IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

MUMIA ABU-JAMAL

Plaintiff,

v.

JOHN KERESTES, Former Superintendent State Correctional Institution Mahanoy

Theresa DelBalso, Superintendent State Correctional Institution Mahanoy

Andre Norris, DOC Acting Director of Bureau of Health Care Services

Christopher Oppman, DOC Deputy Secretary for Administration

Dr. John Lisiak, SCI Mahanoy

Dr. Shaista Khanum, SCI Mahanoy

Scott Saxon, Physician's Assistant, SCI Mahanoy

Chief Health Care Administrator John Steinhart, SCI Mahanoy

GEISINGER MEDICAL CENTER

Defendants.

Case No. 15-Cv-00967 (RDM)(KM)

Judge Robert D. Mariani

Magistrate Judge Karoline Mehalchick

ELECTRONICALLY FILED

PLAINTIFF'S ANSWER TO STATEMENT OF FACTS

1. Admitted. The Plaintiff, Mumia Abu-Jamal ("Plaintiff"), is an inmate confined within the Pennsylvania state correctional system at the State

Correctional Institution at Mahanoy ("SCI-Mahanoy"). (Hearing Transcripts, Volume 1 [hereafter transcripts referred to as "v.1"] at 46.)

2. Admitted. Plaintiff admits that as of December 2015, John W. Kerestes was the Superintendent for SCI-Mahanoy.

3. Admitted in part and denied in part. Plaintiff lacks the information necessary to respond to the allegations contained in this paragraph. By way of clarification, Plaintiff admits that Mr. Kerestes is no longer the Superintendent of SCI Mahanoy. See Fed.R.Civ. P. 56(d) Declaration.

4. Denied. Plaintiff lacks the information necessary to respond to the allegations contained in this paragraph. See Fed.R.Civ. P. 56(d) Declaration.

5. Denied. Plaintiff lacks the information necessary to respond to the allegations contained in this paragraph. See Fed.R.Civ. P. 56(d) Declaration.

6. Admitted. Plaintiff admits that John Steinhart is the Corrections Healthcare Administrator at SCI-Mahanoy.

7. Denied. Plaintiff lacks the information necessary to respond to the allegations contained in this paragraph. See Fed.R.Civ. P. 56(d) Declaration.

8. Denied. Plaintiff lacks the information necessary to respond to the allegations contained in this paragraph. See Fed.R.Civ. P. 56(d) Declaration.

9. Admitted. Plaintiff admit that Christopher Oppman, is identified as the Director for the Department's Bureau of Healthcare Services.

10. Denied. Plaintiff lacks the information necessary to respond to the allegations contained in this paragraph. See Fed.R.Civ. P. 56(d) Declaration.

11. Admitted. Plaintiff admits that he has been incarcerated since approximately 1981 and was previously on death row. (v.1 at 46.).

12. Admitted. Plaintiff's case is well-known world-wide.

13. Admitted. Plaintiff has been confined at SCI-Mahanoy since 2011.

14. Admitted in part and denied as stated by way of further clarification. In 2012 bloodwork revealed the antibody for the hepatitis C virus. There was no follow-up testing to determine whether the disease was chronic. (v.1 47).

15. Admitted. Hepatitis C ("HCV") is a virus that infects the liver cells. (v.1 at 111.)

16. Admitted. Approximately 15-25 percent of individuals infected with HCV will spontaneously clear the virus (v.1 at 112, v.2 at 199-200.)

17. Admitted. The remaining 75-85 percent will develop chronic HCV, which is an inflammation of the liver. (v.1 at 112, v.2 at 199.)

18. Admitted. The inflammation caused by the hepatitis C virus can lead to fibrosis, which is scarring of the liver. (v.1 at 111, v.2 at 199-201.)

19. Admitted. The degree of fibrosis sustained is measured on a Metavir scale, which ranges from F0 (indicating no fibrosis) to F4 (indicating cirrhosis). (v.2 at 23, 202.)

20. Admitted in part, and denied as stated by way of further clarification. Some estimate that 20-30 percent of those who develop chronic HCV will develop cirrhosis. However, others estimate that 20-50% of chronic hepatitis C patients will develop cirrhosis (Pl. Ex. 13, p. 1).[1] Moreover, according to the Center for Disease Control (CDC) 60-70% of those infected with the hepatitis C virus will go on the develop some form of chronic liver disease (Plaintiff's Appendix, Ex. 2).[2] In the United States hepatitis C caused more deaths each year than any other infectious disease.

21. Admitted. It can take 10 to 20 years from infection for cirrhosis to develop in chronic HCV patients. (v.2 at 199).

22. Denied. Plaintiff disputes the defendant's allegations. Rather, according to DOC witness Jay Cowan, of those who suffer from chronic hepatitis C, 2-7% per year will develop hepatocellular carcinoma (HCC) (liver cancer). (v.3 at 21). Moreover, the overall progression rate to liver cancer among those with chronic hepatitis C has been estimated to be 11-19% (Plaintiff's Ex. 13, p. 1). In addition, 20% of chronic hepatitis C patients will die from complications of the disease (liver cancer or cirrhosis). (CDC Report, Pl. Appendix Ex. 2).

[1] "Plaintiff's Ex. " refers to the Exhibits admitted as evidence during the December 2015 preliminary injunction hearing.
[2] "Plaintiff's Appendix" refers to the Appendix filed in opposition to the instant motion

23. Admitted in part with additional information to clarify. Cirrhosis can be characterized by a distortion in the liver's architecture. Cirrhosis will not necessarily have abnormal liver enzymes as those functions fluctuate. (v.2 at 201).

24. Admitted. As fibrosis progresses toward cirrhosis, the amount of scarring in the liver increases, slowing the circulation of blood through the liver. (v.2 at 204-5).

25. Admitted. Fibrosis scarring can cause a backup of blood platelets in the spleen, and a resulting decrease of platelets in the blood stream. (v.2 at 204-5).

26. Denied as stated. By way of clarification, individuals with fibrosis can show decreasing platelet levels as the degree of scarring increases. (v.2 at 204-205.). However, that decrease may not be linear as platelet levels can fluctuate. (Harris Declaration, August 4, 2016 attached in Plaintiff's Appendix as Exhibit 3).

27. Admitted in part and denied as stated by way of further clarification. The inflammation associated with chronic HCV can cause an increase in the liver enzyme aspartate aminotransferase ("AST"). (v.2 at 203-204.). However, those with significant fibrosis may continue to have normal liver

enzyme levels. (AASLD Guidelines Plaintiff's Exhibit 18, p. 11[3]; Cowan: v.3, p. 37).

28. Admitted. Clinicians do use blood tests measuring platelet count and AST levels to assess the degree of fibrosis. (v.2 at 202.).

29. Admitted.One of these tests is the Aspartate minotransferase-to-Platelet-Ratio-Index ("APRI") test. (v.2 at 202-3.)

30. Admitted. The APRI is obtained by drawing the individual's blood and conducting distinct blood tests—comprehensive metabolic panel ("CMP") and Complete Blood Count ("CBC"). (v.2 at 205, 209-10.).

