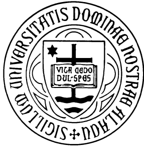

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Inmates of New York State with HIV v. New York

Legal Aid Society of New York

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MODEL COMPLAINT

Editors's Note

[The following is a complaint filed by the New York Legal Aid Society on behalf of all inmates of the New York State Prison System in the federal district court for the Northern District of New York. The Journal *has chosen to publish the complaint because it represents a novel and unique piece of legal literature. However, the reader should note that the facts alleged in the complaint are only allegations; no legal determination as to the validity of these allegations has yet been rendered by the court in which the complaint was filed. Also, the views expressed by the complaint do not necessarily reflect the views of the* Journal *or the University of Notre Dame.]*

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

——————————————————— X

INMATES OF NEW YORK STATE WITH HUMAN IMMUNE DEFICIENCY VIRUS, for themselves and all others similarly situated, :

Plaintiffs, :

- against - :

MARIO M. CUOMO, Governor of the State of New York; THOMAS A. COUGHLIN III, Commissioner of the New York State Department of Correctional Services; ROBERT GREIFINGER, Deputy Commissioner and Chief Medical Officer of the New York State Department of Correctional Services; GLENN S. GOORD, Deputy Commissioner for Facility Operations of the New York State Department of Correctional Services; MARION BORUM, Deputy Commissioner for Program Services of the New York State Department of Correctional Services; RAYMOND BROADDUS, Assistant Commissioner of the New York State Department of Correctional Services; RICHARD C. SURLES, Commissioner of the New York State Office of Mental Health; and JOEL A. DVOSKIN, Assistant Commissioner for the Bureau of Forensic Services of the New York State Office of Mental Health,

Defendants.

——————————————————— X

CLASS ACTION COMPLAINT

No.: 90-CU-252

Nature of Action and Jurisdiction

1. This is a class action for declaratory and injunctive relief on behalf of all persons who are infected with human immune deficiency virus (HIV) and who are or will be confined in the custody of the New York State Department of Correctional Services (DOCS) against officials of the State of New York who have responsibility for and complete control over plaintiffs' health care and conditions of confinement. Defendants, under color of state law, with deliberate indifference to plaintiffs' serious health care needs and in violation of their rights to privacy, to due process of law, and to be free of cruel and unusual punishment, have subjected plaintiffs to illegal and unconstitutional conditions of confinement, resulting in unnec-

essary and premature death, substantial pain, physical and psychological suffering, and unnecessary injury.

2. Plaintiffs seek redress for deprivations of rights secured by the Eighth, Ninth and Fourteenth Amendments to the United States Constitution. The claims for relief are filed under 42 U.S.C. § 1983, and this Court has jurisdiction of the claims pursuant to 28 U.S.C. §§ 1331 and 1343.

PARTIES

3. Each of the plaintiffs is a prisoner currently in the custody of DOCS. The plaintiffs sue for themselves and for all other present and future inmates in DOCS custody who are infected with HIV.

4. Defendant MARIO M. CUOMO is the Governor of the State of New York in whom the executive power is vested. As such, he is ultimately responsible for the operation of executive agencies in New York, including DOCS and the New York State Office of Mental Health (OMH), and has control of the conduct of agency commissioners and other employees through his appointment and removal powers. He has budgetary authority over agency funding and resource allocations.

5. Defendant THOMAS A. COUGHLIN III is the Commissioner of DOCS and its chief executive officer. He has superintendence, management and control of all New York State correctional facilities and DOCS employees and is responsible for the custody and conditions of confinement of all members of the plaintiff class.

6. Defendant ROBERT GREIFINGER is the Deputy Commissioner and Chief Medical Officer of DOCS. He is responsible for the provision of health care services to the plaintiff class, the organization and supervision of DOCS' Division of Health Services, and the performance of DOCS' health care employees.

7. Defendant GLENN S. GOORD is the Deputy Commissioner for Facility Operations. He is responsible for inmate and correctional facility security.

8. Defendant MARION BORUM is the Deputy Commissioner for Program Services of DOCS. He is responsible for the delivery of program services to the plaintiff class, including recreation, education and visiting.

9. Defendant RAYMOND BROADDUS is an Assistant Commissioner of DOCS. He is responsible for the delivery of mental health and dietary services to the plaintiff class.

10. Defendant RICHARD C. SURLES is Commissioner of OMH and its chief executive officer. He is responsible for the executive management of OMH and the superintendence and control of the provision of mental health services to members of the plaintiff class at DOCS facilities and at Central New York Psychiatric Center.

11. Defendant JOEL A. DVOSKIN is the Assistant Commissioner for the Bureau of Forensic Services of OMH. He is responsible for the operations of the Bureau, which is charged with delivering mental health services to the plaintiff class.

Class Action Allegations

12. The named plaintiffs bring this action on their own behalf and, pursuant to Rule 23 of the Federal Rules of Civil Procedure, as representatives of a class of all persons who are or will be confined in the custody of DOCS and who are infected with HIV. The class seeks declaratory and injunctive relief pursuant to Rules 23(b)(1) and 23(b)(2).

13. The proposed class meets the requirements of Rule 23(a) in that:

a. There are more than 50,000 people confined in the custody of DOCS and approximately 20% of these persons are infected with HIV. The class includes persons who are asymptomatic as well as those who have developed an HIV-related illness or Acquired Immune Deficiency Syndrome (AIDS). The class is fluid and transitory as well as numerous, rendering joinder of all members impracticable. Moreover, joinder of all members is impossible since the identity of all present class members is not known and the class includes future members.

b. The conditions, practices, procedures, failures, and omissions that form the basis of this complaint are common to all members of the class, and therefore there are questions of law and fact common to all class members, including, but not limited to, whether there is a systemic failure to provide for the serious health care needs of the class and whether there are conditions of confinement that deny the class privacy, due process of law, and freedom from cruel and unusual punishment, all in violation of their rights under the United States Constitution.

c. The claims of the named plaintiffs are typical of the claims of the entire class in that they are all infected with HIV and are currently in the custody of DOCS. Their health care treatment, or lack thereof, and the conditions of their con-

finement arise from the same systemic deficiencies, practices, procedures, failures, and omissions that violate the rights of the entire class.

d. The named plaintiffs will fairly and adequately represent the interests and claims of the class and are represented by counsel experienced in prisoners' rights litigation.

14. The class meets the requirements of Rules 23(b)(1) and 23(b)(2) in that:

a. The prosecution of separate actions by individual class members would create a risk of inconsistent adjudications that would establish inconsistent standards of conduct for defendants. Such adjudications would, as a practical matter, be dispositive of the interests of members of the class who are not parties to the adjudications and would substantially impair their ability to protect their interests.

b. Defendants have acted or refused to act on grounds generally applicable to the class, making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole.

