**UNITED STATES DISTRICT COURT**
**NORTHERN DISTRICT OF ILLINOIS**
**EASTERN DIVISION**

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| Keith Rogers, *et al.*, | ) | |
| | ) | |
| Plaintiffs, | ) | |
| | ) | No. 15-cv-11632 |
| *-vs-* | ) | |
| | ) | Hon. Edmond E. Chang |
| Sheriff of Cook County and Cook County, | ) | |
| | ) | |
| Defendants. | ) | |

**DEFENDANTS' ANSWER TO PLAINTIFFS' RULE 56.1(a)(2) STATEMENT OF UNCONTESTED FACTS (Dkt. 300)**

Defendants Cook County and Sheriff Thomas Dart, by their attorney Eileen O'Neill Burke, Cook County State's Attorney, through her respective Assistant State's Attorneys, and in answer to Plaintiff's Rule 56.1(a)(2) Statement of Uncontested Facts (Dkt. 300) states as follows[1]:

1. Opioid use disorder ("OUD") is a chronic disease with symptoms characterized by uncontrollable cravings for opioids, loss of control, increased tolerance to opioids, and withdrawal symptoms. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3.)

**ANSWER:** Not disputed.

2. The most serious risks of OUD include overdose and death: Over a thousand people in Cook County die each year from opioid overdose; 467 persons died in the

[1] Defendants' answers are for the purposes of summary judgment only, and do not preclude challenging any of Plaintiffs' assertions at a later hearing, trial, or proceeding.

first six months of 2021 in Chicago. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3.)

**ANSWER:** Not disputed. Defendants object to the relevance of 2021 statistics when the relevant time period for this suit is December 23, 2013, to July 1, 2017.

3. Withholding medication or tapering medication from someone with OUD triggers symptoms of withdrawal and increases the risk for relapse. Withdrawal and relapse are serious and potentially dangerous medical conditions that require appropriate medical attention. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3.)

**ANSWER:** Disputed. Plaintiff cites no support for the general contention that a diagnosis of OUD creates a risk of withdrawal when tapering or stopping medication generally. Plaintiff also challenges the relevance of medications for opioid use disorder (MOUD) other than methadone to this lawsuit. Dkt. 284 at ¶¶ 10-11. Further, this lawsuit does not concern methadone prescribed for any purpose other than treating OUD.

In the specific context of tapering methadone prescribed for OUD, Dr. Fatoki testified that not every patient who is tapered off methadone suffers from withdrawal symptoms. Dkt. 302, Plaintiffs' Statement of Facts ("PSOF") Ex. 12, Fatoki Dep. at 103:12-14. Dr. Mangat also testified that not every patient who is tapered suffers withdrawal symptoms. Dkt. 302, PSOF Ex. 11, Magnat Dep. at 76:12-13. Even for patients who suffer withdrawal, some withdrawal symptoms are mild and not serious. Dkt. 276, Defendants' Statement of Facts ("DSOF") at ¶¶ 32, 33, 41, 52, 53, 54, 56, 57, 60. Dr. Fatoki testified that withdrawal symptoms are "just like – it's just like having a bad case of the flu. They will

be ok." Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 41:11-13. The use of Medication for Opioid Use Disorder ("MOUD") for detoxification or medically supervised withdrawal from opioids is a well-recognized treatment protocol. Dkt. 276, DSOF at ¶¶ 16-18. Among the reasons that methadone in particular is so highly regulated are the risks of abuse and the danger of potential overdose. *Id.* at ¶ 16.

4. Tapering patients off methadone during incarceration destabilizes the patient and significantly increases the risk of relapse and overdose upon release back into the community. (Plaintiffs' Exhibit 21, Fatoki Report at 2.)

**ANSWER:** Disputed. Dr. Fatoki is not aware of any named Plaintiffs or patients who suffered any overdoses after undergoing tapering at CCDOC. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 95:15-96:6. Dr. Fatoki also testified maintenance programs can be problematic in jail settings because inmates can give their medication to other detainees, leading to overdose, and detainees may be transferred to facilities without maintenance programs where they would then be forced to quit "cold turkey". *Id.* at 97:3-98:18. Dr. Fatoki testified that tapering is better than "cold turkey", and that during the class period he worked at facilities that did not provide any methadone treatment at all to inmates. *Id.* at 128:9-130:1. The use of MOUD for detoxification or medically supervised withdrawal from opioids is a well-recognized treatment protocol. Dkt. 276, DSOF at ¶ 18. Among the reasons that methadone in particular is so highly regulated are the risks of abuse and the danger of potential overdose. *Id.* at ¶ 16. Stating further, the record shows that two of the three named Plaintiffs chose to get off of methadone. *See* below, Answers to PSOF ¶¶ 35,

41.

5. The consensus in the medical community since at least 2007 is that opioid use disorder is a chronic brain disease and patients need to be maintained on their treatment. (Plaintiffs' Exhibit 21, Dr. Fatoki Dep. 106:13-23.)

**ANSWER:** Disputed. The above-cited testimony was in the context, according to Plaintiff's expert, of the consensus that maintenance has better outcomes than tapering, and not that, as an absolute matter, patients need to maintain their treatment. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 105:18-106:23; 1-2:15-20. Dr. Fatoki testified that maintenance is a relatively novel form of treatment as opposed to tapering. *Id.* at 106:3-8. Dr. Fatoki testified that tapering is a common treatment some patients choose to undergo, and which Dr. Fatoki himself has engaged in. *Id.* at 43:2-46:17; 105:18-106:8. Dr. Fatoki further testified that tapering is better than "cold turkey", that during the class period he worked at facilities that did not provide any methadone treatment at all to inmates, and that during the class period less than 5% of correctional facilities were providing any kind of treatment. *Id.* at 128:9-130:1. The use of MOUD for detoxification or medically supervised withdrawal from opioids is a well-recognized treatment protocol. Dkt. 276, DSOF at ¶ 18. Stating further, Defendants refer to their own Statement of Facts detailing the extraordinary and exemplary nature of CCDOC's methadone program during the relevant class period. Dkt. 276, DSOF at ¶¶ 16-24. Stating further, the record shows that two of the three named Plaintiffs chose to get off of methadone. *See* below, Answers to PSOF ¶¶ 35, 41.