31. Admitted. The platelet level is determined in the CBC lab and the AST levels are determined in the CMP lab. (v.2 at 209-210.).

32. Admitted. The APRI score is calculated by dividing the AST level by the upper limits of normal AST, then dividing that quotient by the platelet count (AST/upper limit of normal considered/platelet count). (v.2 at 203.)

33. Denied. Plaintiff disputes that the possibility of advanced fibrosis or cirrhosis is directly proportional to the APRI score—the higher the APRI score, the greater the possibility of advanced fibrosis. (v.2 at 205-206.). This is not so because at lower levels the APRI score has a sensitivity of

[3] For this Court convenience, the AASLD Guidelines, admitted into evidence as Plaintiff's Exhibit 18 at the December 2015 hearing, is also included as Exhibit 9 in Plaintiff's Appendix in opposition to the instant motion.

only 37% meaning that it only identifies 37% of those who actually have the disease (Cowan: v.3, p. 36; Noel: v.3 115: "half the time the [APRI] score is wrong in terms of the result you are looking for.").

34. Admitted in part and denied as stated by way of further clarification. Some consider an APRI score of less than or equal to 0.3 as consistent with unlikely significant fibrosis or cirrhosis; a score of greater than 0.3 and less than 0.5 as indicating "significant fibrosis possible, cirrhosis unlikely" and that a score greater than 0.5 but less than or equal to 1.5 representing significant fibrosis or cirrhosis possible; greater than 1.5 and less than or equal to 2 represents likely fibrosis, cirrhosis possible; greater than 2 represents likely cirrhosis. (v.2 at 206.). Plaintiff disputes the accuracy of the APRI test at that range (See ¶ 33 *supra*).

35. Admitted. Another diagnostic tool is the Halt-C score, which is a calculation based upon platelet level, AST and ALT levels (v.2 at 211, v.3 at 110).

36. Admitted. Plaintiff admits that the Halt-C score indicates the percentage of probability that an individual currently has cirrhosis. (v.3 at 110.)

37. Denied. Plaintiff disputes that damage to the liver is not considered to be irreversible until an individual reaches the late stages of cirrhosis. (v.3 at 78.). First, Dr. Cowan never identified the point where, in his opinion, damage would be irreversible. He testified that if "someone developed decompensated liver disease, I would say that would be irreversible damage.

However, early stages of fibrosis , it's thought that it can be reversed." (v.3, p. 78). Second, the assertion is not true. (Harris Dec. 8/4/16, ¶ 9 included in Plaintiff's Appendix as Exhibit 3). In addition, plaintiff disputes any inference that damage, including irreversible damage, to an individual's health does not occur long before late-stage cirrhosis. For example, people with any stage of cirrhosis have a much higher risk of developing liver cancer. (Harris Dec. 8/4/16 ¶¶ 10-12; Plaintiff's Ex. 13, p. 1; Pl.Ex 18, p.4). Those with untreated, chronic, hepatitis C at any stage can suffer from extrahepatic manifestations of the disease, including renal impairment, skin disorders, depression, fatigue and diabetes (Plaintiff's Ex. 8, p. 1, Plaintiff's Ex. 10, p. 1, Plaintiff's Ex. 18, p. 5-7)).

38. Admitted in part and denied as stated by way of further clarification. Cryoglobulinemia, porphyria cutanea tarda ("PCT"), and lichen planus are generally accepted among experts as associated with HCV but they are not the only skin conditions that can be manifestations of hepatitis C. (v.1 at 115, 116, vol. 2 at 60, 106, 217, v.3 at 43,). Skin conditions are a common extrahepatic manifestation of the disease. (v.1, p. 113-117; Plaintiff's Exhibits 8 and 10).

39. Admitted.The American Association for the Study of Liver Diseases ("AASLD") has stated that there is insufficient evidence that successfully treating HCV will resolve PCT or lichen planus. (Plaintiff's Ex. 2, p. 9.)

40. Admitted. Plaintiff admits that some studies, however, have shown that Interferon-based treatment actually exacerbated lichen planus in some cases. (Ex. P2 at 9.) By way of further clarification this paragraph is immaterial as Interferon-based treatments for hepatitis C are now obsolete and no longer utilized by the DOC.

41. Denied. Plaintiff disputes the assertions in paragraph 41. Studies have shown that 20-40% of HCV sufferers have skin conditions and that 15-20% of all patients presenting to dermatologists have chronic hepatitis C. "Common" dermatological disorders linked with HCV include pruritis and psoriasis (Plaintiff's Exhibit 8; v.1, Harris: p. 113-117). The DOC's experts Dr. Schleicher and Dr. Cowan admitted that at least 20-40% of hepatitis C patients suffer from skin conditions, including itching (pruritis) and psoriasis (v. 2, p. 82; v. 3, p. 44). See also Plaintiff's Exhibit 10, Journal of Dermatology stating that hepatitis C "can be an inducing factor for psoriasis").

42. Denied. Plaintiff's expert, Dr. Harris, testified that NAE is underdiagnosed because it does not differ histologically (under a microscope) from common psoriasis (Plaintiff's Exhibit 28). He testified that a study in Philadelphia determined that 1.7 % of chronic hepatitis C patients suffered from NAE (v.2, p. 27). Dr. Harris did not testify that the one (1) patient with NAE who did not have hepatitis C has furthered a debate about whether there is

a relationship between NAE and hepatitis C. He testified that the one or two cases of NAE where the patient was HCV negative has prompted a debate "on the necessity of hepatitis C with NAE...the big debate among pathologists is whether it's a continuation of NAE or something different. So the vast majority of cases have Hepatitis C" (v.2 p. 28).

43. Denied. Plaintiff disputes that the AASLD does not recognize NAE or psoriasis as extrahepatic manifestations of HCV in the skin. (See Ex. P2, P184.). The referenced guidelines do not purport to set forth all conditions associated with HCV. It sets forth treatment protocols.

44. Denied. The relationship between chronic hepatitis C and type 2 diabetes has been established. (Plaintiff Ex. 18, p. 6: "In the United States, type 2 diabetes occurs more frequently in HCV patients, with more than 3-fold greater risk in persons over 40 years." The relationship has been "confirm[ed]."); Harris: v.1, p. 125: "Hepatitis C is considered to be a risk factor for diabetes type 2.").

45. Admitted. Prior to 2011, HCV was primarily treated with an injectable medication, Interferon, and related oral agents. (v.1 at 118, v.2 at 213, Ex. P175 at 5).

46. Admitted. Those medications generally had severe negative side-effects, had a lengthy treatment period, and offered only limited efficacy. (v.1 at 118-120, v.2 at 213).

47. Admitted. Because of the severe side effects and limited efficacy of those medications, patients who had not developed cirrhosis, and were not otherwise severely compromised, were not treated with these medications; rather, the patients were monitored until new medications could be developed. (v.1 at 121).