15. Because of the nature of the class, without class certification there is a danger that the claims of individual plaintiffs may become moot through their release from custody or their deaths from HIV-related illnesses of AIDS, although the conditions, practices, procedures, failures, and omissions that deny the rights of others similarly situated persist.

FACTUAL ALLEGATIONS

The Human Immune Deficiency Virus and Acquired Immune Deficiency Syndrome

16. "HIV" is a retrovirus identified as the cause of AIDS. It attacks the body's immune system, and, when it has seriously impaired this system, the host is subject to various illnesses and diseases, known as opportunistic infections, normally combated by a healthy immune system. Some of these opportunistic infections are life-threatening and must be aggressively treated for the patient to survive.

17. "AIDS" is a clinical diagnosis of a disease complex characterized by infection with HIV, the dysfunction of the immune system, and the presence of one or more opportunistic diseases or other manifestations taking advantage of the suppressed immune system. The criteria warranting a diagnosis of "AIDS" are decreed for surveillance purposes by the Centers for Disease Control, and they have been revised from time to time.

18. There is no test for AIDS itself. Commonly available tests determine, with varying degrees of accuracy, whether the body has developed antibodies to HIV. Despite infection with HIV, the host may continue to test negatively for HIV antibodies for a period of time that may extend up to eighteen months.

19. The presence of HIV antibodies in a patient (seropositivity) does not mean that the patient has AIDS or necessarily will ever get AIDS or an opportunistic infection. Some seropositive persons remain asymptomatic for months or years; others develop stages of HIV-related illness that do not meet the surveillance definition of AIDS; still others develop AIDS quickly. For those diagnosed with AIDS there is no known medical cure.

20. There are treatments and therapies available that help asymptomatic seropositive persons avoid developing AIDS or an HIV-related illness. There are also therapies and medications available for the treatment of HIV-related opportunistic illnesses and for the care and comfort of the patient.

21. The early detection and management of HIV infection and the treatment of HIV-related illnesses and AIDS require a complex, comprehensive, coordinated, dedicated, and intensive regime of monitoring and medical interventions. Signs and symptoms suggestive of only minor ailments in patients without HIV infection may portend life-threatening illness for infected patients. Among these are swollen glands, mouth infections, skin rashes, fever, bone and joint pain, sore throat, night sweats, shortness of breath, headaches, and neurological problems.

22. Prevalence of HIV is disproportionately high in certain segments of society, such as intravenous drug users and gay men. Particular vigilance is required when assessing the health status of members of these risk groups.

23. The detection of HIV infection and the early diagnosis of HIV-related illness and AIDS, along with timely and appropriate monitoring, therapies, and treatments, can prolong the life and reduce the suffering of seropositive patients.

24. There are numerous laboratory tests utilized for the proper monitoring and management of patients with HIV infection. Although no one test is definitive, various "T-cell subset counts," which assess the status of certain types of lymphocytes (white cells) in the blood and their relation to each other, are widely utilized. One such count, the "absolute CD4 cell count," is used by the Centers for Disease Control and the

Food and Drug Administration as a marker of various stages of the disease and as a triggering point for initiation of various treatments. [For simplicity, this test is referred to hereinafter as the "T4 count."] As the disease progresses, the T4 count drops below its normal range of approximately 500-1500 in healthy persons. When the T4 count falls below 200, the infection is considered to be in an advanced stage.

25. Although AIDS is an infectious disease, HIV is not easily transmitted, and casual interpersonal contacts pose no risk. HIV is transmitted by contact with blood, semen or vaginal secretions in unsafe sexual relations, by infusion or inoculation of blood in transfusions, intravenous needle sharing activities or tattooing, or perinatally during pregnancy.

The Impact of HIV and AIDS on Correctional Health Care and Administration

26. HIV infection and AIDS require defendants to provide a full range of medical and support services in order to meet the serious needs of the plaintiff class and prevent unnecessary suffering.

a. Because AIDS itself and many of its attendant opportunistic infections are unfamiliar to most practitioners, prison medical personnel must be provided with adequate and up-to-date training in the diagnostic and treatment procedures that are available and necessary to avoid unnecessary suffering and premature death on the part of class members.

b. Because of the disease's complexity and the continuing rapid development in means of evaluation and treatment, adequate care for class members requires regular and frequent access to the services of infectious disease specialists.

c. Because the symptoms of HIV infection (e.g., persistent headaches, respiratory discomfort, weight loss, oral infections, night sweats, abnormal blood tests, and neurological problems) can mimic the symptoms of common minor infections, "sick call" or medical screening procedures must be sufficiently thorough, and the relevant personnel sufficiently trained, so HIV-related illnesses can be promptly recognized and treated and to ensure, e.g., that what appears to be a cold, headache or influenza is not in fact a potentially fatal condition like pneumocystis carinii pneumonia or toxoplasmosis, a brain infection.

d. Because AIDS and related infections sometimes proceed with deceptive slowness and sometimes proceed very rapidly toward preventable death or disability, class members require close and continual monitoring of their conditions.

e. Because HIV infection can be treated at increasingly early stages, a program of education, voluntary testing, and detection, followed by aggressive treatment and monitoring is needed to prolong life.

f. Because persons with HIV infection or AIDS require such close monitoring, additional primary health care staff is required at the prisons in order to meet the increased need for services.

g. Because many of the opportunistic infections associated with AIDS can only be treated in an acute care hospital setting and can become life-threatening in a very short time after onset, a sufficient number of hospital beds must be available to the plaintiff class, often on short notice.

h. Because AIDS, as well as many of the opportunistic infections associated with it, results in prolonged or progressive mental and physical disabilities in many patients, skilled nursing and hospice services are required to provide minimally adequate care and treatment for seriously ill and dying patients.

i. Because HIV infection is a chronic and progressive condition, adequate treatment requires the maintenance of reasonable continuity of care and the avoidance of interruptions in treatment and delay or denial of ordered care.

j. Because AIDS is a fatal condition for which no cure has been found, prisoners suffering from it often experience extreme emotional anguish and mental disturbance requiring mental health counselling or therapy.

k. Because AIDS and some of its related opportunistic infections cause neurological and brain disorders, including AIDS-related dementia, HIV-infected prisoners require regular psychiatric monitoring.

l. Because untreated mental problems can have physical as well as emotional consequences, failure to provide proper psychiatric services adversely impacts on the progress of the disease.

m. Because ignorance about AIDS and HIV infection is widespread in prisons on the part of both inmates and staff, educational programs are needed to assure that medical care is sought by inmates at an early stage and that staff do not by fearful or intolerant behavior deter patients from coming forward for treatment.

n. Because breaches of confidentiality about medical information concerning patients with HIV infection often lead to discrimination, harassment, and other adverse consequences, patients' privacy must be protected to assure that they can freely seek and receive care.