6. There is significant suffering associated with withdrawal: Symptoms can include anxiety, irritability, restlessness, chills, muscle pain, weakness, tremor, nausea, and vomiting; psychological symptoms from withdrawal can also be painful and debilitating. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 3-4.)

**ANSWER:** Disputed. Dr. Fatoki testified that not every patient who is tapered off methadone suffers withdrawal symptoms. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 103:12-14. Dr. Mangat also testified that not every patient who is tapered suffers withdrawal symptoms. Dkt. 302, P's Ex. 11, Magnat Dep. Tr. 76:12-13. Even for patients who suffer withdrawal, some withdrawal symptoms are mild and not serious. Dkt. 276, DSOF at ¶¶ 32, 33, 41, 52, 53, 54, 56, 57, 60. Dr. Fatoki testified that withdrawal symptoms are "just like – it's just like having a bad case of the flu. They will be ok." Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 41:11-13. The use of MOUD for detoxification or medically supervised withdrawal from opioids is a well-recognized treatment protocol. Dkt. 276, DSOF at ¶ 18. Individuals at CCDOC had access to treatments for their withdrawal symptoms, and the relevant policy permitted pauses and adjustments to tapering depending on how the patient was tolerating the taper. Dkt. 284, Plaintiffs' Response to DSOF ¶¶ 32-36 and cited material in DSOF.) Stating further, withdrawal from methadone and withdrawal from heroin or other illicit drugs have similar symptoms, and doctors cannot tell the difference, that is, whether a patient is withdrawing from one or the other or both. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 90:1-92:18; P's Ex. 11, Magnat Dep. Tr. At 88:21-89:18.

7. Withdrawal symptoms can last up to several weeks. (Plaintiffs' Exhibit 23,

Dr. Mangat Report at 4.)

**ANSWER:** Disputed. The above-cited material does not support this statement of fact. This assertion is not found on page 4 of Dkt. 303, PSOF Ex. 23, Dr. Mangat's Report. Plaintiffs appear to be referring to bullet point 4 on page 1, which states "Withdrawal symptoms . . . often require days or weeks to resolve". Dkt. 303, PSOF Ex. 23, Mangat Report at 1. Dr. Fatoki testified that not every patient who is tapered off methadone suffers withdrawal symptoms. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 103:12-14. Dr. Mangat also testified that not every patient who is tapered suffers withdrawal symptoms. Dkt. 302, PSOF Ex. 11, Mangat Dep. at 76:12-13.

8. Moreover, patients do not return to their pre-OUD baseline after withdrawal symptoms diminish, but often continue to experience symptoms of OUD, such as cravings for opioids, indefinitely. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 4.)

**ANSWER:** Disputed. The above-cited material does not support this statement of fact. This assertion is not found on page 4 of Dkt. 303, PSOF Ex. 23, Dr. Managat's Report. Plaintiffs appear to be referring to bullet point 4 on page 1, which states "Withdrawal symptoms . . . often require days or weeks to resolve, though some symptoms, such as cravings for opioids, may remain indefinitely". Dkt. 303, PSOF Ex. 23, Mangat Report at 1. This material says nothing about a "pre-OUD baseline" or defines what that means. Further, Plaintiffs conflate "withdrawal symptoms" and opioid use disorder ("OUD") itself. As Plaintiffs note above, "Opioid use disorder ("OUD") is a chronic disease with

symptoms characterized by uncontrollable cravings for opioids, loss of control, increased tolerance to opioids, and withdrawal symptoms. Dkt. 300, PSOF ¶ 1, citing Dkt. 303, PSOF Ex. 23, Mangat Report at 3. The cravings are symptom of having OUD, and not of the withdrawal.

9. OUD is best treated by a stable dose of medication assisted treatment ("MAT"), such as methadone maintenance. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 5.)

**ANSWER:** Disputed. Dr. Mangat's opinion of "best" is irrelevant given that the Constitution does not require that prisoners receive the best treatment possible. *Pulera v. Sarzant*, 966 F.3d 544, 554 (7th Cir. 2020); *Williams v. Ortiz*, 937 F.3d 936, 944 (7th Cir. 2019); *Forbes v. Edgar*, 112 F.3d 262, 267 (7th Cir. 1997); *Arnett v. Webster*, 658 F.3d 742, 754 (7th Cir. 2011); *Petties v. Carter*, 836 F.3d 722, 728-31 (7th Cir. 2016); *Steele v. Choi*, 82 F.3d 175, 179 (7th Cir. 1996). Dr. Mangat's opinion regarding an abstract "best" is also irrelevant because it is not tied to the relevant time period for this suit of December 23, 2013 to July 1, 2017, nor does it consider what is "best" in a correctional facility; Dr. Fatoki testified maintenance programs can be problematic in jail settings because inmates can give their medication to other detainees, leading to overdose, and detainees may be transferred to facilities without maintenance programs where they would then be forced to quit "cold turkey". Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 97:3-98:18. Dr. Mangat testified that, during the relevant time period, neither the Illinois Department of Corrections nor any other jail in Illinois offered any medication assisted treatment ("MAT") for opioid use disorder at

all, and that CCDOC was offering better MAT than the majority of jails in the entire country, including Rikers Island in New York where Dr. Magnat worked. Dkt. 302, PSOF Ex. 11, Mangat Dep. at 94:15-96:8; 100:4-7; 115:20-117:14; 134:4-10; 138:7-140:5.

Dr. Mangat admitted that "withdrawal symptoms from opioids can be minimized, though not avoided, with a taper." Dkt. 303, PSOF Ex. 23, Mangat Report at 1, bullet point # 5. Withdrawal symptoms are also treated separately with other medications at CCDOC. Dkt. 276, DSOF ¶¶ 32, 33, 41. Among the reasons that methadone in particular is so highly regulated are the risks of abuse and the danger of potential overdose. *Id.* at ¶ 16. Stating further, the record shows that two of the three named Plaintiffs chose to get off of methadone. *See* below, Answers to PSOF ¶¶ 35, 41.

10. Tapering the dosage of medication assisted treatment induces painful withdrawal symptoms that places the patient at a higher risk of relapse. (Plaintiffs' Exhibit 23, Dr. Mangat Report at 5.)