48. Admitted. Such monitoring, also referred to as "active surveillance," consisted of regular blood tests to monitor liver enzymes and viral load. (v.1 at 121).

49. Admitted. Periodic liver biopsies were also done. (v.1 at 121).

50. Admitted. In 2014 new medications were administered known as direct-acting antivirals. (v.1 at 119, v.3 at 71).

51. Denied. Plaintiff disputes the assertion that the field is in flux. The change has occurred. The direct-acting anti-virals cure 95-100% of those with genotype 1 and the leading hepatitis C organization, the AASLD and the Center for Disease Control (CDC) have stated that they are the standard of care and recommended treatment for everyone. (Harris, v.1, p. 119-120; Plaintiff's Exhibit 18, AASLD Guidelines).

52. Admitted. The first of these medications, Sovaldi, was approved for use in HCV treatment by the Food and Drug Administration ("FDA") in December 2013. (v.2 at 201).

53. Admitted. Another medication, Harvoni, was approved in October 2014. (*Id.*)

54. Admitted. Both are administered orally once per day, generally over an eight- to twelve-week period. (v.1 at 119).

55. Admitted in part and denied as stated by way of further clarification. The drugs have a reported cure rate of 90-95% and probably higher (Harris: v.1 119).

56. Admitted with further clarification. Treatment with these medications has cost between $84,000 and $90,000 per patient if the drugs are purchased in the United States on the open market. (v.1 at 142.).

57. Admitted. Both the Center for Disease Control ("CDC") and the AASLD have published guidance on the testing and treatment of HCV. (v.2 at 7-9.)

58. Admitted. The CDC has advised that use of direct-acting antiviral agents that include Sovaldi and Harvoni, rather than Interferon-based regiments, is the standard of care. (Plaintiff's Ex. 17 p. 6).

59. Admitted. The CDC has further advised that guidance for testing and treatment of HCV is available through the AASLD. (Id.)

60. Denied. Plaintiff disputes defendants' paragraph 60 as it is misleading. In its June 2015 guidelines the AASLD placed in "high priority for treatment owing to high risk for complications" those with fibrosis level 2 and those who have experienced "debilitating fatigue". (Plaintiff's Ex. 2, p. 4).

Moreover, the AASLD stated in June 2015 that "treatment is recommended for all patients with chronic HCV infection except those with short life expectancies owing to comorbid conditions." (Plaintiff's Ex. 2, p. 3).

61. Denied. Plaintiff disputes Defendants' paragraph 61 as out of context and misleading. Prioritization was conceived, said the AASLD,

> before real world experience of the tolerability and safety of the newer HCV medications. More importantly, from a medical standpoint, data continue to accumulate that demonstrate the many benefits, within the liver and extrahepatic, that accompany HCV eradication. Therefore the panel continues to recommend treatment for all patients with chronic HCV infection. Accordingly, prioritization tables are now less useful and have been removed from this section.

(Plaintiff's Ex. 18, p. 1)

62. Denied. Plaintiff disputes Defendants' paragraph 62 to the extent that it is misleading for the reasons set forth in Plaintiff's paragraph 61.

63. Denied as stated by way of further clarification. Prioritization was abandoned because there is no longer a medical justification for it. (Plaintiff's Exhibit 18, p. 1).

64. Denied. In the accompanying press release, the AASLD was not making a medical recommendation that treatment should be delayed. (Plaintiff's Ex. 18, p. 1).

65. Denied. Plaintiff disputes that the AASLD was making a medical recommendation since they state that all chronic hepatitis C patients should be treated. (Plaintiff's Exhibit 18, p. 1). In addition, both Dr. Jay Cowan

and Dr. Paul Noel testified at the December 2015 hearing that there is no medical justification for denying Mr. Abu-Jamal's request that he be administered the direct-acting anti-viral medication. (Cowan: v.3, 68, stating that if he had a patient of any fibrosis level who could pay for the direct-acting anti-virals, he would recommend treatment; Noel: v.3, 154, stating that there was no medical reason for denying treatment to Mr. Abu-Jamal). In addition, Dr. Cowan admitted that it is money, not medicine, that determined treatment options in the prison setting. (Cowan: v.3, p. 77).

66. Denied. Plaintiff disputes that prioritization remains the practice "in the community". Both Drs. Harris and Cowan testified that treatment prioritization is not medically justifiable (Harris: v.2, p. 6; Cowan: v.3, p. 24-25). In addition, The Veterans Administration has now abandoned prioritization and is treating all chronic hepatitis C patients irrespective of fibrosis level. (See Plaintiff's Appendix, Exhibit 5).

67. Denied. Dr. Paul Noel testified at the preliminary injunction hearing that the DOC protocol does not have levels of prioritization (v.3, 127).

68. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

69. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration. Notwithstanding that objection, the Defendants have refused to treat the Plaintiff with direct-

acting anti-viral medications. Dr. Paul Noel admitted that the only inmates that the DOC has chosen to treat are those who have progressed to decompensated cirrhosis and also have esophageal varices. The language of the DOC's hepatitis C treatment protocol produced during the December hearing only mandates treatment for individuals with advanced cirrhosis and esophageal varices. This means that an inmate must be on the verge of a catastrophe, i.e. bleeding to death, in order to be accorded treatment (DSMF ¶ 84, n. 12; v.3, p. 106, 129, Noel. Dec. ¶ 3(d)). The protocol falls below accepted medical practices (Harris Dec., Plaintiff's Appendix, Ex. 3 ¶ 9).

70. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

71. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

72. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

73. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

74. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

75. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

76. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

77. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

78. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

79. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

80. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

81. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration. In addition, the Veterans Administration no longer uses the HLAT-C score but rather treats everyone irrespective of fibrosis level. Ex. __ "VA Expands Hepatitis C Drug Treatment," Press Release.

82. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

83. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

84. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration. In addition, plaintiff disputes the assertion that "advanced progression" does not occur before the development of esophageal varices (Harris: literature) Denied.

85. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

86. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

87. Admitted. Plaintiff tested positive for the Hepatitis C antibody in 2012. (Ex. D-1 at 167.)

88. Denied as stated. Plaintiff received a blood transfusion in December 1981. Before screening for the hepatitis C virus began in 1992, blood transfusions were considered a means of transmission. (CDC Report, Plaintiff's Appendix, Ex. 10, p. 5)

89. Denied as stated. Defendants' characterization is misleading. It was not until 2015 and only after complaints by plaintiff's counsel, that a viral load test was conducted and it was determined that Mr. Abu-Jamal suffers from chronic hepatitis C. (Letter from Robert J. Boyle, Esq. to Laura Neal, Esq. dated June 19, 2015, Plaintiff's Appendix, Ex. 11).

