dental treatment needs."

230. The 2024 report concluded that GCCC was routinely failing to respond to prisoners' requests for dental care, discouraging prisoners from filing requests for dental care, and failing to assign a neutral investigator for grievances related to dental care, as required by policy.

231. The 2024 Ombudsman Report made various recommendations, including hiring additional dental staff, providing training on the proper handling and investigation of medical grievances, and implementing the recommendations from the 2021 Ombudsman Report, which had not yet been implemented.

232. None of the 2024 Ombudsman recommendations have been implemented. Although DOC brought in temporary dental providers for approximately two months in the

middle of 2024 to see patients, the temporary dental staff are no longer on-site and the long delays and waitlists for dental care have returned.

233. Defendants' dental care consists almost exclusively of extracting teeth, even if a much less invasive procedure is medically appropriate and would preserve the tooth. Rarely are other treatments provided, such as fillings and/or root canals, rather than extraction.

234. Because of DOC's de facto "extraction only" policy, prisoners regularly face the dilemma of keeping a tooth and suffering severe pain and possible infection, or ending the pain and losing a tooth that otherwise could be saved.

235. For example, for more than two years, Plaintiff Shirley, who suffered from debilitating tooth pain, repeatedly pleaded with DOC medical staff to offer him dental treatment other than tooth extraction. DOC refused. Despite having three fractured teeth, DOC would not provide restorative treatment and he had to pull shards of tooth from the inside of his mouth with a tweezer in order to eat. Because the sharp edges of fractured teeth continuously cut his lips, he developed extensive sores on his inner lips that later needed suturing and caused constant pain and further deterioration of his oral health. As described above, Mr. Shirley ended up losing teeth that might have been repaired.

236. Extractions of teeth that could be salvaged are so common that many prisoners will not visit the dentist because they know the DOC will pull their teeth, regardless of the underlying problem.

237. Defendants' refusal to provide dental care other than tooth extraction deters incarcerated people from seeking dental care and leads to some taking matters into their own hands. For example, at least two incarcerated men have filed down a tooth with a nail file

because the tooth was cutting into their gums. Plaintiff Naomi Holt had to use a pair of clippers and a nail file to shave off part of her denture that was causing her pain.

238. Defendants do not regularly provide dentures, and when they do, there are years-long delays. This causes incarcerated people to have difficulty eating, which risks poor nutrition, extreme weight loss, pain, and damage to the jaw bones. Not being able to properly chew their food or relying upon "soft diets" also places people without teeth or dentures at risk of choking or aspiration of their food.

239. The 2021 Ombudsman Report concluded that long delays in dental care "were the result of a shortage of DOC dentists and program resources." Across DOC, there was one dentist for every 720 patients. Upon information and belief, the number of dentists has not increased since then.

240. Incarcerated people continue to wait years for the provision of dental care, including acute dental needs.

241. Defendants have failed to provide dentures for Plaintiff Adams, who has no teeth, despite their legal obligation to do so. Although Mr. Adams was evaluated as a "likely candidate" for dentures, the hygienist informed him that the process to obtain dentures was long, with no guarantee of the wait time. His complete lack of teeth does not allow him to maintain adequate nutrition.

242. Plaintiff Rory Vail, suffering chronic pain and difficulty chewing caused by untreated dental cavities and gum disease, waited months even for evaluation. His cavities manifest as tooth decay and breakdown because of bacterial infection, and the periodontitis destroys the gums and the outer tooth layer, resulting in loose and damaged teeth and placing him at risk of other infections and sepsis. Defendants failed to provide Mr. Vail with needed

fillings because while he was waiting for fillings, a DOC dentist pulled several of his teeth because the dentist determined that his teeth deteriorated to the point that fillings were no longer a viable option.

243. Defendants delayed providing dentures for an incarcerated person for so long that he has chronic pain in his jaw and impaired hearing on his right side.

N. Defendants Fail to Provide Adequate Mental Health Care

244. Mental health care in DOC is virtually nonexistent. Defendants offer no counseling or therapy for many incarcerated people with serious mental illnesses including schizophrenia, bipolar disorder, and PTSD, leaving them dangerously vulnerable to catastrophic decompensation.