**ANSWER:** Disputed. Dr. Mangat admits that "withdrawal symptoms from opioids can be minimized, though not avoided, with a taper. Dkt. 303, PSOF Ex. 23, Mangat Report at 1, bullet point # 5. Dr. Fatoki testified that not every patient who is tapered off methadone suffers withdrawal symptoms. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 103:12-14. Dr. Mangat also testified that not every patient who is tapered suffers withdrawal symptoms. Dkt. 302, PSOF Ex. 11, Magnat Dep. at 76:12-13. Withdrawal symptoms are also treated separately with other medications at CCDOC. Dkt. 276, DSOF ¶¶ 32, 33, 41.

11. Defendant Cook County established an opioid treatment and detoxification program at the Cook County Jail in 2007. (Plaintiffs' Exhibit 32 at 1, Richardson Report 1.)

**ANSWER:** Not disputed.

12. The program provided methadone maintenance for pregnant persons who entered the Jail and required mandatory tapering to zero for all others. (Plaintiffs' Exhibit 32 at 1, Richardson Report 1.)

**ANSWER:** Disputed. The Cermak OTP does provide methadone maintenance for pregnant patients. Non-pregnant patients in the Cermak OTP were *prescribed* methadone with a linear taper to zero, but not all received a linear taper to zero, nor was it mandatory, because:

> their daily dose of methadone decreased at an integer rate proportional to the initial dose, starting at the verified prior dosage and decreasing not more than 7 mg each day. Prior to July of 2017, all patients subject to tapering were provided with tapering plans, based on the amount of their verified prior dosage and their individual healthcare needs. These plans were customized to the need of each patient, and how they reacted to the taper. While the tapering could not decrease by more than 7 mg each day, the amount of the decrease was explicitly tailored to each patient's needs. A physician determined the amount of each patient's taper and could decide to decrease the taper using their medical discretion. From July of 2017 to the present, patients in the OTP are not automatically tapered. Some patients are tapered and others are continued on their verified prior dosage for the duration of time they are in the CCJ. These decisions are made on an individual basis based on the needs and specific circumstances of each patient. Given the transient nature of the patient population at the CCJ, many patients are released or transferred before they are tapered to zero. Some patients are given only one or two doses of methadone prior to release or transfer. Withdrawal symptoms at the OTP were addressed on a patient-by-patient basis. To the extent a patient experienced severe withdrawal

> symptoms, the level of care would be heightened, up to and including hospitalization outside of Cermak.

Dkt. 303, PSOF Ex. 32, Richardson Report at 1-2.

Further, the policies in question explicitly provided guidance allowing medical providers discretion to reduce the rate of taper based on patients' withdrawal symptoms. Dkt. 302, PSOF Ex. 16, OTP Policy effective July 2012 at 5, §D.2.c ("consider slowing rate of taper if symptoms are severe"); Dkt. 303, PSOF Ex. 33, OTP Policy effective February 2016 at 5, §D.2.c (same language). The policies also allowed clinicians to seek a waiver to maintain a patient on constant dose of methadone if they believed that the situation required it. Dkt. 302, PSOF Ex. 16, OTP Policy effective July 2012 at 6, §D.3.b.ii ("The program medical director will . . . request a waiver from CSAT for these special cases: . . . ii. Maintenance rather than detoxification, for a reason other than pregnancy"); Dkt. 303, PSOF Ex. 33, OTP Policy effective February 2016 at 2, §A.4.c ("The program medical director will be an authorized methadone prescriber and will: . . . c. request waivers from CSAT when required for individual patients . . ."). It is therefore inaccurate to say that the policy "required mandatory tapering to zero for all others."

13. Plaintiffs' Exhibit 16 is the methadone tapering policy in force at the Cook County Jail from July 2, 2012, to February 4, 2016.

**ANSWER:** Not disputed that Plaintiffs' Exhibit 16 is Cook County Health and Hospitals System's "Opioid Treatment Program" policy which went into effect on July 2, 2012. Disputed in that the document itself does not include an end date, nor is it titled "methadone tapering policy", and includes directives related to pregnant patients who

are not to be tapered. Dkt. 302, PSOF Ex. 16 at 4, § 6.h. Based on Dkt. 303, PSOF Ex. 33, this policy's end date does not appear to have been February 4, 2016.

14. Plaintiffs' Exhibit 33 is the methadone tapering policy in force at the Cook County Jail from February 5, 2016, to October 6, 2019.

**ANSWER:** Not disputed that Plaintiffs' Exhibit 33 is Cook County Health and Hospitals System's "Opioid Treatment Program" policy which went into effect on February 25, 2016. Disputed to the extent that the document itself does not include an end date, nor is it titled "methadone tapering policy", and includes directives related to pregnant patients who are not to be tapered. *Id.* at 1; 3, § 5.f.

15. Plaintiffs' Exhibit 34 is the methadone tapering policy in force at the Cook County Jail starting on October 7, 2019.

**ANSWER:** Objection to relevance given that this policy went into effect more than two years after the close of the relevant class period. Not disputed that Plaintiffs' Exhibit 34 is Cook County Health and Hospitals System's "Cook County Health Medication Assisted Treatment (MAT) in Cook County Jail" policy, which went into effect on October 7, 2019. Disputed to the extent that the document itself does not include an end date, it is not clear that this policy is currently "in force," nor is the policy titled "methadone tapering policy". Dkt. 303, PSOF Ex. 34 at 1.

16. Defendants' justification for the mandatory tapering policy was explained by Dr. Avery Hart at a Rule 30(b)(6) deposition of Cook County in *Parish v. Sheriff,*

07-cv-4369. (Plaintiffs' Exhibit 35.)

**ANSWER:** Disputed. The above cited material does not support this statement of fact; Plaintiffs' citation is to a 71-page deposition transcript without any indication of what part of that transcript Plaintiffs are referring to. *See Bunn v. FDIC*, 908 F.3d 290, 297 (7th Cir. 2018) (citations and quotation marks omitted) ("As has become axiomatic in our Circuit, Judges are not like pigs, hunting for truffles buried in the record."). The Hart deposition was also not taken in the instant litigation but in another case, on May 10, 2011, before the relevant class period in this case began. Plaintiffs offer no evidence that the reasons for the policy remained the same throughout the relevant class period.