90. Admitted. Two CT scans and two ultrasounds were performed in 2015. (v.2 at 24-25; Ex. D-1 at 434, 637, 640.)

91. Admitted in part, and denied as stated by way of further clarification. On May 18, 2015 a CT scan was performed. It noted that "the overall appearance of the liver is irregular. Correlate for cirrhosis." A sonogram of the liver performed in March 16, 2015 found an "echogenic liver" suggestive of "some sort of parenchymal disorder." According to Dr. Harris the findings are consistent with liver inflammation consistent with hepatitis C. (Plaintiff's Appendix Ex. 7, p.1, 4-5; Harris: v.1 131-132).

92. Admitted. A report issued for the April 2015 CT noted that there was a "[s]lightly diminished attenuation…which could relate to a very mild fatty infiltration." (Ex. D-1 at 637.)

93. Denied. Dr. Harris did not testify that the test report noting an irregularity could be attributable to a difference in the doctor. Rather, he testified that the May 2015 CT scan at Geisinger means that plaintff has some degree of fibrosis if not cirrhosis (Harris: v.1 p. 131). He only agreed in theory that differences in readings can be attributed to different personnel conducting the tests. (v.2 at 25.). Indeed, defendants' expert Dr. Jay Cowan came to his opinions without being shown the May 2015 CT scan performed at Geisinger that found distortion of the liver architecture, a sign of cirrhosis. (Cowan: v.2 201). Cowan admitted that the CT result is "concerning" (Cowan, v.2, p. 61).

94. Denied as stated. Plaintiff's platelets have been monitored monthly during some of the time period at issue, but between 2012 through the middle of 2015 this was not the case. His blood work in 2016 has not occurred every month. Blood work that was done for at least the first half of 2015 was done on account of plaintiff's skin condition and diabetes, not as part of any alleged hepatitis C monitoring program. Additionally, plaintiff's platelet counts have consistently been below the normal range since October 2015. (Plaintiff's Appendix, Ex. 3, Harris Dec. 8/4/18 ¶ 5, referencing Plaintiff's Appendix, Ex. 6, p. 47, 48, 49 and 50). His most recent platelet count of June 2016 was 124, still in the abnormally low range. Plaintiff's Appendix, Ex. 13.)

95. Admitted. Additionally, however, Plaintiff's hemoglobin levels have been either below normal or at the bottom of the normal range. The latest blood test, administered in June 2016, show that his hemoglobin level is again below normal. (Declaration of Mumia Abu Jamal Dated August 4, 2016, ¶ 15, included in Plaintiff's Appendix, as Exhibit 4).

96. Admitted. Plaintiff admits that a Comprehensive Metabolic Panel ("CMP") lab was drawn on April 13, 2016.

97. Admitted in part and denied in part. Plaintiff admits that he was seen on April 4, 2016. Plaintiff disputes whether this was done as part of a chronic

care clinic examination as he has not been provided with discovery. See Fed.R.Civ.P. 56(d) Declaration.

98. Admitted. Dr. Harris estimates that Plaintiff's degree of fibrosis is F2-F2.5 on the Metavir scale. (v.2 p. 21-22). Dr. Cowan estimates it to be F2. (v.3, p. 75.). In additional, both estimates are consistent with significant liver scarring (Harris: v.2, 21-22).

99. Admitted. At of the time of the December 2015 preliminary injunction hearing in this action, Plaintiff had a calculated APRI score of 0.392 (v.2 at 210) and a Halt-C score of 63 (v.3 at 120).

100. Admitted with clarification. With respect to the APRI score, that means unlikely cirrhosis, significant fibrosis possible. Additionally, that test has a sensitivity of 37% meaning it only identifies 37 % of those who actually have cirrhosis. (v.3, p. 36) The HALT-C score of 63 means that there is a 63% chance that the plaintiff currently has cirrhosis (v.3, p. 120, 123).

101. Admitted with clarification. Plaintiff's April 13, 2016 platelet count (141) and AST level (22) resulted in an APRI score of 0.39. That placed him in the same category, to wit, cirrhosis unlikely, significant fibrosis possible.

102. Denied. According to the AASLD, "the presence of existing fibrosis is a strong risk factor for future fibrosis progression." (Plaintiff's Exhibit 18, p. 11; Plaintiff's Appendix, Ex. 9, p. 11).

103. Admitted with clarification.Plaintiff's HALT-C score, also based on his April 13, 2016 labs is 42, indicating that there is a 42% chance that he has already progressed to cirrhosis. (Cowan Decl. ¶ 4.; Noel, v.3, p. 120, 123).

104. Denied. Plaintiff disputes the allegation that he is unlikely to suffer irreparable injury to his liver until he reaches a state of advanced cirrhosis. Dr. Cowan did not testify to that. He stated that the liver damage of those in the early stages of fibrosis may, when treated with anti-virals, be reversible. (v.3, 78). In addition, the assertion in the paragraph is not true. Liver damage to many patients who have advanced to cirrhosis remains even after successful treatment with anti-virals. In addition, all untreated patients remain at a higher risk of developing liver cancer (Plaintiff's Appendix Ex. 3, Harris Dec. 8/4/16, ¶¶ 9-10).

105. Denied. Given that Mr. Abu-Jamal has, at a minimum, significant fibrosis, low platelet counts for nearly ten months, a skin condition that has not resolved after two years, persistent anemia one CT scan that showed an irregularly shaped liver, and a sonogram that showed an irregular liver, it can be stated to a reasonable degree of medical certainty that his disease is progressing to cirrhosis, if it hasn't already, and is life threatening (Harris: v.1, 151-152; Plaintiff's Appendix, Ex. 3, Harris Dec. 8/4/16 ¶¶ 3-5).

106. Denied. Defendants' experts Jay Cowan and Paul Noel agree that there is no medical justification for refusing to treat Mr. Abu Jamal with the direct-

acting anti-viral medication. (Cowan, v.3, p. 129; Noel, v.3, p. 154). Dr, Cowan agreed that even under the July 2015 AASLD guidelines that endorsed risk stratification, the plaintiff would be in the "high priority" category for treatment (Cowan, v.3, p. 81 referencing Plaintiff's Exhibit 2, p. 5).

107. Denied. In Dr. Harris' opinion, the skin condition, anemia and hyperglycemia are extra-hepatic manifestations of hepatitis C. That opinion reinforces his conclusion that the hepatitis C should be treated immediately. (Harris: v.1, p. 151-152). Moreover, in preparation for his testimony, Dr. Harris consulted with the leading experts in the field of hepatitis C and described Plaintiff's condition. They all said that Plaintiff should be treated. (Harris v.2, p. 36-38).

108. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

109. Denied. Plaintiff cannot respond to the assertions in this paragraph without discovery. See Fed.R.Civ.P. 56(d) Declaration.