245. When class members request mental health care, they are routinely given only workbooks or crossword puzzles in response. One incarcerated man, who had previously been suicidal, asked correctional staff, "What do I do next time I am on the verge of hurting myself?" The staff member responded, "Send me an RFI and I'll send you a list of recommended reading." Another man wrote to medical staff that he was hearing voices, and he was told he would receive reading materials.

246. Interactions with psychiatric professionals are severely limited. Incarcerated people with serious mental illness in need of close management are only seen by a mental health provider once every two or more months. These "check-in" appointments last mere minutes, and are conducted remotely via video, by a provider who is not on site. Such "video visits" make it difficult or impossible for the provider to assess the patient for involuntary movements — a frequent side effect of psychotropic medications — and are categorically inappropriate for some psychiatric patients.

247. When incarcerated people inform their provider during these check-ins that their psychiatric medication is not working to control their serious mental illness, the providers often tell them "there's nothing more we can do" and leave the issue dangerously unresolved, undermining the core function of medication management.

248. For example, Plaintiff Shirley, who suffers from PTSD and TBI related to his military service, informed DOC mental health staff that he was having auditory and visual hallucinations, along with chronic insomnia and night terrors. In response, DOC mental health staff provided no medical interventions except some talk therapy and an increase of Prazosin, a medication used to treat nightmares in PTSD patients that had not relieved his symptoms. No further intervention was considered in his treatment plan, and his PTSD symptoms continue.

249. Plaintiff Olrun requested mental health care due to high levels of stress after being transferred to a new facility, including feelings of dissociation. She was told "DOC does not provide counseling."

250. When Plaintiff Gilliam told a DOC mental health provider of his severe depression, the provider responded, "I'm only here to prescribe medication," instructing Mr. Gilliam to talk to his clinician. When Mr. Gilliam brought his depression and suicidal thoughts to his clinician, he was seen for less than ten minutes and offered sudoku puzzles and coloring books.

251. Incarcerated people receive no meaningful treatment for their mental health conditions. Mental health "treatment" often consists of superficial, routine questions (such as "how are you feeling?"), often posed by unqualified staff at cell-front or in other non-confidential settings. These drive-by encounters are an exercise in box-checking and leave patients with mental illness at serious risk of harm.

252. Incarcerated people who have anxiety disorders have been denied treatment and instead were told by staff that "everyone feels anxiety in jail."

253. As a result of inadequate staffing and facilities, Defendants provide little or no mental health treatment. There are long delays to see mental health staff. When patients are eventually seen, the mental health staff often ask only if the patient is actively suicidal. If the person says they are not, the encounter is ended; if the person says they are suicidal, they are stripped naked, given only a smock to wear, and moved into the harsh and deprived solitary confinement conditions of so-called "suicide protocol."

254. Staff routinely punish class members for symptoms of their mental illness. For example, medical staff failed to renew a prescription for psychotropic medication that an incarcerated man had successfully taken for years. When he began kicking the door of his cell in frustration, he was pepper-sprayed by staff and written up for a disciplinary report. When a woman with depression failed to get out of bed to take medications, medical staff did not refer her for mental health evaluation but instead described her as difficult and manipulative.

255. Another incarcerated man, who is a veteran with 100% disability benefits for PTSD, was cut off from all mental health medications the VA had prescribed for him when he entered DOC. He asked to see a provider at least 19 times over 10 months. When he was seen by a mental health provider, they refused to prescribe him medication for his PTSD because mental health staff said that he was not psychotic.

256. Despite being aware of Plaintiff Holt's multiple psychiatric diagnoses, DOC mental health staff failed to see her in a timely manner after she repeatedly asked for help. Delays of many months occur between her evaluations, and she is not regularly nor timely seen

by mental health providers. As a result, she has experienced depression, ruminating thoughts, auditory and visual hallucinations, and insomnia.

257. Incarcerated people with severe mental health conditions are routinely housed in dangerous conditions with no supervision. For example, two men with severe mental illness were housed together in general population at ACC. One man beat the other man to death in December 2024. According to media reports, he told investigators he was annoyed that the other man was talking to himself.

III. Defendants Deny Health Care to Pre-Trial Detainees Because of Their Pre-Trial Status

258. DOC policies and procedures provide that "[t]he same quality of care shall be provided to sentenced and un-sentenced prisoners unless, the prisoner's release date does not provide sufficient time for the prisoner to follow through to completion of an intervention or treatment and/or the request is nonurgent."