17. When he was deposed as a 30(b)(6) witness in *Parish,* Dr. Hart was the Chief Medical Officer at the Cook County Jail. Plaintiff's Exhibit 13, Dr. Richardson Dep. 36:10-12.) (filed under seal)

**ANSWER:** Disputed. The above-cited material does not support this statement of fact. Not disputed that Dr. Hart had previously been the "Medical Director at Cook County Jail", but this material does not provide any date for when that was. Dkt. 290, PSOF Ex. 13, Dr. Richardson Dep. at 36:6-37:2. Defendants also object to the relevance of this deposition given that it was not taken in the instant litigation but in another case, and it was taken on May 10, 2011, before the relevant class period in this case began.

18. Dr. Hart was asked at the Rule 30(b)(6) deposition in *Parish* to explain the reason for the mandatory tapering policy. (Plaintiffs' Exhibit 35, Hart Dep. 10:9-18.) Hart answered as follows:

Dr. Hart: Well, the -- our goal is not to run a methadone maintenance program. Our goal is to alleviate the symptoms of withdrawal from methadone. The exception, as I said, being pregnant women.

Q: Now, do you know why it is that your goal is not to run a methadone maintenance program?

Dr. Hart: Our positive goal is to alleviate the symptoms of methadone withdrawal.

Q: But my question is do you know why your goal is not to run a methadone maintenance program?

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Dr. Hart: That's not part of our mission.

Q: And when you say "our mission," who is the "our?"

Dr. Hart: Cermak Health Services of Cook County.

Dr. Hart: [O]ur goal is not to run a methadone maintenance program,

(*Id.,* Hart Dep. 10:5-11:6.)

**ANSWER:** Defendants object to this purported statement of fact given that the cited deposition was not taken in the instant litigation but in another case, on May 10, 2011, before the relevant class period in this case began, and Plaintiffs cite to no evidence indicating that goals or reasons were the same at the start of the relevant class period or remained unchanged throughout the relevant class period. Subject to the foregoing objection, not disputed that Dr. Hart testified as stated in 2011, and that the positive goal at that time was to alleviate the symptoms of methadone withdrawal at a time when the vast majority of correctional facilities in Illinois and the country were not offering any methadone treatment but were instead forcing inmates to go "cold turkey." Dkt. 276, DSOF ¶¶ 19-24.

19. The plaintiff class in *Parish* challenged, *inter alia*, the Jail's methadone program. *Parish v. Sheriff of Cook County.*, No. 07 C 4369, 2019 WL 2297464, at *4 (N.D. Ill. May 30, 2019).

**ANSWER:** Disputed. While the above cited *Parish* case addressed various aspects of CCDOC's then-current methadone program, it addressed different aspects of that program, from a different time-period, and with differences from the program at issue here. *Parish v. Sheriff of Cook County.*, No. 07 C 4369, 2019 WL 2297464, 2019 U.S. Dist. LEXIS 90844 at *1-3 (N.D. Ill. May 30, 2019) (generally providing an overview of the claims in *Parish* and noting that CCJ utilized a mandatory 21-day methadone tapering program at that time, which is not the program at issue in the case at bar). *Parish* also addressed initial medical intake screenings, the provision of mental health care, and the provision of various other kinds of medication, meaning methadone was a small component of that case.

20. The record in *Parish* also included expert reports from three of plaintiff's experts explaining flaws in the Jail's methadone policies:

**ANSWER:** Defendants object to this statement of fact because Plaintiffs did not disclose any experts or expert reports from *Parish* in this suit. If a witness is not properly disclosed, a preclusion order is "automatic and mandatory." *Salgado v. General Motors Corp.*, 150 F.3d 735, 742 (7th Cir. 1998) (affirming trial court's sanction of barring late disclosed experts and resulting dismissal of plaintiff's case on summary judgment); *Carter v. Finley*, 2003 U.S. Dist. LEXIS 20619 (N.D. Ill. Nov. 17, 2003) (the sanction of exclusion is

automatic and mandatory unless the party to be sanctioned can show that its violation of Rule 26(a) was either justified or harmless.); *Zingerman v. Freeman Decorating Co.*, 2003 U.S. Dist. LEXIS 15281, *10-11 (N.D. Ill. Aug. 29, 2003), aff'd 99 Fed. Appx. 70 (7th Cir. 2004) (excluding testimony of witnesses untimely disclosed during the last week of the discovery even though the disclosing party argued witnesses were well-known).

Defendants also object to this statement of fact because, as discussed above in Answer to PSOF ¶ 19, the *Parish* case concerned different aspects of the methadone program in effect at Cook County Jail during a different time period. Any opinions rendered in that case are thus not relevant because they would address different policies, be based on different data, and considered in light of a different standard of care. Relatedly, Defendants would not have been able to prepare rebuttal reports, or depose those *Parish* experts, on assumptions and opinions in the context of the case at bar, and are thus prejudiced by any admission of evidence from the *Parish* matter. Stating further, in addition to methadone tapering (and the methadone tapering program at issue in *Parish* is different from the one at issue here), the *Parish* suit addressed other issues related to intake, mental health screening, and alleged delays in providing various other medications, meaning the methadone aspects of *Parish* would have been examined, rebutted, and litigated in different ways from in the case at bar. Defendants are prejudiced by the wholesale importing of expert opinions from a different case covering a different time period, different policies, and different issues, in a different litigation posture, and any statements of fact based on *Parish* should be stricken.

Defendants also object to this Statement of Fact because it contains no citation to

evidence supporting this statement.

Subject to the foregoing objections, not disputed that in *Parish*, a different case, different plaintiffs had experts offering opinions on a different methadone policy.

21. Dr. Steven Whitman, a biostatistician, concluded that most inmates who go on a methadone tapering program are released prior to being tapered appropriately. (Plaintiffs' Exhibit 36.)