110. Admitted in part and denied as stated by way of further clarification. At the December 2015 hearing in this matter, Plaintiff's expert, Dr. Harris, addressing the treatment that plaintiff has received for the skin condition, stated that the treatment without resolution only reinforced his opinion that the skin condition was secondary to the Hepatitis C. He testified:

> I'd like to point out that he's still having very extensive treatments and [the skin condition] hasn't resolved…if you look at this kind of treatment modality, that's big guns, you're loaded for bear, and if it doesn't get better from that, you have to look for some other etiology…I think that speaks strongly for either necrolytic acral erythema or some condition that's predicated on the Hepatitis C that nots going to get better without treatment of the Hepatitis C…In fact two specialists I consulted with, Dr. Brown who is head of Hepatology at Cornell and Douglas Dietrich, who is… head of hepatology at Mt. Sinai, and they didn't really care about what the skin condition was, they said, Treat him and it will go away.
>
> (v.1 p. 144-145.)

111. Denied. The allegations in this paragraph state a legal conclusion. In addition, plaintiff is unable to respond to this paragraph absent discovery. See Fed.R.Civ.P. 56(d) Declaration.

112. Denied. Plaintiff experienced minor skin issues prior to January 2014. (v.1 p. 48).

113. Admitted. Along with the skin issues, in August 2014 Plaintiff's energy level also decreased. He was prescribed triamcinolone cream and the rash seemed to disappear. (v.1 p. 49).

114. Denied. By the late summer of 2014, the rash returned and spread to Plaintiff's back, causing constant itching and fatigue. (v.1, p. 50). Mr. Abu Jamal was given creams and ointments. Deny that there were treatment plans "to address the rash". That is a conclusion.

115. Admitted in part and denied as stated by way of further clarification. By early 2015 the itchy rash had spread to virtually plaintiff's entire body, his chest, back, neck and arms (v. 1, p. 52; v.2, p. 83). Different treatments were administered but they had little or no effect on the severity of the rash. Mr. Abu-Jamal was told that the rash was "eczema" but that the physicians at SCI Mahanoy did not know the underlying cause (v.1, p. 54-55; Plaintiff's Ex. 6 and 7).

116. Admitted. A dermatologist, Dr. Steven Schleicher, was first consulted in February 2015. Additionally, Dr. Schleicher admitted that when he first saw Mr. Abu Jamal he was covered from head to toe with the rash. Dr. Schleicher admitted that current literature instructs that hepatitis C must be considered when patients present with an unexplained rash. However, he never inquired as to whether Mr. Abu-Jamal had been exposed to the hepatitis C virus (v.2, 82-84).

117. Admitted in part, and denied in part. Plaintiff admits that he has consulted periodically with Dr. Schleicher. Plaintiff disputes whether his treatment has been "coordinated" with Dr. Schleicher and cannot adequately respond to that claim absent discovery, See Fed.R.Civ.P. 56(d) Declaration.

118. Denied. Following a June 23, 2015 skin biopsy a dermatopathologist did not come to a definitive diagnosis. The doctor noted that the condition could be "psoriasis, but possibly nummular eczema." (Ex. D-1 at 415). In any

event, that diagnosis is consistent with the skin condition being a manifestation of hepatitis C (Harris: v.1, p. 129).

119. Denied. Plaintiff disputes that he has been "treated" for the skin condition by Dr. Schleicher. The skin condition is a manifestation of the hepatitis C and the hepatitis C has not been treated (Harris: vol.1, p. 145).

120. Denied. Plaintiff disputes that he has been treated for his skin condition as the cause of the skin condition, hepatitis C, has not been treated (Harris: vol. 1, p. 145).

121. Admitted in part, and denied in part. Plaintiff admits that he has been provided with baths, triamcinolone cream, Vaseline, and phototherapy sessions. (vol.1 p. 91.). He disputes that these are "treatments" for the skin condition that is caused by hepatitis C which has not been treated. (Harris: vol.1, p. 145).

122. Admitted in part, Denied in part. For a time in late 2015 the skin condition, and the itching associated with it, improved. (v.1 at 90-1.). Since that time that skin condition worsened (Dkt. 120, Declaration of Mumia Abu Jamal sworn to April 3, 2016) .

123. Admitted. On one day in late 2015, plaintiff told Dr. Schleicher that he felt "great". (v.1 at 90).

124. Denied. Plaintiff disputes that the skin condition has improved by as much as 90% since Dr. Schleicher first examined him. Additionally, after a brief

improvement in late 2015, it has worsened. (Dkt. 120, Declaration Mumia Abu-Jamal, dated April 3 2016 ¶¶ 1-7).

125. Admitted in part and denied in part. Dr. Schleicher did order reduction of phototherapy treatments for a period of time in early 2016. Plaintiff disputes that any of the procedures directed toward the skin condition constituted "treatment" for that condition as the condition is caused by the hepatitis C that has not been treated. (Harris: vol.1, p. 145).

126. Admitted in part and denied as stated by way of further clarification. Dr. Schleicher did order reduction of phototherapy treatments for a period of time in early 2016. Plaintiff disputes that any of the procedures directed toward the skin condition constituted "treatment" for that condition as the condition is caused by the hepatitis C that has not been treated. (Harris: vol.1, p. 145).

127. Admitted. Plaintiff remained on his topical steroid, petroleum jelly and Benadryl as needed for itching. However, those "treatments" have resulted in no improvement (Dkt. 120, Declaration of Mumia Abu Jamal sworn to April 3, 2016 ¶ 5).

128. Denied. Plaintiff lacks the information necessary to admit or dispute whether Dr. Schleicher has reviewed medical records generated since the December 2015 hearing as there has been no discovery. See Fed.R.Civ.P. 56(d) Declaration. Plaintiff disputes that Dr. Schleicher's Declaration was

submitted in accordance with this Court's June 3, 2016 order as that order did not solicit opinion testimony.

129. Admitted in part and denied as stated by way of further clarification. Plaintiff acknowledges that he has been administered baths three times per week, issued topical steroid creams, self-administered petroleum jelly, received benedryl, been administered a kenalog injection, been administered Otzela and undergone phototherapy sessions in varying frequency and length. Plaintiff disputes that these procedures constitute "treatment" for his skin condition as the skin condition is caused by the hepatitis C which has not been treated. (Harris: vol.1, p. 145).

130. Admitted. Plaintiff acknowledges that he has had dermatology consult examinations, via telemed, on February 12, 2015, March 28, 2016, April 11, 2016, April 26, 2016 and May 27, 2016. (Schleicher Decl. ¶ 2).

131. Admitted. Mr. Abu-Jamal had a telemed conference with Dr. Schleicher on February 12, 2016. During that visit Mr. Abu-Jamal explained that the skin condition had worsened. The itching has increased, the scaly patches have re-appeared on his forearms and remained on his buttocks and lower back. In addition, during that visit Dr. Schleicher told Mr. Abu-Jamal that he would be increasing phototherapy sessions back to three times per week for three minutes at a time and recommended that he self-administer Vaseline

three times a day (Dkt. 120, Declaration of Mumia Abu Jamal Dated April 3, 2016) Schleicher Dec. ¶ 8).

132. Admitted. As a result of the worsening condition phototherapy sessions were increased to three times per week fort three minutes each (Schleicher Decl. ¶ 8).