259. Defendants routinely deny medical services to pre-trial incarcerated people solely because of their pre-trial status.

260. People are routinely held in pre-trial status for *years* in DOC facilities, and pre-trial status alone is not a justifiable basis for DOC to deny health care.

261. The Alaska court system has widespread delays in resolving criminal cases, as documented by numerous media reports in recent months. This has caused the pre-trial population within DOC to balloon. As a result, more individuals are subject to DOC's policy denying medical care based on pre-trial status.

262. For example, DOC Defendants denied Plaintiff Shirley any and all dental treatment other than tooth extraction, telling him this was because he is pre-trial.

263. Defendants denied needed eye surgery to Plaintiff Ephamka, who has been in custody pre-trial for more than six years, because of his pre-trial status. As described above, although Defendants were aware for at least two years of his worsening cataracts which severely impaired his vision and ability to function, they denied him necessary cataract surgery for this reason.

264. Pre-trial incarcerated people have been denied medically necessary specialist care altogether, with DOC staff telling them the reason is that they are awaiting trial.

265. For example, DOC Defendants required a man to wait over a year to undergo a needed medial collateral ligament surgery for his knee due to his pre-trial status.

266. Plaintiff Adams, who has chronic and worsening pain from a prior spinal injury, was denied appropriate care for years as he awaited resolution of the criminal case against him because, as the provider notes, approval of that care may be dependent on his criminal case status.

267. Defendants informed Plaintiff Vail, who has been denied surgery evaluation for a worsening and enlarging hernia, that he may not receive this needed medical intervention because he is awaiting resolution of the criminal case against him.

268. Defendants refused to provide hearing aids to a man with hearing loss, saying the denial was because of his pre-trial status.

269. One incarcerated man had severe back pain and was told by a medical provider that he needed back surgery. Defendants refused to provide surgery because the man was pre-trial. Instead, in 2023, the man was left in solitary confinement for weeks without care, lying in his own excrement and unable to walk because of his severe back pain. The man died by suicide in April 2023.

IV. Defendants' Custody Practices Impede or Deny Health Care

270. Defendants' policies and practices, including custody operations practices, impede the timely delivery of health care, or result in the denial of health care to Plaintiffs and class members.

271. Defendants' policies and practices have the effect of punishing incarcerated people for receiving off-site medical care. At many facilities, when an incarcerated person has an off-site medical appointment, they are often forced to move to medical segregation for days or weeks at a time prior to the appointment. This results in people losing jobs, access to programming, legal paperwork, housing location, and property. To avoid these consequences, many incarcerated people have declined necessary medical care, including surgery, MRIs, and colonoscopies.

272. Defendants refused to transport one man to appointments for his MOUD treatment after he was accused of having (non-drug related) contraband in his cell. It is dangerous and wholly inappropriate to cut off a patient's medication as summary punishment for having contraband in a cell. As a result of this punishment, the man was forced to go through painful opioid withdrawal alone in segregation. He asked custodial staff for a RFI form so he could request help from medical staff during the withdrawal, but staff members told him that no RFI forms were available. When he was eventually seen by medical staff, the DOC nurse said she was going to start the protocol for opioid withdrawal. A nearby officer overheard the encounter, intervened, and told the nurse that he would not allow her to provide him care, and returned the man to segregation where he continued to experience painful withdrawal symptoms.

CLAIMS FOR RELIEF

First Cause of Action

(All Plaintiffs v. All Defendants)
(42 U.S.C. § 1983; Eighth Amendment)

273. By their policies and practices described in this Complaint, Defendants DUNLEAVY, WINKELMAN and WELCH subject all Plaintiffs and the proposed Plaintiff Class to a substantial risk of serious harm from inadequate health care, including medical, mental health, and dental care. These policies and practices have been, and continue to be, implemented by Defendants and their agents, officials, employees, and all persons acting in concert with them under color of state law, in their official capacities, and are the proximate cause of the Plaintiffs' ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

274. Defendants have been and are aware of all of the deprivations complained of herein, and are deliberately indifferent to the substantial risk of serious harm posed by these deprivations.

275. Plaintiffs and the proposed Class have suffered and will imminently suffer irreparable injury as a result of Defendants' policies, practices, and failures to act, and are entitled to injunctive relief to avoid any further injury.