**ANSWER:** Disputed. Defendants incorporate by reference their Answer to PSOF ¶ 20, above, disputing and objecting to undisclosed material from the *Parish* case. Stating Further, Defendants object to this Statement of Fact because Plaintiff cites to a 194-page exhibit without any indication of where that material is to be found. *See Bunn v. FDIC*, 908 F.3d 290, 297 (7th Cir. 2018) (citations and quotation marks omitted) ("As has become axiomatic in our Circuit, Judges are not like pigs, hunting for truffles buried in the record."). Defendants also dispute this Statement of Fact because the closest similar statement they can find in the cited material is the statement that "This case also aims to show that most inmates who go on a methadone tapering program are released prior to being tapered appropriately." Dkt. 303, PSOF Ex. 36, at 12. What a case "aims to show", however, is a far cry from a conclusion, and, again, that statement of an aim was rendered on November 2, 2011, in a different case, two years before the relevant class period even began in this matter.

22. Dr. Lambert King, a physician with experience managing, monitoring, and reforming health systems in correctional settings, described the mandatory tapering

policy as causing "gratuitous physical pain and psychological discomfort" and concluded that the policy is "an arbitrary and capricious practice whereby proper dosages of a legitimately prescribed medication needed to treat severe drug addiction are withheld, thereby placing patients at high risk for subsequent death or disability associated with drug overdoses and life-threatening infections, including HIV infection." (Plaintiffs' Exhibit 37, Dr. King Report at 6.)

**ANSWER:** Disputed. Defendants incorporate by reference their Answer to PSOF ¶ 20, above, disputing and objecting to undisclosed material from the *Parish* case. Defendants also dispute this statement of fact because the above cited material does not support the asserted fact. The source of the statement regarding Dr. King's experience is not readily apparent, and the quoted language does not appear on the cited page, although it does appear on the following page referenced. However, that language is specifically in reference to a 21-day tapering period, which is not the tapering program at issue in this lawsuit. Dr. King's declaration is dated June 30, 2012, before the relevant class period in the case at bar and addresses a policy not at issue here. Indeed, Dr. King expressly states that her "Findings and Conclusions" are based on information from "October 1, 2006 to November of 2010", and "I am not expressing any opinion about whether detainees presently entering the Cook County Jail are receiving in a timely fashion prescription medication required by the detainee for serious health needs." Dkt. 303, PSOF Ex. 37, King Report at 1, 6, 7.

23. Dr. Pablo Stewart, also a physician with experience managing, monitoring,

and reforming health systems in correctional settings, stated as follows:

> Methadone tapering can cause severe withdrawal discomfort. There is no justification to require a person to undergo opiate withdrawal syndrome when he (or she) has been receiving lawfully prescribed methadone. Methadone is a medically accepted treatment for opiate abuse/dependence and should not be arbitrarily withdrawn, as required by the Jail's automatic tapering policy.

(Plaintiffs' Exhibit 38, Dr. Stewart Report at 30.)

**ANSWER:** Disputed. Defendants incorporate by reference their Answer to Plaintiff's Statement of Fact ¶ 20, above, disputing and objecting to undisclosed material from the *Parish* case. Defendants also dispute this statement of fact because the above cited material does not support the asserted fact. Dr. Stewart dated his report June 30, 2012, and his opinions were based on the time period "before October of 2010" or "From October 1, 2006 to the present" at the latest. As such, Dr. Stewart's opinions have no bearing on a relevant class period that starts on December 23, 2013, and concerns a different methadone tapering program. Dkt. 303, PSOF Ex. 38, Stewart Report at 1-3. Dr. Stewart also stated that data from October 1, 2010 to March 31, 2011 already showed improvement in dispensing prescription medication." *Id.* at 16. Disputed because the quoted material does not appear on page 30, although it does appear on page 31. However, the above quoted material is expressly in relation to a 21-day detoxification program, which is not the program at issue in this lawsuit, making it irrelevant in the case at bar. *Id.*

Dr. Fatoki also testified maintenance programs can be problematic in jail settings because inmates can give their medication to other detainees, leading to overdose, and

detainees may be transferred to facilities without maintenance programs where they would then be forced to quit "cold turkey". Dr. Fatoki testified that tapering is better than "cold turkey", and that during the class period he worked at facilities that did not provide any methadone treatment at all to inmates. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 97:3-98:18; 128:9-130:1. Among the reasons that methadone in particular is so highly regulated are the risks of abuse and the danger of potential overdose. Dkt. 276, DSOF ¶ 16.

24. Plaintiffs Keith Rogers, James Hill, and Wanda Hollins are each individuals who were detained in the Cook County Department of Corrections (CCDOC) between September 2013 and February 2014, and each was lawfully taking methadone to treat Opioid Use Disorder (OUD) when admitted to the Jail, as explained below.

**ANSWER:** Disputed. Plaintiffs have not provided any support for this statement as required by Local Rule 56.1(a)(2). To the extent that Plaintiff incorporates statements below into this statement of fact, Defendants incorporate their answers below. Stating further, the relevant class period is between December 23, 2013 and July 1, 2017, meaning material dating to September 2013 is irrelevant.

25. Plaintiff Keith Rogers was enrolled in a methadone program when he entered the Cook County Jail on January 20, 2014 (Plaintiffs' Exhibit 1, Jail Intake Records) to serve a 90-day sentence (Plaintiffs' Exhibit 18, Rogers Dep. 50:19-20), for driving on a suspended license (Plaintiffs' Exhibit 24, Circuit Court Docket Entries.)

**ANSWER:** Not disputed that Plaintiff Rogers had been enrolled in a methadone

program prior to his admission to CCDOC, and that his last dose of methadone appears to have been administered on January 17, 2014. Dkt. 302, PSOF Ex. 1. Not disputed that Plaintiff Keith Rogers was found guilty of driving on a suspended license, and that charges for operating an uninsured motor vehicle were stricken with leave to reinstate, and charges for an improper turn at an intersection were nonsuited. Dkt. 303, PSOF Ex. 24, Circuit Court Docket Entry. According to Dkt. 303, PSOF Ex. 24, Circuit Court Docket Entry, Rogers' initial court date, and guilty plea, were on January 23, 2014. Disputed to the extent that the cited records do not indicate a 90-day sentence or indicate when Defendants would have known about the length of Rogers' sentence.