27. Meeting these serious needs requires planning, funding, staffing, training, and coordination among different DOCS prisons and their staffs; between DOCS and civilian hospitals, physicians, and other outside providers of medical and mental health services; between DOCS and OMH; and among DOCS, the Governor, and state budgetary personnel. These issues can only be resolved at the executive level of the Governor and the central offices of DOCS and OMH.

28. Defendants have failed to meet their constitutional duties in multiple respects.

Medical Care Claims

29. DOCS has chosen to operate a loosely decentralized health care system, in which each of approximately sixty prisons is largely autonomous. Decisions about management of resources and standards for patient care are made by each prison. This feudal system of health care delivery is inadequate to meet the needs of HIV-infected prisoners. It fosters wide variations in delivery of care, defeats coordination and continuity of treatment, and causes unnecessary delays and outright failures in provision of services to the more than 50,000 inmates currently in DOCS custody. As such, it is particularly devastating to the plaintiff class.

30. Defendants have failed to mount a comprehensive and coordinated effort to meet the medical needs of the plaintiff class, despite the fact that class members are in particular need of coordinated and complex monitoring and treatment. Class members die prematurely and suffer needlessly; many are simply left to die without provision of adequate care, relief of pain, and provision of simple comforts.

31. Although DOCS has in its custody approximately 40% of prisoners with AIDS in the United States, DOCS has no

infectious disease specialist coordinating its AIDS care from its central office, and the central staff it has fails adequately to monitor in the various prisons the provision of health services to the plaintiff class. Moreover, DOCS has failed to retain or utilize the services of public health specialists to develop policy, including appropriate steps to prevent transmission of HIV.

32. Defendant Coughlin requires health care staff to be hired by and responsible to the superintendents of each prison or their lay designees, who are unable adequately to evaluate the medical staff's professional services and who can and do interfere with their professional judgments. Discipline of health care staff is also the province of lay employees, and on professional matters discipline and oversight of the provision of care is virtually non-existent.

33. Defendants Cuomo, Coughlin and Greifinger fail to assure sufficient health care staff for the provision of primary health care services at DOCS facilities, whose need for additional resources are unmet.

34. Defendants Coughlin and Greifinger have a policy of allowing each correctional facility to determine for itself the method by which patients will obtain access to health care, resulting in a sick call system under which access to physicians is rationed. Patients often wait weeks for an appointment with a physician, while their medical complaints remain unresolved or treated only palliatively. Defendants Coughlin and Greifinger, although aware or the infirmities of their sick call system from audits, reviews and other federal court litigation, have refused to require reform of the system. The effect of these inadequate sick call systems on plaintiffs is severe. Plaintiffs suffering from opportunistic infections often must wait weeks to see prison doctors for diagnosis and treatment of these infections. Often diagnosis and treatment do not even occur until plaintiffs are in an acute state and are rushed to emergency rooms of outside hospitals.

35. Defendants Cuomo, Coughlin, and Greifinger staff state prison health clinics primarily with physician's assistants and nurses and allow insufficient physician staffing for proper supervision. The result is the unsupervised delivery of health care by inadequately trained personnel and the delegation of responsibility for the care and management of patients with HIV infection to non-physicians. Defendants have resisted recommendations for greater physician involvement in the delivery of health care. These failures result in the non-recognition or misdiagnosis of plaintiffs' opportunistic infections, with accompanying premature death and needless suffering.

36. Defendants Coughlin and Greifinger fail to require facilities to maintain priority systems for provision of care to assure that patients receive health care according to the seriousness of their conditions. This failure to prioritize the health care needs of plaintiffs results in untimely and haphazard provision of care, or outright denials of care—a problem exacerbated when patients are transferred from one prison to another. This problem has been documented repeatedly and is well known to defendants.

37. Defendants Coughlin and Greifinger fail to assure that facility medical staff obtain appropriate laboratory tests to identify at an early stage and to monitor patients with HIV infection and HIV-related illnesses. Often no baseline laboratory values are obtained with which to compare the patients' clinical progress or deterioration. These failures result from, among other things, the absence of adequate training and protocols governing treatment of seropositive prisoners.

38. Defendants Cuomo, Coughlin, and Greifinger, although aware of deficiencies in delivery of ordered care, fail to provide adequate resources, to set up administrative structures, and to take other steps to assure that HIV-infected patients receive timely tests, specialty treatments, and necessary procedures. The result is delay of such care or a total failure to provide it, particularly when such care must be delivered outside a correctional facility.

39. Defendants Cuomo, Coughlin, and Greifinger, although aware of the need, fail to provide sufficient resources to assure that prisons have access to medical specialists for class members requiring such services, resulting in delays in, denials of, and errors in diagnosis and treatment. Access to infectious disease specialists is so limited that plaintiffs often wait months for an initial or return consultation, or prisons inappropriately attempt to manage these patients without the assistance of specialists by using facility providers with inadequate HIV expertise. Defendants permit their facilities to send seropositive patients to specialists without x-ray and laboratory data or sufficient information about medical history or current problems to permit a meaningful consultation.

40. Defendants' failure to provide infectious disease and other specialist consultation in their prisons contributes to delays in and denials of diagnosis and treatment and forces ill class members to endure long trips in security restraints in order to obtain access to specialists. These trips often result in needless pain and suffering and deterioration in medical condition.

41. Specialty care delivered by outside medical providers and hospitals is often rendered ineffective because defendants Coughlin and Greifinger have failed to institute systems to ensure that follow up care ordered by the specialist or hospital is provided. For example, defendants fail to assure that physicians obtain and review specialists' reports and discharge summaries from outside hospitals for plaintiffs who have been sent back to DOCS prisons following consultations or hospitalizations, thereby causing failures to provide ordered care or follow up.

42. Defendants Cuomo, Coughlin, Greifinger fail to provide access to sufficient numbers of acute care hospital beds to meet the in-patient needs of the plaintiff class, resulting in avoidable or premature deaths, unnecessary delays in receipt of care, needless suffering, and reduced likelihood of favorable outcomes of planned procedures. As a result, prisoners with HIV-related illnesses are often not hospitalized until long after hospitalization is medically indicated.