Second Cause of Action

(Plaintiffs Vail, Nickalaskey, Shirley, Ephamka, and Whitlow on behalf of themselves and the Pre-Trial Plaintiff Subclass v. All Defendants)
(42 U.S.C. § 1983; Fourteenth Amendment)

276. By their policies and practices described in this Complaint, Defendants DUNLEAVY, WINKELMAN and WELCH violate their duty to provide adequate health care to people incarcerated pre-trial, including medical, mental health, and dental care, and demonstrate

deliberate indifference to a substantial risk of serious harm to subclass Plaintiffs and members of the proposed Subclass, in violation of their rights under the Fourteenth Amendment to the U.S. Constitution.

277. Defendants' actions also constitute punishment of subclass members, who are not convicted of the crimes charged that resulted in their detention, in violation of their rights under the Due Process Clause of the Fourteenth Amendment.

278. Subclass members have suffered and will imminently suffer irreparable injury as a result of Defendants' policies, practices, and failures to act, and are entitled to injunctive relief to avoid any further injury.

PRAYER FOR RELIEF

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

280. WHEREFORE, Plaintiffs and the class and subclass they represent request that the Court grant them the following relief:

a. Declare that the suit may be maintained as a class action pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(1) and (2);

b. Adjudge and declare that the acts, omissions, policies, and practices of Defendants, and their agents, employees, officials, and all persons acting in concert with them under color of state law or otherwise, as described

herein, violate the rights of Plaintiffs and the class and subclass they represent under the Eighth Amendment and the Fourteenth Amendment;

c. Preliminarily and permanently enjoin Defendants, their agents, employees, officials, and all persons acting in concert with them under color of state law, from subjecting Plaintiffs and the class and subclass they represent to the illegal and unconstitutional conditions, acts, omissions, policies, and practices set forth above;

d. Order Defendants and their agents, employees, officials, and all persons acting in concert with them under color of state law, to develop and implement, as soon as practical, a plan to eliminate the substantial risk of serious harm suffered by Plaintiffs and the class and subclass they represent as a result of Defendants' inadequate medical, mental health, and dental care. Defendants' plan shall include at a minimum the following:

i. Staffing: Staffing shall be sufficient to provide Plaintiffs and the Class and Subclass with timely access to qualified and competent clinicians who can provide routine, urgent, emergent, and specialty health care;

ii. Timely Access to Care: Policies and practices that provide timely access to on-site and off-site health care in response to patients' requests for treatment, as medically indicated, and without regard to the patient's legal status as pre-trial or post-conviction;

iii. Screening: Policies and practices that reliably screen for medical, dental, and mental health conditions that need monitoring or treatment;

iv. Medication and Supplies: Timely prescription and distribution of medications, supplies, and medical/assistive devices needed to provide adequate medical, dental, and mental health treatment;

v. Emergency Response: Timely and competent responses to health care emergencies by health care and custody staff;

vi. Chronic Care: Timely access to competent and appropriate care for chronic diseases;

vii. Mental Health Care: Timely access to competent and appropriate treatment for serious mental illness, including medication, therapy, inpatient treatment, suicide prevention, and suicide watch;

viii. Dental Care: Timely access to competent and appropriate treatment for dental problems, including medication, X-rays, fillings to reduce the need for extractions, and dentures;

ix. Quality Assurance: A regular assessment of health care staff, services, procedures, and activities designed to improve outcomes, and to identify and correct errors or systemic deficiencies. Such a Quality Assurance system necessarily includes a functional grievance system, whereby incarcerated people are able to access a grievance system that provides timely and substantive responses to

grievances, without retaliation or punishment for using the grievance process;

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

f. Retain jurisdiction of this case until Defendants have fully complied with the orders of this Court and there is a reasonable assurance that Defendants will continue to comply in the future without continuing jurisdiction;

g. Appoint the undersigned counsel as class counsel pursuant to Federal Rule of Civil Procedure 23(g); and

h. Award such other and further relief as the Court deems just and proper.

RESPECTFULLY SUBMITTED, this 1st day of May, 2025.

/s/ *Ruth Botstein* .
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* *pro hac vice* motion forthcoming.
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*** District Court admission forthcoming.