133. Admitted. Dr. Schleicher saw Plaintiff again on March 28, 2016 via telemedicine as a follow-up appointment. (Schleicher Decl. ¶ 9).

134. Admitted with clarification. On that date, Plaintiff informed Dr. Schleicher that the itching was still constant. (Dkt. 120, Declaration of Mumia Abu Jamal Dated April 3, 2016, ¶ 6). Dr. Schleicher himself noted some lichenified placques in the area affected by his rash. (Schleicher Decl. ¶ 9.).

135. Admitted. Dr. Schleicher recommended increasing Plaintiff's ultraviolet therapy to three times per week for three minutes, thirty seconds. (Schleicher Decl. ¶ 9).

136. Admitted. Dr. Schleicher also recommended administering a kenalog injection. (Schleicher Decl. ¶ 9).

137. Admitted in part and denied as stated by way of further clarification. The medical records indicate that those procedures were administered. Plaintiff disputes that this was "treatment" for the skin condition as that is a manifestation of the hepatitis C which has not been treated. (Harris: vol.1, p. 145).

138. Admitted. Dr. Schleicher saw Plaintiff again on April 11, 2016 as a follow-up appointment. (Schleicher Decl. ¶ 10).

139. Admitted. On that date, Plaintiff stated that while the itching had briefly improved, it had worsened again. (Schleicher Decl. ¶ 10).

140. Admitted. According to Dr. Schleicher, Plaintiff's skin showed improvement on his abdomen and chest and his back remained stable. (Schleicher Decl. ¶ 10).

141. Admitted. Dr. Schleicher increased the phototherapy duration per session to three minutes, forty-five seconds. (Schleicher Decl. ¶ 10.). However, Plaintiff continues to experience pruritis (Declaration of Mumia Abu Jamal sworn to August 4, 2016, ¶¶ 9, 12, Plaintiff's Appendix, Ex. 4).

142. Admitted. Dr. Schleicher also prescribed Diprolene AF, a topical steroid ointment, twice daily for two weeks. (Schleicher Decl. ¶ 10.).

143. Admitted. The medical records indicate that Plaintiff was offered that treatment. (Schleicher Decl. ¶ 10).

144. Denied as stated. By way of further clarification. Plaintiff expressed apprehension about using a topical steroid given that prior use of steroids had led to a life-threatening rise in blood glucose levels (Declaration of Mumia Abu Jamal dated August 4, 2016, ¶¶ 7-8, Plaintiff's Appendix, Ex. 4).

145. Admitted in part and denied as stated by way of further clarification. Further, during one of his medical exams in April 2016, Plaintiff was asked what he was using for his skin condition and he omitted mention of Diprolene and other steroidal topical treatments because he was not using them. (*Id.*)

146. Admitted. Dr. Schleicher saw Plaintiff again on April 26, 2016 for a follow-up exam. (Schleicher Decl. ¶ 11.)

147. Admitted. On that date, the records noted some continued improvement of the rash. (*Id.*)

148. Admitted in part and denied as stated by way of further clarification. Plaintiff further reported that his itching had been somewhat relieved with use of the prescribed Benadryl. (*Id.*)

149. Admitted. Dr. Schleicher recommended changing back to triamcinolone ointment at that point due to Plaintiff's stated apprehension about using the Diprolene cream. (*Id.*)

150. Admitted. Because plaintiff continued to complain of itching, Dr. Schleicher also increased his phototherapy sessions to four minutes in duration. (Id.)

151. Admitted. Dr. Schleicher saw Plaintiff again on May 27, 2016. (Schleicher Decl. ¶ 12.)

152. Admitted in part and denied in part. Plaintiff continued to complain of itching and dry skin. The appearance of the skin had not improved.

(Declaration of Mumia Abu-Jamal dated August 4, 2016, ¶ 12, Plaintiff's Appendix, Ex. 4).

153. Admitted. Plaintiff continued to experience itching. Dr. Schleicher recommended the oral therapy Otezla and increased his phototherapy sessions to four minutes, thirty seconds per session three times per week.

154 Admitted. Dr. Schleicher did not write an order for the Otezla, but provided a month's worth of samples to gauge Plaintiff's response. In addition, Mr. Abu-Jamal was subsequently given a prescription beyond the month sample. (Declaration of Mumia Abu-Jamal dated August 4, 2016, ¶ 10, Plaintiff's Appendix, Ex. 4).

155. Admitted. The medical records show that Plaintiff was offered this medication. (Id.)

156. Admitted with clarification. Around this same time, Plaintiff recently began refusing his phototherapy sessions. (Schleicher Decl. ¶ 13.). On June 27, 2014, Mr. Abu-Jamal suffered a first degree burn after a phototherapy session. It was upon the advice of Dr. Eisenberg that he declined further phototherapy treatments as the Otzela may be making his skin sun sensitive (Declaration of Mumia Abu-Jamal Dated August 4, 2016, ¶ 13, Plaintiff's Appendix, Ex. 4).

157. Admitted in part and denied as stated by way of further clarification. Mr. Abu Jamal has stated that he wears his boxers in the phototherapy booth,

though he disputes this is the reason that the rash remains in those areas. It effects skin that is not covered by the boxers and the pruritis is present all over his body. (Declaration of Mumia Abu Jamal dated August 4, 2016, ¶ 12, Plaintiff's Appendix, Ex. 4).

158. Admitted. With respect to Plaintiff's request for treatment with Protopic, the Protopic cream was initially recommended as a non-steroidal alternative to the triamcinolone cream, which can affect blood sugar. (v.2 at 68.)

159. Admitted with clarification. Plaintiff refused that medication at a time when it was suspected that he may have lymphoma as that medication is contraindicated for that disease. (Id. at 66-67; Ex. D-1 at 119-131.)

160. Admitted. After Plaintiff was admitted to GMC for treatment of a flare in his skin condition, physicians at that facility advised against using the Protopic. (v.2 at 69, Ex. D-1 at 166-67.)

161. Admitted. Dr. Schleicher does not recommend treatment with the Protopic medication based on plaintiff's improvement on his current treatment. (v.2 at 68.)

162. Denied. According to Dr. Harris, the skin condition is an extra-hepatic manifestation of hepatitis C (Harris: v.1, p. 135-137, 145).

163. Denied. Dr. Schleicher admitted that he knows little about hepatitis C or its treatment protocols. (v.2, p. 111-112).

164. Denied. That the skin condition has not resolved after nearly two years after a battery of various procedures strongly suggests that it is an extrahepatic manifestation of hepatitis C. (Harris: v.1, p. 145).

165. Admitted. According to CHCA John Steinhart, after the December 2015 preliminary injunction hearing Plaintiff was discharged from SCI-Mahanoy's infirmary care on January 15, 2016 following a review by his treating physicians. (Steinhart Decl. ¶ 2.)

166. Admitted. He remained housed in the infirmary until he was returned to general population housing on January 25, 2016. (Steinhart Decl. ¶ 2).