43. Defendants Cuomo, Coughlin, and Greifinger have created a regional system of "catchment" areas for the delivery of specialist and hospitalization care to HIV-infected patients that is inadequate to meet the needs of the plaintiff class. Moreover, this system forces each prison to fend for itself or to compete with other prisons to attempt to secure specialist services and hospital beds, although the problem requires a coordinated statewide effort. This subjects plaintiffs to untimely, haphazard, and unpredictable provision of specialty services and outside hospitalizations.

44. Defendants Coumo, [sic] Coughlin and Greifinger provide inadequate reimbursement of specialists and hospitals that discourages access to health care providers, despite the existence of alternative payment arrangements. On information and belief, defendants often reimburse at levels one-fourth to one-fifth of the prevailing market rate. Payment, when made, is often so tardy that providers refuse to continue to accept DOCS' patients.

45. Defendants Cuomo, Coughlin and Greifinger fail to provide for skilled nursing and hospice services to plaintiffs who need it, despite the widely recognized need for such care, and warnings and criticism on this subject. This failure results in the placement of patients in settings whose level of care is inappropriate to their medical conditions, with resultant premature death and needless pain and suffering. Defendant Coughlin disputes that provision of skilled nursing care or hospice services to plaintiffs who need them is the responsibility of

his Department, although DOCS is charged with this responsibility under law.

46. Defendants Cuomo, Coughlin and Greifinger fail to assure that prisons have sufficient resources to establish adequate infirmary space for the non-ambulatory needs of their patients or that sufficient monitoring of infirmary patients occurs. Rounds of infirmaries that house even gravely ill class members are not made by physicians on a regular or adequate basis, and in some facilities these plaintiffs must request a physician appointment through the normal sick call channels. Defendants also permit the therapeutic function of their infirmaries to be compromised by allowing or directing the placement of healthy inmates in infirmaries along with ill patients.

47. Defendants three "Special Needs Units," ostensibly for the management of patients with HIV-related difficulties, have no admission criteria so that inmates are admitted to them without regard to their individual needs. The first such unit, at Sing Sing Correctional Facility, was found and continues to be found to be severely deficient by the New York State Commission of Correction, a governmental watchdog agency (Commission of Correction). As part of the prisons in which they are located, all such units reflect the failures detailed throughout this Complaint.

48. Defendants fail to assure that prompt and appropriate emergency care is available to the plaintiff class, thereby subjecting them to life-threatening risks, unnecessary pain and suffering, and premature and unnecessary death. Defendant Cuomo has failed to enforce state law requiring hospitals to provide emergency care to class members, and defendants Coughlin and Greifinger fail to insure that the health staff they employ report instances in which patients are refused hospital care, although class members suffer such denials frequently.

49. Defendants fail to provide class members with sufficient information about the nature and course of their illness and their individual prognosis and treatment needs. As a result, class members' right to participate in their own treatment decisions is compromised. Some patients refuse necessary treatment because of inadequate, incomplete, or inaccurate information.

50. Defendants Coughlin and Greifinger fail to assure that facilities maintain adequate patient medical records, without which documentation of class members' medical problems and continuity of follow up care is impossible. Since coordination of care is the hallmark of adequate care of HIV-related ill-

ness, these failures have particularly dramatic consequences for plaintiffs' health. Defendants Cuomo, Coughlin, and Greifinger, although aware of the deficiencies of prison medical recordkeeping, have persistently failed to staff medical units with certified medical record technicians or even sufficient clerical staff; they also fail to provide appropriate medical chart folders and storage cabinets for proper maintenance of needed records.

51. Defendants Cuomo, Coughlin and Greifinger fail to provide necessary resources to assure that prisons have adequate, safe, and appropriate equipment on site for the diagnosis and treatment of members of the plaintiff class. These failures result in delays in and denials of treatment and diagnostic delays and errors. For example, patients on aerosolized pentamidine—a prophylactic treatment for the prevention of pneumocystis carinii pneumonia, the leading killer of prisoners with AIDS—are often forced to inhale this medication by using inappropriate equipment designed for treatment of asthma or other illnesses, thus compromising the effectiveness of this medication and subjecting plaintiffs to an increased risk of death.

52. Although defendants Cuomo, Coughlin and Greifinger require their prisons to rely upon a central pharmacy for provision of medications and supplies, they have failed to institute or enforce an adequate system for inventory control and ordering, thereby causing shortages of medications and medical supplies needed by plaintiffs and denial of prescribed care. DOCS' central formulary does not include many of the items needed for treatment of HIV-related illness, and defendants do not require their prisons to obtain them promptly by other means.

53. Defendants Coughlin and Greifinger fail to assure that prisons create, maintain, update and follow protocols and standards for the provision of health care services and treatment of HIV-related illness. Those protocols and standards that exist are not enforced, and individual prisons are permitted to determine for themselves how services will be delivered. These failures, as noted in numerous reports of which these defendants are aware, foster confusion and lack of coordination in care and make unnecessary patient suffering inevitable.

54. Defendants Coughlin and Greifinger fail to require or provide for continuing education for their health care staff. In fact, they discourage staff from availing themselves of educational opportunities by frequently requiring them to take personal leave and bear their own expenses for attending seminars

and conferences in their respective fields. In-service training is likewise rare. In view of the rapidity of change in medicine generally and in the treatment of HIV-related illness in particular, these policies have severe consequences for the medical care provided to plaintiffs.

55. Quality assurance and peer review, necessary components of any large scale health care system in order to maintain standards of care and avoid unnecessary suffering, effectively do not exist, and central office personnel fail even to visit prison health clinics on a regular basis. Defendant Greifinger has failed to date to implement adequate reforms in this area, although he concedes the need for them, and defendants Cuomo and Coughlin, by limiting his budget and operational authority, have thwarted his efforts as they did those of other DOCS employees with similar responsibility. Since a large number of prison health care providers are not adequately experienced in recognizing and treating HIV-related illness, and in view of rapidly changing medical knowledge about HIV-related illness, defendants' failures to institute and maintain a system for quality assurance and peer review have particularly devastating effects upon the care provided to the plaintiff class.

56. Defendants Coughlin and Greifinger have failed to institute adequate systems to detect, treat, and control tuberculosis within DOCS' prisons. This highly contagious disease can weaken or become life-threatening to a seropositive person fighting the development of HIV-related illnesses. Yet, defendants fail to provide adequate respiratory isolation for patients who need it, thereby risking their health and that of class members who are nearby. Infection control procedures in general are severely lax, and defendants have inadequate staff to implement and monitor the procedures that do exist. The result is unnecessary exposure of this fragile class to life-threatening disease.