26. The Jail verified Rogers' participation in a methadone program on January 21, 2014, when a physician at the Jail ordered that Rogers receive "methadone 200mg then taper per protocol." (Plaintiffs' Exhibit 2, Rogers Dosing History.) Rogers began to receive methadone on January 26, 2014 with his dosage reduced (or "tapered") by 7 mg per day. (Plaintiffs' Exhibit 3, Dosing History.) Thus, Rogers received his regular dosage of 200 mg on January 26, 193 mg on January 27, 186 mg on January 28, and so on until he left the Jail on February 16, 2014, when his dosage had been tapered to 53 mg. (*Id.)*

**ANSWER:** Defendants object to this statement of fact in that it is vague as to "The Jail" verifying Rogers's participation. Disputed. Dkt. 302, PSOF Ex. 3, Dosing History, indicates that Rogers received a 100 mg dose on January 26, 2014, followed by a 200 mg dose on January 27, 2014, which was then tapered by 7 mg per day until a 67 mg dose on February

15, 2014.

27. Rogers experienced withdrawal symptoms (nausea, diarrhea, aching pain) before he received his first doses of methadone. (Plaintiffs' Exhibit 18, Rogers Dep. 41:8-15.) The diarrhea would last "[p]retty much all day." (*Id.*, Rogers Dep. 42:19.) The symptoms subsided when he began to receive methadone (*Id.*, Rogers Dep. 36:21-37:2), but returned shortly after the tapering began. (*Id.*, Rogers Dep. 37:2-3.)

**ANSWER:** Not disputed that Rogers experienced the above symptoms. Stating further, the severity of Rogers' symptoms would "fluctuate", some problems were due to a pre-existing accident that left two steel plates and nine titanium screws in his foot, and eventually the diarrhea went away. Dkt. 302, PSOF Ex. 18, Rogers Dep. at 41:8-43:17. Plaintiff also received medication to help with the nausea. *Id.* at 43:19-22. Plaintiffs' above referenced citations are inaccurate but Defendants admit Rogers' symptoms went away once he received the first 100 mg dose of methadone, and then the pain slowly returned; however, Rogers' pain continued to fluctuate and was never as bad as it was when he did not receive any methadone, and he did not have any more diarrhea while tapering. *Id.* at 48:8-50:6.

28. Rogers filed a grievance on February 14, 2014, stating: "at times pain gets quite severe. I break into sweats and get nausea. Sometimes resulting in vomiting or dry heaves." (Plaintiffs' Exhibit 27, Rogers Grievance.)

**ANSWER:** Disputed. The above-cited material does not support this statement of

fact. PSOF Ex. 27 is not a grievance. It is also not dated February 14, 2014. The purported quote is inaccurate.

29. Rogers re-enrolled in his methadone program when he left the Jail and returned to his previous dose of 200 mg. (Rogers Dep. 39:22-14-40:9, Plaintiffs' Exhibit 4 at 39-40.)

**ANSWER:** Disputed. The above-cited material does not support this statement of fact.

30. Plaintiff James Hill was enrolled in a methadone program when he entered the Cook County Jail on December 23, 2013. (Plaintiffs' Exhibit 4.) Hill entered as a pre-trial detainee following his arrest for misdemeanor theft. (Plaintiffs' Exhibit 25, Circuit Court Docket Entries.)

**ANSWER:** Not disputed that Plaintiff James Hill was enrolled in a methadone clinic and received an 80 mg dose on December 22, 2013. Not disputed that Plaintiff James Hill's bail was set at $10,000.00 on December 23, 2023 for misdemeanor theft of property. Dkt. 288, PSOF Ex. 25, Circuit Court Docket Entries.

31. The Jail verified Hill's participation in a methadone program, and on December 25, 2013 a physician at the Jail ordered that Hill receive "methadone 80mg today then taper per Cermak protocol. Decrease by 4 mg daily until finished." (Plaintiffs' Exhibit 5.)

**ANSWER:** Defendants object to this statement of fact in that it is vague as to "The

Jail" verifying Hill's participation. Subject to the foregoing objection, not disputed.

32. Hill received his regular dosage of 80 mg on December 25, 2013, 76 mg on December 26, 72 mg on December 27, and so on until he left the Jail on December 31, 2014, when his dosage had been tapered to 56 mg. (Plaintiffs' Exhibit 6.)

**ANSWER:** Not disputed, subject to the objection to the term "regular dosage" which is vague, assumes facts not in the record, and is not supported by the cited material.

33. Hill experienced withdrawal symptoms during the tapering: he had trouble sleeping, felt nauseous, was throwing up, and experienced running diarrhea. (Plaintiffs' Exhibit 20, Hill Dep. 27:23-28:3, Exhibit 9 at 15-16.)

**ANSWER:** Not disputed that Plaintiff James Hill experienced those symptoms during the first day-and-a-half he was in CCDOC. Disputed that those symptoms were all due to methadone withdrawal given that Hill testified he was also not receiving his psych meds and his dormitory setting in CCDOC "was loud and it was crazy". Dkt. 302, PSOF Ex. 20, Hill Dep. at 27:18-29:14.

34. Hill pleaded guilty and received a sentence of time considered served on December 21, 2013. (Plaintiffs' Exhibit 25, Circuit Court Docket Entries.)

**ANSWER:** Disputed. The above-cited material does not support this statement of fact. Based on the cited material, Hill pled guilty on December 31, 2013, and his initial bond hearing was on December 23, 2013. Dkt. 288, PSOF Ex. 25, Circuit Court Docket

Entries.

35. Hill re-enrolled in his methadone program when he left the Jail. (Hill Dep. 35:11-14, Plaintiffs' Exhibit 9 at 23.)

**ANSWER:** Not disputed that Hill enrolled in a methadone program after he left CCDOC. Disputed to the extent that this statement of fact implies it was immediate or continuous given that Hill testified he did not get methadone the day he got out of CCDOC, that he was only in a program for "probably a year" because "I probably got locked back up", and that, as of the date of Hill's deposition on September 17, 2019, he had not taken any methadone since 2016. Dkt. 302, PSOF Ex. 20, Hill Dep. at 34:12-36:24.

36. Plaintiff Wanda Hollins was enrolled in a methadone program when she entered the Cook County Jail on September 12, 2013. (Plaintiffs' Exhibit 7, Methadone referral form.)