167. Admitted. Since that date, he continued to receive his Cutar emulsions and phototherapy in the infirmary three times per week. Recently he stopped receiving the phototherapy upon recommendation of Dr. Eisenberg on account of plaintiff having suffered a first-degree burn. (Steinhart Decl. ¶ 3); (Declaration of Mumia Abu-Jamal sworn to August 4, 2016 ¶ 13, Plaintiff's Appendix, Ex. 4)). However, he has not received the anti-viral hepatitis C drugs.

168. Admitted. He has also been seen in the infirmary by medical staff as indicated in his medical records. (Steinhart Decl. ¶ 4.)

169. Denied. A blood test conducted on February 17, 2015 showed that plaintiff's blood sugar had risen to the abnormally high 106 and on February

20 had risen to 167. A test on March 6, 2015 showed that it had risen to 419. He was not told of those results. (Plaintiff's Ex. 1, p. A9-A14).

170. Denied. On March 30, 2015, Plaintiff fell into unconsciousness and was rushed to the hospital where it was determined he had a blood sugar level of 519. Although the glucose level was controlled, plaintiff experienced weakness and mental confusion for the next several weeks. (v.1, p. 60-64).

171. Denied. Plaintiff disputes. Dr. Noel is not qualified to render this opinion.

172. Denied. Plaintiff disputes. Dr. Noel is not qualified to render this opinion.

173. Denied. Adult onset diabetes is an extrahepatic manifestation of hepatitis C. (AASLD). Plaintiff's Exhibit 18, p. 6; Plaintiff's Appendix Ex. 9.

174. Denied. The current normal sugar levels could be the result of a "honeymoon period". (Harris, v.1 p. 148 In any event, untreated hepatitis C places Plaintiff at a greater risk of developing adult onset diabetes. Plaintiff's Ex. 18, p. 6.

175. Admitted. Plaintiff's most recent hemoglobin Alc lab from April 13, 2016 was 5.6, which is within the normal range.

176. Admitted. Plaintiff prior hemoglobin A1c lab from October 29, 2015 was 5.4. (Cowan Decl. ¶ 5.). Plaintiff disputes the term "significant" as it could still be the "honeymoon" period. (v. 1, p. 148).

177. Denied. The normal blood glucose and hemoglobin A1c can be attributed to the honeymoon period (v.1 p. 148).

178. Denied as stated. Plaintiff has been and is anemic. Dispute the term "was". (Ex. D-1 at 133, 141, 182-186, 385-400, 598-607.).

179. Admitted. Plaintiff admits that medical staff at SCI Mahanoy caused blood work to be performed and that this bloodwork showed consistently abnormally low hemoglobin levels. (Ex. D-1 at 133, 141, 182-186, 385-400, 598-607.). Plaintiff further points out that medical staff at Geisinger Medical Center could not find the cause of plaintiff's anemia and classified it as "anemia of chronic disease". Amemia of chronic disease is a manifestation of hepatitis C . (Harris: v.1, p. 132-133, 146, v.2 44-45).

180. Admitted. Plaintiff has had consultations with an oncologist, Dr. Maholtra. (Ex. D-1 at 211, 212-13, 409, 422, 424, 426-27, 430, 442, 656).

181. Admitted. Dr. Maholtra recommended treatment with iron therapy and Procrit. (Ex. D-1 at 656, v.3 at 57).

182. Admitted. Plaintiff had a bone marrow biopsy that could not determine the cause of his anemia (Ex. D-1 at 200).

183. Denied as misleading. Admitted that plaintiff's hemoglobin levels rose after administration of Procrit, but denied to the extent it implies he no longer had anemia, as his hemoglobin levels did not return to normal range. (Harris: v. 2. p. 44).

184. Admitted with clarification. At one point plaintiff told the oncologist that he was "feel[ing] better." (Ex. D-1 at 409.) Plaintiff denies that the statement had anything to do with rising hemoglobin levels.

185. Admitted. Plaintiff admits that Dr. Maholtra informed him that his hemoglobin levels had improved. (v.1 at 97.)

186. Denied. At the time of the December 2015 hearing in this matter, the latest blood tests showed that Plaintiff's hemoglobin remained below normal (Ex. D-1 at 385).

187. Denied. Dr. Harris opined that given that Plaintiff suffers from chronic hepatitis C, and that a battery of tests, including a bone marrow biopsy has not been able to determine the cause of his persistent anemia, it is his opinion that the anemia is an extrahepatic manifestation of the hepatitis C. (v. 1, p 117, 125, 146; v.2, p. 53).

188. Denied. Dr. Harris bases that opinion in part on the fact that even after administration of Procrit, the hemoglobin levels have not consistently been within the normal range. (v.1 p. 146).

189. Admitted that Dr. Cowan offered such an opinion; denied that the opinion is credible. Given the persistence of the anemia, iron supplementation and Procrit, it is a manifestation of the hepatitis C (Harris: v.1, p. 117, 125, 146; v.2 p. 53).

190. Denied. Dr. Harris continues to opine that the anemia is an extrahepatic manifestation of hepatitis C. (Declaration of Joseph Harris, M.D. sworn to August 4, 2016, ¶ 7, Plaintiff's Appendix, Ex. 3).

191. Denied. Plaintiff's most recent hemoglobin level from his June labs was 12.9 which is below the normal range (Declaration of Mumia Abu Jamal dated August 4, 2016, ¶ 15, Plaintiff's Appendix, Ex. 4).

192. Denied. His hemoglobin, at 12.9, is once again below normal. (*Id.*; Plaintiff's Appendix Ex. 6, p. 35 stating normal range as 13.5-17.5.)

193. Denied. Dr. Harris's opinion is supported by Plaintiff's persistent anemia in the absence of any other medically sound cause for that anemia. (v.1, p. 132-133, 146, v.2 44-45; Harris Declaration, 8/4/16 ¶ 7).

194. Denied. See Paragraph 193.

195. Denied. That plaintiff's hemoglobin levels are once again below normal reinforces Dr. Harris's opinion that the anemia is a by-product of hepatitis C. (*Id.* See Paragraph 193).

196. Admitted. Plaintiff was transferred from SCI-Mahanoy to Geisinger Medical Center on May 12, 2015. (Doc. 57 ¶ 8.).

197. Admitted that defendants believe this to be the case.

198. Admitted. As a result, when Plaintiff was taken to Schuylkill Medical Center (prior to May 2015) and to GMC (in May 2015) additional armed officers were used as escorts. (v.2 at 183-84.).

199. Admitted in part and denied in part. While Plaintiff was at Schuylkill Medical Center, approximately 10-15 friends, family, and counsel arrived at the hospital. Only a handful sought to visit Mr. Abu-Jamal. To the extent that the statement implies that these individuals attempted to circumvent rules of the hospital it is denied. Friends and family of Mr. Abu-Jamal were peaceful and rule-abiding at all times. (Grote Declaration ¶¶ 30-31, Plaintiff's Appendix, Ex. 1).