57. Although they are aware of the special dietary needs of patients with HIV infection and their frequent inability to eat and swallow normally, defendants Coughlin, Greifinger, Goord, Borum, and Broaddus fail to assure that seropositive patients receive meals that are nutritionally appropriate, appetizing, and easy to eat, nor do they assure that prisons provide dietary supplements when needed or prescribed. Pursuant to statewide policy and regulations, defendants Coughlin and Goord permit seropositive inmates to be placed on restricted rations or to be served unpalatable food as a means of punishment and behavior control, and they receive regular reports about them. Defendants Greifinger, Borum, and Broaddus

acquiesce in this policy even though it is medically contraindicated.

58. Defendants fail to ensure that plaintiffs have sufficient clothing to keep them warm in winter. Patients with chills and lowered resistance from HIV-related illnesses are frequently told that such items as insulated underwear are reserved for outdoor work gangs only. Meanwhile, such patients are housed in drafty or improperly heated areas and made to walk outdoors to move among various prison buildings.

59. Defendants Coughlin, Borum, and Goord maintain a policy of transferring inmates frequently, and tens of thousands of such transfers occur each year, most of which are not compelled by security needs. Inmates are often transferred among prisons without regard to the effect of such transfers on patients' medical conditions or their proximity to needed care, resulting in denial or delay of such care and deterioration of plaintiffs' physical condition. During transfers, class members also have been placed in medically inappropriate housing, including gymnasiums and dormitories, in which more than one hundred inmates may reside in close proximity—thereby increasing their risk of infection.

60. Defendants Coughlin, Greifinger, Borum, and Goord fail to assure that continuity of care occurs when plaintiffs are transferred between prisons, despite the frequency of such transfers. This results in interruptions of care, delays in and outright denials of care, and unnecessary repetition of diagnostic procedures. Receiving prisons often place a newly transferred patient at the bottom of a waiting list for a procedure or test for which the patient already had been waiting for an extended time at the sending prison; some class members suffer this fate repeatedly, with accompanying delays in and outright denials of care.

61. Defendants Coughlin and Goord maintain a policy authorizing exaggerated responses to otherwise legitimate security concerns that permits security staff to interfere inappropriately with the medical orders of health care providers. They also in general fail to provide sufficient security staff to assure timely access to medical care. These problems are particularly acute for plaintiffs in Special Housing Units or under keeplock status. Among the consequences are punitive denials of medical treatment; missed medical appointments based upon a patient's security status and the absence of security staff to escort the patient to the appointment; and the inability of Special Housing Unit patients to take medications, including

AZT, as prescribed because defendants' rules prohibit such inmates having watches or clocks. Defendants do not adequately train security staff regarding their relationship with health care staff or class members' constitutional health care rights.

Defendants' Knowing Deliberate Indifference to Plaintiffs' Serious Medical Needs

62. For at least the last ten years, numerous independent audits and evaluations of DOCS health care services have condemned the absence of adequate supervision and control by DOCS' Division of Health Services and have called upon the highest officials of state government to remedy this problem. In repeated audits by the New York State Comptroller addressed to defendant Coughlin, DOCS' management of health care services has been criticized. Numerous lawsuits have also alerted defendants to the constitutional deficiencies in the health care delivery system and to the unnecessary suffering of inmates within their custody.

63. Although the number of inmates and the number of prisons have both doubled in the last ten years, defendants Cuomo and Coughlin have largely ignored the dramatic increase in the need for medical services, refusing adequately to augment central office health staff and other medical resources. On information and belief, expenditures for medical care per inmate patient in New York are far lower than those of other states with comparable prison populations. This is particularly egregious given the fact that New York has a far higher percentage of HIV-infected patients who need extensive medical attention.

64. Defendants' lack of a professionally sound and coordinated approach to deal with the crisis engendered by HIV-related illness has resulted in premature deaths and needless suffering.

65. According to a 1988 mortality study conducted by the Commission of Correction, New York State prisoners with AIDS have one-third the survival rate of unincarcerated people with AIDS. This is true even after controlling for demographic factors and personal history (e.g., intravenous drug use) of both populations. According to the study, 28% of patients who die from AIDS while in DOCS custody are not diagnosed until autopsy—an *increase* over the percentage of such cases in earlier Commission reports. The Commission found that DOCS fails to provide even nominal care.

66. The Commission of Correction mortality reviews also document repeated failures in individual treatment and cite denials of access to outpatient and hospitalization care in numerous cases. Among the Commissions' findings in individual deaths are the following:

a. In reviews of five deaths at Eastern New York Correctional Facility, the Commission reported to DOCS that Eastern's health care capabilities were rudimentary and, because it is not staffed or equipped to provide care to AIDS patients, DOCS should not house or attempt to manage AIDS patients at that prison. Nevertheless, DOCS continues to do so.

b. Physicians and other health care staff at Sing Sing and Great Meadow Correctional Facilities were found to ignore or treat only palliatively symptoms clearly suggestive of HIV disease.

c. Attica Correctional Facility lacks guidelines for the management of HIV-related illness, as well as procedures for specialist clinic access, and fails to provide thorough and vigorous evaluation and treatment of opportunistic infections.

d. The clinical staff at Auburn Correctional Facility lack training in the detection of HIV disease and protocols for medical workup of HIV-related illnesses. The prison does not have a policy requiring that inmates showing obvious signs of HIV-related deterioration be examined by a physician in a timely manner.

e. The Special Needs Unit for AIDS patients at Sing Sing Correctional Facility—one of three Units specifically designated by DOCS' for care of AIDS patients—was found late last year to lack a comprehensive, coordinated, multidisciplinary approach to HIV patients. Needed medication is not dispensed as ordered, physicians do not properly monitor unstable patients and are unavailable when summoned on call, and medical recordkeeping, laboratory tests and physical examinations are inadequate.

67. The Commission of Correction has similarly criticized HIV-related deaths throughout the state prison system, warning that DOCS lacks the capacity adequately to diagnose, monitor, and aggressively treat inmates with symptomatic HIV disease and recommending the institution of centralized policies for diagnostic workup, case management and continuity of care throughout incarceration. Nevertheless, despite these recommendations and the advance of medical knowledge about

HIV and AIDS, DOCS' Division of Health Services continued to rely as late as the fall of 1989 solely on a brief set of guidelines that had not been updated since 1985.