**ANSWER:** Not disputed. Stating further, Wanda Hollins is not a member of the class at issue because she did not enter the jail between December 23, 2013 and July 1, 2017.

37. Hollins entered as a pre-trial detainee following her arrest for misdemeanor domestic battery. (Plaintiffs' Exhibit 31, Circuit Court Docket Entries.)

**ANSWER:** Not disputed.

38. The Jail verified Hollins' participation in a methadone program on September 21, 2013, when a physician at the Jail ordered that Hollins receive

"methadone 85 mg po on 9/21/13 taper by 3 mg/day until finished." (Plaintiffs' Exhibit 8.)

**ANSWER:** Disputed. Defendants object to this statement of fact in that it is vague as to "The Jail" verifying Hollins' participation. Disputed because Hollins first received a methadone prescription for 120 mg, decreasing by 5 mg per day, on September 13, 2013. Hollins then received a change in her prescription dose on September 21, 2013, calling for a 3 mg decrease per day after starting at 85 mg. *See* Excerpts from Cook County Health Medical Records of Wanda Hollins, Bates Stamped Rogers 3333, 3440, 3443, attached as Ex. 1, (filed under seal).

39. Hollins received her regular dosage of 85 mg on September 21, 2013, 82 mg on September 22, 79 mg on September 23, and so on until she left the Jail on October 5, 2013, when her dosage had been tapered to 46 mg. (Plaintiffs' Exhibit 9.)

**ANSWER:** Not disputed, subject to the objection to the term "regular dosage" which is vague, assumes facts not in the record, and not supported by the cited material. Stating further, Dkt. 302, PSOF Ex. 9, indicates that Hollins received 85 mg methadone on September 20, 2013. That record also indicates that Hollins missed what would have been a 70 mg dose on September 26, 2013, but that she then received 70 mg on September 27, 2013, indicating that her taper was adjusted to account for the missed dose when, otherwise, the September 27 dose should have been 67 mg. *Id.* Stating further, because Hollins left CCDOC on October 5, 2013, she is not a member of the class which relates to individuals who entered CCDOC between December 23, 2013 and July 1, 2017.

Defendants also incorporate by reference their Answer to PSOF ¶ 38, above, which shows Hollins began receiving methadone on September 13, 2013.

40. Hollins experienced withdrawal symptoms while being tapered: she felt cold, experienced body aches and stomach cramps. (Hollins Dep. 59:19-20, Plaintiffs' Exhibit 19.) Hollins also experienced nausea. (Hollins Dep. 60:7-8, Plaintiffs' Exhibit 19.)

**ANSWER:** Not disputed that Hollins suffered the above symptoms. Hollins also testified that she felt better while tapering than when she was not getting any methadone. Dkt. 302, PSOF Ex. 19, Hollins Dep. at 59:21-24.

41. Hollins re-enrolled in her methadone program when she left the Jail and returned to her previous daily dose of 85 mg. (Hollins Dep. 63:20- 64:4, Plaintiffs' Exhibit 19.)

**ANSWER:** Disputed. The above-cited material does not support this statement of fact. According to Hollins, the last time she took methadone prior to her September 17, 2019 deposition was approximately one year after her 2013 release from CCDOC. Dkt. 302, PSOF Ex. 19, Hollins Dep. at 63:19-65:15. Further, Hollins testified that she asked to be tapered down from a 120 mg dose to an 80 mg dose because she was on a "high dose for so long," and after she reached an 80 mg dose she "decided to get myself together", which presumably led to her decision to stop taking methadone. *Id.*

42. Data produced in this case show 1,847 admissions to the Jail's methadone

program between December 13, 2013, and July 1, 2017. Plaintiffs' Exhibit 26, Admissions to Methadone Program December 13, 2013 to July 1, 2017.)

**ANSWER:** Defendants object to this statement of fact to the extent that the relevant class period begins December 23, 2023, and thus the relevant number appears to be inflated by 17 admissions. Subject to the foregoing objection and for the purposes of summary judgment, not disputed.

43. The data show that the dosage of methadone was not tapered in 50 of these admissions, presumably for pregnant persons. (Plaintiffs' Exhibit 28, Admissions to Methadone Program December 13, 2013 to July 1, 2017 Not Tapered.)

**ANSWER:** Disputed. The above-cited material does not indicate that any of these 50 admissions were for pregnant individuals. Stating further, Plaintiff's Memorandum on Cross-Motions for Summary Judgment indicates that 39 individuals were not tapered. Dkt. 301 at 10.

44. A linear taper at a constant reducing dosage was applied in 1,619 of the remaining 1,797 admissions. (Plaintiffs' Exhibit 29, Persons Tapered at Constant Rate.)

**ANSWER:** Disputed. Again, Defendants dispute this statement of fact because the cited Exhibit includes admissions from before relevant class period begins on December 23, 2013. Although Plaintiff has captioned Exhibit 29 as containing admissions as early December 13, 2013, which is itself before the class period begins, CCDOC booking numbers indicate the date that a person was admitted to the jail in the format of a four-

digit year followed by a two-digit month, a two-digit day, and a three-digit number representing that individual's number in the sequence of individuals admitted that day. For example, a booking number of 20130503220 would be for the 220th individual admitted on May 3, 2013. Plaintiffs' Exhibit 29 includes booking numbers for individuals entering the CCDOC as early as May 3, 2013. Over four pages of the data include individuals not included in the class definition in this lawsuit.

Dr. Fatoki testified that patients at CCDOC were tapered at a percentage rate, that CCDOC could slow that rate, and that methadone could be reduced by no more than 7 milligrams per day. Dkt. 302, PSOF Ex. 12, Fatoki Dep. at 103:12-104:14. Stating further, Plaintiffs' assertion shows that approximately 10% of patients (178/1797) were not tapered at a constant rate, indicating medical judgement was executed to alter the rate of taper. Moreover, Plaintiffs' exhibits show that many patients were discharged after short stays at CCDOC, meaning they could have had their rate of taper altered, but they were not in custody long enough to experience withdrawal symptoms and have their rate of taper reevaluated. Dkt. 300, PSOF at ¶¶ 45-46; Dkt. 303, PSOF Ex. 30; Dkt. 303, PSOF Ex. 40.