200. Admitted. Prior to Plaintiff's transfer to GMC, Plaintiff had received visits from Attorney Grote on May 8, 2015 and from family, friends and other attorneys on occasions on the dates leading up to his transfer. (See Sorber Decl. Ex. A.) (Submitted as App. Ex. 19).

201. Admitted. Plaintiff returned to SCI-Mahanoy from Geisinger Medical Center on May 19, 2015. (Doc. 57 ¶ 8.)

202. Admitted. He received a telephone call from Attorney Grote on that date and also the following day, May 20, 2015. (Doc. 12, Status Report) ("Attorney Grote spoke with the plaintiff Mumia Abu-Jamal via telephone on the evening of May 19 and on the morning of May 20.)

203. Admitted. He also received a visit with Attorney Grote on May 22, 2015. (Sorber Decl. Ex. A.)

204. Admitted in part, denied in part. The administrative remedies for certain inmate grievances are provided for in Department of Corrections

Administrative Directive 804 ("DC-ADM 804"). (Varner Decl. ¶ 6.) (Submitted as App. Ex. 20.) Other grievances are dealt with via the DC-ADM 801, DC-ADM 802, the Prison Rape Elimination Act Policy, and the Reasonable Accommodation Policy (Submitted as Plaintiff's Appendix Ex. __).

205. Admitted. The Department of Corrections' grievance system is a three-tiered system. (Id. at ¶ 7.)

206. Admitted. Pursuant to DC-ADM 804, the first step in the inmate grievance process is an initial review. An inmate must submit a grievance within 15 working days of the event on which the grievance is based. (Id. at ¶ 8.)

207. Admitted. Grievances must be filed at the institution where the incidents complained of occurred. (Id. at ¶ 9.)

208. Denied as misleading. During the relevant time period, the DC-ADM 804 stated, "If the inmate desires compensation or other legal relief normally available from a court, the inmate must request the specific relief sought in his/her initial grievance." (Id. at Ex. A, Sect. 1(A)(12)(d).) Plaintiff disputes that this is mandatory requirement for facilitating merits review of the grievance and allowing the prison the opportunity to take remedial action. Plaintiff further disputes that compensation is available via the DOC's grievance process for medical care complaints Plaintiff further disputes that other forms of "legal relief normally available from a court" are available via

the grievance process. Further, plaintiff requires discovery to develop facts regarding whether DOC officials provide compensation or other "legal relief normally available from a court" via the grievance process. See Rule 56(d) declaration.

209. Admitted. An inmate who is dissatisfied with the initial review decision is permitted to appeal to the Facility Manager within 15 working days of the initial review decision. (Id. at ¶ 10).

210. Admitted. At a state correctional institution, the Facility Manager is the institution's Superintendent. (Id. at ¶ 11.)

211. Admitted. An appeal to final review may be sought through SOIGA by filing an appeal within 15 working days of the date of the Superintendent's decision. Extensions to these deadlines may be granted at the discretion of the agency if the inmate submits a written explanation for a failure to timely file the grievance or an appeal. (Id. at ¶ 12.)

212. Denied. Plaintiff has filed another grievance since Ms. Hinman's declaration. (Declaration of Mumia Abu-Jamal Dated August 4, 2016, ¶¶ 16-18, Plaintiff's Appendix, Ex. 4).

213. Denied. Plaintiff has filed at least 7 grievances, two of which dealt with medical care issues. (Id.).

214. Denied as stated. Grievance 561400 dealt with the entirety of his medical care claims as has been recognized by this court on two occasions.

Admitted that this grievance was submitted by Plaintiff on or about April 11, 2015 and was accepted for filing on April 13, 2015. (Id. at ¶ 7.)

215. Admitted. Plaintiff requested an "acknowledgement of wrongdoing, improper care, and a detailed plan to prevent any recurrence….[and] that SCI-Mahanoy officials permit me to be examined by doctors of my own choosing…." (Id. at Ex. A.)

216. Admitted in part and denied in part. Plaintiff appealed the initial review decision on that grievance to Superintendent Kerestes. The appeal was accepted and, by decision that was dated May 26, 2015, Supt. Kerestes denied the appeal, though plaintiff did not receive this decision until June. In his decision, the Superintendent noted that he had reviewed the underlying documents and the response which indicated that his condition continued to be "properly monitor[ed] and treat[ed]." (Hinman Decl. at ¶ 8, Ex. A.)

217. Admitted in part and denied in part. He sent his appeal to final review of Grievance 561400 on June 26, 2015. It was marked accepted on July 6, 2015. Following a review of the issues raised and the relief requested, a decision on the merits of the medical care complaints he raised was issued on September 24, 2015. (Varner Decl. ¶ 17.)

218. Admitted in part, denied in part. The remaining grievances (446348, 447053, 449271, 510516, and 620529) related to complaints regarding mail, telephone

issues and visiting issues inside institutional grounds. (Hinman Decl. ¶ 9.). Mr. Abu-Jamal has submitted another grievance regarding medical care. (Declaration of Mumia Abu Jamal Dated August 4, 2016, ¶ 18, Plaintiff's Appendix, Ex. 4).

219. Admitted. None of these grievances related to visits or family/attorney contact during treatment at outside medical facilities. (Id.)

220. Denied. Plaintiff has filed another grievance subsequent to Ms. Hinman's declaration in this case. (See ¶ 218)

221. Admitted. He has not filed any appeals to final review regarding medical care or attorney/family visitation while at outside facilities. (Id. at ¶ 18.)

Respectfully submitted,

/s/ Bret D. Grote
Bret D. Grote
PA I.D. No. 317273
Abolitionist Law Center
P.O. Box 8654
Pittsburgh, PA 15221
Telephone: (412) 654-9070
bretgrote@abolitionistlawcenter.org

/s/ Robert J. Boyle
Robert J. Boyle
277 Broadway
Suite 1501
New York, N.Y. 10007

(212) 431-0229
Rjboyle55@gmail.com
NYS ID# 1772094
Pro hac vice

CERTIFICATE OF SERVICE

I hereby certify that I served a copy of this Counter-Statement of Facts in Opposition to DOC Defendants' Motion for Summary Judgment upon each defendant in the following manner:

Service Via ECF:

For Defendants Kerestes, DelBalso, Norris, Oppman, and Steinhart:
Laura Neal, Esquire
Pennsylvania Department of Corrections
1920 Technology Parkway
Mechanicsburg, PA 17050
lneal@pa.gov

For Defendants Lisiak, Khanum, and Saxon:
Samuel H. Foreman, Esquire
Caitlin Goodrich, Esquire
sforeman@wglaw.com
cgoodrich@wglaw.com

Fore Defendant Geisinger Medical Center:
Jack Dempsey, Esquire
Myers, Brier & Kelly, LLP
425 Spruce Street, Suite 200
Scranton, Pennsylvania 18503
jdempsey@mbklaw.com

s/ Bret D. Grote
Bret D. Grote
Abolitionist Law Center
P.O. Box 8654
Pittsburgh, PA 15221

Dated: August 5, 2016