68. Defendants' failures in health care delivery to the plaintiff class have been documented by numerous other sources:

a. The New York State Department of Health found in December of 1988 in a report issued to defendant Coughlin, that DOCS' most severe deficits were associated with the medical care of HIV-infected inmates and noted a lack of appropriate identification, treatment, consultation and follow up of their medical conditions.

b. The Correctional Association of New York, a non-governmental watchdog organization with legislative authority to investigate prison conditions in New York, issued similar findings in yet another recent public report.

c. Albany Medical Center, which provides HIV treatment to numerous class members, found, in a study published in 1989, that inmates admitted to the hospital with a first case of HIV-related pneumocystis carinii pneumonia have a mortality rate almost three times that of the Center's community patients with similar demographic background.

d. The Joint Subcommittee on AIDS in the Criminal Justice System of the Association of the Bar of the City of New York [hereinafter "NYC Bar Association Report"] concluded, after conducting hearings, that DOCS operated a patchwork and fragmented system for delivery of medical care to HIV-infected prisoners that results in the delivery of poor care.

e. Even a report conducted at DOCS' request by the Macro Corporation criticized the lack of managerial ability in the operation of DOCS' Division of Health Services.

69. Most recently, the Ad Hoc Committee on AIDS and Correctional Facilities of the AIDS Advisory Council [hereinafter "AIDS Advisory Council Report"] found numerous deficiencies in health care and other services for inmates with HIV infection, noting that they receive less care and die sooner than comparable groups who are not incarcerated. Their November 1989 report cited numerous managerial and organizational inadequacies, including inadequate funding, quality assurance, staffing, and access to hospitalization, specialist and long term care—all of which are part of defendants' executive responsibility. They concluded that, without dramatic changes, the New York State prison system could become "a charnel house in

which inmates sentenced to reform and punishment are consigned to a tragic and hastened death, in pain and isolation."

70. When defendants receive criticisms or recommendations in investigative reports, corrective action is rarely taken. For example, in most cases, DOCS does not even reply to criticisms or recommendations made to defendant Coughlin by the Commission of Correction concerning the health care of inmates who have died, one half of whom succumbed to AIDS. DOCS thus continues to subject future inmates to the same conditions found to contribute to inmate deaths in the past.

71. Although DOCS ostensibly has its own committee of physicians to investigate the health care of inmates who have died and to report their findings to defendant Greifinger, defendants Coughlin and Greifinger permit the committee to be years behind in reviewing such cases. On information and belief, they have established no standards for review of HIV-related deaths. Those cases that are reviewed are nearly always closed without comment or with praise for the care the decedent received, while independent auditors reviewing the same cases often find serious deficiencies in care.

72. At times, defendants' actions and omissions have had consequences directly contrary to the serious needs of the plaintiff class. They have failed to request and expend adequate funds for the provision of services to members of the plaintiff class. Defendant Cuomo's "Five Year Plan" for dealing with AIDS in New York State fails to meet the needs of incarcerated persons or to protect the rights of the plaintiff class. When legislation was presented to defendant Cuomo that would have required the Commission of Correction to promulgate standards for caring for prisoners with AIDS, he vetoed it. Defendant Cuomo now proposes to reduce the budget of the Commission for the next fiscal year, further jeopardizing its oversight ability.

73. Despite his knowledge that far greater resources are needed to prolong and save the lives of class members, defendant Cuomo has recently submitted a budget for the next fiscal year that is tens of millions of dollars short of the funding required.

74. Despite warnings from all sides and ample documentation of their failures, defendants have not responded to the epidemic they face, and their health care system and policies and procedures related to the provision of care to HIV-infected prisoners remain grossly inadequate.

Mental Health Claims

75. Because AIDS is a fatal condition for which no cure has yet been found, those who are infected with HIV or who have HIV-related illness or AIDS are often in need of emotional support and counselling. Nevertheless, defendants routinely fail to provide appropriate counselling before and after HIV testing, even though this need has been recognized by New York State law.

76. Many class members who test positive for HIV antibodies suffer extreme emotional anguish, believing they have AIDS. Some are told that they have a dread disease for which there is no cure. Others are informed that they will be dead shortly. This incorrect information exacerbates the patients' distress and depression over their condition. Most class members are provided little or no emotional support or counselling, and they are largely forbidden or discouraged from forming their own peer support groups.

77. Among the opportunistic infections associated with AIDS are neurological and brain disorders, including AIDS-related dementia, delirium, suicidal intent, and depression. Some large proportion (by some studies as high as two-thirds) of patients with AIDS die with some degree of dementia. Yet, defendants Coughlin, Greifinger, and Broaddus fail to train their health staff in the identification of such problems and their relation to the disease process and to the patients' behavior.

78. Defendants Coughlin, Goord, Greifinger, and Broaddus permit class members who "act out" or violate prison rules to be punished regardless of the existence of an organic or anxiety based explanation for their behavior. Some such patients are placed in Special Housing Units or under special security restrictions, where the harsh conditions of confinement contribute to further deterioration or mental illness. Defendants fail to educate staff about the psychological distress and related behavior that accompany HIV-related illness.

79. Although the Office of Mental Health (OMH) is charged by law with providing in-patient and out-patient services to inmates incarcerated in New York, it fails to deliver necessary psychiatric and psychological services to class members. Full time psychiatric services are offered at only nine prisons of the more than sixty operated by DOCS. Many prisons have a psychiatrist only on an on-call basis or have no direct OMH services at all.

80. Defendants Cuomo, Coughlin, Greifinger, Surles, and Dvoskin employ too few mental health professionals to meet the mental health needs of the plaintiff class and to treat their symptoms. As a result of inadequate resources, class members needing mental health services often wait weeks or months for treatment or die without receiving it. Defendants rely inappropriately upon inadequately trained and supervised lower level practitioners for assessment, referral and treatment of mental health problems.

81. Defendants Cuomo, Coughlin, Greifinger, Broaddus, Surles, and Dvoskin permit their respective Departments to maintain separate records, and to fail to coordinate health care when they are seeing the same class member. OMH and DOCS fail to assure that their respective staff consult one another regarding class members' care, resulting in fragmentation of services and an absence of clinical coordination.

82. Defendants have been apprised of the inadequacies in mental health services to prison inmates from numerous sources. At least three class action lawsuits have produced substantial evidence of unconstitutional care. The Correctional Association of New York produced a comprehensive study of mental health services and concluded that substantial changes were needed in all phases of delivery of prison mental health services, from reception to parole. The NYC Bar Association Report found that improvements were needed to meet the mental health needs of HIV-infected patients in prison, calling, at a minimum, for mental health care staff trained to deal with HIV-specific emotional and psychiatric problems, and liaison and referral mechanisms between DOCS and other providers of mental health services. Nevertheless, the failures persist.