45. The data also show 99 admissions of persons to serve misdemeanor sentences, all for less than one year; 66 served less than 30 days in the Jail. (Plaintiffs' Exhibit 30, Misdemeanant Admissions in Methadone Program.)

**ANSWER:** Defendants object to this statement of fact because this Exhibit includes admissions from before relevant class period begins on December 23, 2013. Plaintiffs'

Exhibit 30 includes approximately 20 booking numbers indicating admissions between August 30, 2013 and December 22, 2013. These individuals are not members of the class in the suit at bar. Subject to the foregoing objection, not disputed.

46. The Sheriff's records also show that of the 759 persons who left the Jail within 21 days after admission, 174 were released on bond, 324 were released because charges were dropped, and 21 were transferred to the Illinois Department of Corrections. (Plaintiffs' Exhibit 40, Persons Released from the Jail in Less than 21 Days.)

**ANSWER:** Disputed. Defendants object to this statement of fact to the extent that the relevant class period begins December 23, 2023, and some entries on Dkt. 303, PSOF Ex. 40, pre-date that time. Further, the above referenced material is a chart with various undefined terms. While there are 759 separate Jail Numbers listed, it is not clear if these are 759 separate individuals, or if it could represent the same individual(s) being admitted to and released from CCDOC on multiple occasions during this time period. As to the "Type of Release", the various terms are again not defined and open to interpretation. There appear to be 145 entries for "Bond Paid", 29 for "Bond", 21 for "Shipped to Ill. Dep. Corrections", and 102 for "Deliver to Appropriate Authority" (which presumably could be some other jail or prison that did not offer any methadone). There were only 49 entries for "Charge Dropped," although there were several others for "No Probable Cause", or "Court Discharge", which may imply a similar result, although, again, PSOF Ex. 40 contains numerous undefined terms.

47. Dr. Stamatia Richardson is the Medical Director of the Opioid Treatment Program. (Plaintiffs' Exhibit 13, Dr. Richardson Dep. 7:2-7.) (filed under seal)

**ANSWER:** Not disputed that, at the time of her deposition on May 10, 2018, one of Dr. Richardson's titles was Medical Director of the Opioid Treatment Program. Dkt. 290, PSOF Ex. 13, Dr. Richardson Dep. at 6:22-7:7.

48. Dr. Richardson stated that the current methodology for determining whether a person being admitted to the jail while in a methadone program should be tapered or continued at maintenance dosage turns on "an educated guess as to whether the patient is going to be there for 60 days or less." (Dkt. 290, Pls' Ex. 13, Dr. Richardson Dep. 44:2-9.)

**ANSWER:** Disputed. First, Defendants object as to relevance of "current methodology" in that Dr. Richardson gave her deposition on May 10, 2018, which is both after the relevant class period and not current. Second, Defendants also dispute that the determination "turns on 'an educated guess'" because the testimony in full shows a host of considerations, and Plaintiffs' truncated portion is a gross misrepresentation. In full, Dr. Richardson answered this question as follows:

> Q. How is a decision made that someone who's in a methadone program and enters the jail should be tapered or should not be tapered?
>
> A. So we have a medical social worker who has worked with our medical patients for years. She doesn't meet these patients. She looks at their court cases, and she makes an educated guess as to whether the patient is going to be there for 60 days or less. Sometimes her guess is wrong, and then we're scrambling to have to taper.

> If a patient has to go to prison or if a patient has to go to another county, we know right away. Let's look for other county warrants, because those patients should continue to taper. Otherwise, they're going to go to a county and, instead of tapering, they're going to have to go cold turkey from a large dose.
>
> None of our surrounding counties have methadone programs. So I don't feel like I'm doing my patients any justice in maintaining those patients. Patients that know they're going to prison have parole holds.
>
> So we're learning, and it's not a crystal ball. We don't always know. We think a patient is going to be on probation. The Public Defender may think they're going to go on probation, and then they get a 60 or 90-day inpatient stay, and we can't find a bed that will take them on methadone.
>
> So it's very individualistic, and it's not a for-sure. We don't know who's coming or going. We're making an educated guess based on past experience of patients for whom, whether we should taper or not, and then we offer that to the patient.
>
> I can tell you that many of my patients don't want to continue on maintenance. They want to taper because they're afraid of what's going to happen in court.

Dkt. 290, PSOF Ex. 13, Dr. Richardson Dep. at 43:23-45:14.

49. Dr. Richardson also stated that under the current methodology, a person like plaintiff Rogers, who entered the Jail to serve a 60 days sentence for a misdemeanor, would not be tapered. (Plaintiff's Exhibit 13, Dr. Richardson Dep. 86:10-14.)

**ANSWER:** Defendants object as to relevance of "current methodology" in that Dr. Richardson gave her deposition on May 10, 2018, which is both after the relevant class period and not current. Defendants also object because, during the deposition, counsel objected to this question as an incomplete hypothetical, and Dr. Richardson said she does not do the vetting of individual cases, and that she would need to see individual medical records, and that generally it is not known how long a specific individual will be in

CCDOC. Dkt. 290, PSOF Ex. 13, Dr. Richardson Dep. at 84:18-86:19. Subject to the foregoing objections, not disputed.

50. The Sheriff of Cook County has refused to share with Dr. Richardson information about how long persons are expected to spend at the Jail. (Plaintiffs' Exhibit 13, Dr. Richardson Dep. 86:20-87:24.)

**ANSWER:** Disputed. This is a mischaracterization of Dr. Richardson's testimony. Dr. Richardson testified that she engaged with the Sheriff's Office in discussions to estimate how long individuals are expected to stay in CCDOC, but Cook County's legal system is different from, for example, New York's, and so there is no way to know when individuals with certain charges will be leaving CCDOC and good data on that issue does not exist. Dr. Richardson did not say the Sheriff "refused to share" this information, and specifically denied being "ignored" by the Sheriff. Dkt. 290, PSOF Ex. 13, Dr. Richardson Dep. at 84:18-88:4.

Respectfully Submitted,
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**CERTIFICATE OF SERVICE**

I, Oliver Kassenbrock, Assistant State's Attorney, hereby certify that I served a copy of the attached document on the parties of record via the ECF electronic filing system on September 16, 2025.

*/s/ Oliver Kassenbrock*
Oliver Kassenbrock