83. As recently as October of 1989, the Commission of Correction criticized the mental health care provided to class members in the Special Needs Unit at Sing Sing Correctional Facility. An HIV patient wit a known manic/hypomanic diagnosis was not evaluated by mental health upon admission to the Unit, nor was any evaluation completed prior to his death. Despite orders that the patient be placed on a special watch, he was permitted to wander in an uncontrolled manner. His behavior problems were not evaluated and his psychotropic medicine was changed without proper medical assessment. OMH services were found to be inadequate and untimely.

84. As a result of inadequate mental health services, many class members succumb to despair or denial and even terminate or interfere with their own treatment. Inadequate mental health services also compromise the care of class mem-

bers who continue treatment, because of the effect of untreated mental disturbances on physical health. Defendants' failure to provide adequate mental health services causes unnecessary suffering and a hastening of death.

Education and Prevention Claims

85. Due to defendants' failure to provide adequate educational programs, a pervasive lack of information about HIV and AIDS exists within DOCS' correctional system, particularly among inmates and security employees. This knowledge gap has serious consequences.

86. Once identified as seropositive, class members are stigmatized and ostracized by staff and other inmates. They are regarded as handicapped and are often labelled for life. Defendants routinely house class members in segregated or isolated areas even though there is no medical or correctional justification for such isolation. Those class members housed in segregated to isolated areas often have no contact with the prison's general population and live in an atmosphere of forced idleness, engendering stress, depression and despair.

87. Lack of accurate information and misinformation about the signs and symptoms of AIDS, the meaning of the HIV test, and the models of transmission of the virus foster hysteria and discrimination against class members by other inmates and correctional employees.

88. Believing incorrectly that HIV is casually transmitted, inmates or staff may request or take degrading and unnecessary precautions to avoid what they believe to be risk of transmission. Seropositive persons have been required to don protective gear, to seal their correspondence in glassine envelopes, to use separate personal hygiene and laundry facilities, or otherwise to isolate themselves from normal human contact. Similarly, DOCS employees have at times refused to escort seropositive persons to appointments or other activities, have denied them services, including medical care, and have themselves insisted on wearing unnecessary protective gear.

89. Since defendants tolerate the refusal of staff members and contractual employees to examine, treat, associate, work with, or even touch class members, defendants in effect fail to assure that class members have equal access to medical care both within and outside their institutions. Staff members or contractual employees who deny care to or harass class members are neither punished nor penalized for their actions.

90. The failure of defendants Coughlin, Goord, Borum, and Greifinger to educate inmates and staff subjects class members to harassment, violence and threats of violence; and it results in avoidable segregation and isolation of those who could otherwise function adequately in general population. Moreover, the consequences of the lack of education deter HIV-infected inmates from coming forward for testing and treatment or cause them to suspend or terminate treatments due to inaccurate information or mistaken beliefs.

91. Lack of education also subjects all inmates to an increased risk of transmission of HIV. Although medical and public health authorities agree that the best way to prevent transmission of HIV is by providing extensive education on safe sex and safe needle use, defendants have no such programs. Inmates are told simply not to engage in sexual activities and not to use drugs or engage in tattooing. Defendants refuse on policy grounds to provide inmates with condoms, although they know that sexual activities occur in their prisons and that condoms are effective in preventing transmission of HIV.

92. Defendants have no effective or coordinated system for educating inmates and staff about HIV and AIDS or for reducing transmission of HIV within their prisons, and there is virtually no education about HIV available for illiterate inmates. Receiving little or no information through official channels, inmates also face resistance from defendants when they attempt to organize their own information network, although such peer group efforts have been shown to be effective. Defendants' failures perpetuate misinformation.

93. Defendants are well aware of their failures in educational [sic] and prevention. Reports from the NYC Bar Association, from the AIDS Advisory Council, and from the Correctional Association of New York, have all documented the need for additional services. Defendants, however, have refused to heed these recommendations.

94. Last year, hundreds of thousands of dollars appropriated by the New York legislature for education of inmates and staff was not even spent. On information and belief, this money was impounded by either defendant Cuomo or defendant Coughlin. Defendant Cuomo's current budget proposals knowingly fix spending far short of what is necessary.

Privacy and Confidentiality Claims

95. Because of the sensitive nature of information relating to the HIV status of individual patients and the likelihood of adverse consequences from breaches of confidentiality, it is necessary both for the provision of health care and for the personal protection of patients that privacy of this information be maintained.

96. Defendants Coughlin, Goord, and Greifinger fail to assure that class members' right to privacy in matters relating to their HIV status and medical condition will be protected or that medical and other personal information will remain confidential.

97. Failure to insure privacy discourages inmates from seeking evaluation and treatment for suspected HIV infection or HIV-related illnesses. It interferes with the provision of medical care to class members; causes them mental distress and anguish; and subjects them to harassment, violence, threats of violence, and discrimination.

98. Defendants' policies also discourage inmates—and class members—from seeking an HIV antibody test by frequently requiring them, as a condition of providing a test, to reveal details of past high risk behavior, such as intravenous drug use or unsafe sex, or to discuss their sexual orientation.

99. Defendants Coughlin, Goord, and Greifinger allow inmates and non-medical staff with no legitimate reason to have access to medical records to handle seropositive patients' medical records or otherwise have access to confidential medical information. They permit staff to discuss medical information in the presence of non-medical staff and other inmates, and they fail to disciplines staff who breach confidentiality.

100. Defendants Coughlin and Greifinger permit their facilities to label medical folders, isolation rooms and others [sic] items and places with conspicuous notices that reveal seropositivity or other confidential information about seropositive patients to non-medical staff, other inmates, and prison visitors.

101. Defendants allow prisons to force seropositive patients to discuss confidential medical information within the hearing of non-medical staff and other inmates or to obtain medical treatment in areas or by means that reveal the patients' conditions to non-medical staff, other inmates, or prison visitors. They fail to provide civilian bilingual medical staff to translate for patients who do not speak English.

102. Defendants are well aware of their failures to assure patients' privacy and confidentiality. Reports from the NYC Bar Association, from the AIDS Advisory Council, and from the Correctional Association of New York, have all documented the need for corrective measures. Defendants, however, have not taken the appropriate steps.

103. The consequences of defendants' failures continue even after class members are released and can result in denial of jobs, education, housing, credit, or insurance. The stigma and discrimination even attaches to their families, greatly compounding their anguish.

The Totality of Defendants' Failings

104. No medical or correctional justification exists for the unconstitutional conditions of confinement detailed in this complaint. The totality of defendants' failures in medical, mental health, education, and preventive services and their disregard of the right of privacy have caused and continue to cause an acceleration of class members' deaths, an inexcusable increase in their suffering, and a loss of their very humanity.

CIRCUMSTANCES OF NAMED PLAINTIFFS

105. PLAINTIFF ONE has been in DOCS custody since 1982 and has been incarcerated at Downstate, Great Meadow, Attica, Auburn, Shawangunk, and Clinton Correctional Facilities.

a. Plaintiff One has a history of intravenous drug use. In early 1985, he begun [sic] to exhibit unmistakable signs of HIV infection. By Spring of 1986, he had HIV-related oral infections, abnormal blood tests, malaise, and anergy (improper immune response). By 1987, he had night sweats, fevers, weight loss, chest pain, chills, fatigue, persistent sore throat, and body aches. Despite the fact that these symptoms were documented in his medical records and indicated the advance of his disease, Plaintiff One was not seen by a physician for more than two years.

b. In February of 1988, Plaintiff One was finally referred to an infectious disease specialist. In May, when he was still awaiting the specialist examination, he had a seizure and was found barely conscious and unable to speak. He was rushed to Upstate Medical Center, where he was diagnosed as suffering from AIDS and HIV-related infections, including progressive multifocal leukoencephalopathy (a

severe deteriorating disease affecting the brain and nervous system).

c. Despite the importance of the Upstate Medical Center records to Plaintiff One's treatment, defendants did not acquire them for over thirteen months. During this time other specialists who were attempting to evaluate this patient's deterioration made repeated requests to see the records, including three such requests from physicians at St. Clare's Hospital.

d. Plaintiff One's health continues to fail. His T4 count dropped to 96 by May of 1989; and to *3*, by October of 1989. During this period, he suffered severe physical pain and also of the use of his legs. He developed multiple ulcers on his legs and ankles and a golf ball-size opening in his hip.

e. Plaintiff One now has no control of his bowels and bladder. He is frequently left to lie in his own urine and feces and at times to dehydrate. He has fallen and been left to lie in his own waste on the floor. Instead of providing humane care, nursing staff have accused him of being "manipulative" and "childish." They have removed bed pans and toilet paper from his room and insisted that he walk to the toilet although, because of the virus' affect on his nervous system, he is unable to do so.

f. Although Plaintiff One continued to soil his bed linens with his own waste for weeks, the prison took no action to correct his situation. While travelling for an outside medical appointment, he was left to sit in his own urine for hours; he therefore refused other such trips. Defendants finally have provided him a catheter and diapers.

g. Even though he has degenerated to the point that he can no longer feed himself or turn over in bed, defendants have not provided Plaintiff One with the skilled nursing services he needs or with prompt hospital care. On one occasion, his fevers spiked to 105 degrees before an ambulance was summoned to transport him. On another occasion, his hospitalization was delayed so long that he required five transfusions of blood after his admission. Frequently defendants have failed timely to obtain hospital discharge summaries vital to his continuity of care.

h. Plaintiff One has a long history of mental disturbance. Throughout his illness, he has been very depressed, but he has not received adequate mental health services, which has led to noncompliance with his own medical treatment. Even as he became increasingly confused and disoriented, defendants continued to accuse him of intentionally misbehaving.

i. Defendants' security staff has also interfered improperly with Plaintiff One's treatment. On at least two occasions, they canceled necessary medical appointments. On another, they forced Plaintiff One to be examined, including being weighed, without removing shackles, even though he was ill and too weak to be of any risk.

j. Defendants have acted so as to publicize Plaintiff One's medical condition. He has repeatedly been forced to take breathing treatments in busy corridors where other inmates can observe the conspicuous apparatus used to administer it. Consequently, at times, he has refused needed therapy.

k. Defendant Greifinger is personally aware of Plaintiff One's circumstances, including his mental disorientation, but he has failed to act.

106. PLAINTIFF TWO has been incarcerated at Downstate, Attica, Great Meadow, Auburn, Elmira, and Clinton Correctional Facilities since December of 1985.

a. Plaintiff Two is gay and has a history of intravenous drug use. Despite these twin risk factors—as well as a notation of ARC ("AIDS-related complex") on his initial prison physical, persistent severe headaches, swollen glands, night sweats, congestion, shortness of breath, and a weight loss of fifty pounds—he was not sent to a specialist on infectious disease for nineteen months. When the specialist ordered a test for HIV, defendants did not provide it for nine months.

b. For the last three years, Plaintiff Two has had chronic and often acute liver pain. Despite continuous abnormal liver function test results, defendants have not diagnosed the cause or provided him with the biopsy needed to determine it.

c. Defendants have failed to perform even the most rudimentary services needed to prevent Plaintiff Two's deterioration. Skin tests for exposure to tuberculosis were not done, even though the need for such tests is prominently noted in his records. Necessary blood work has been delayed for weeks. He has been given antibiotics that are ineffective for his condition. He has been sent for x-ray studies without sufficient medical history for meaningful evaluation. Not even his weight loss has been monitored as ordered.

d. Since his arrival at Clinton in April of 1989, Plaintiff Two's care has been delegated primarily to nurses. During the first eight weeks there, despite recent pneumonia and

difficulty breathing and speaking and nearly constant continuing symptoms requiring sophisticated evaluation, he was never seen by a physician and was seen by a physician's assistant only once. He was forced to endure cold, drafty housing. Although he has difficulty eating and digesting food and often is in too much pain to walk, as of December of 1989, he had not been returned to an infectious disease specialist despite the obvious need.

e. Prior to his incarceration Plaintiff Two had a history of severe depression. Since His HIV diagnosis he has frequently been denied even perfunctory mental health services. He has attempted suicide at least twice. On both occasions, he received disciplinary tickets and confinement to his cell instead of the counseling and mental health treatment he needed. For months, while he cried out for help, he languished on a waiting list for group therapy.

f. Security officers and other inmates have been permitted access to Plaintiff Two's medical records and information about his illness. On the day he returned from his first visit with the infectious disease specialist, his cell was set on fire. He has suffered assaults, harassment, and threats. On at least one occasion, he was doused with hot oil.

g. Defendants Coughlin and Griefinger [sic] have both been apprised personally about this patient and have failed to take appropriate corrective action.

107. PLAINTIFF THREE has been in DOCS' custody since August, 1987 and has been held at Downstate, Elmira and Auburn Correctional Facilities.

a. Plaintiff Three, who has a history of intravenous drug use, entered the state prison system with notations of an abnormally low white blood count, but he was not tested for HIV antibodies until November, 1987. The results of this test were not entered in his medical chart.

b. Despite persistent and obvious signs that he was symptomatic of HIV-related illness—swollen lymph nodes, severe headaches, blurred vision, neurological problems, night sweats, fatigue, difficulty swallowing, fevers, and persistent cold symptoms—during the latter part of 1987 and throughout 1988, he was not referred to an infectious disease specialist until early 1989. Aerosolized pentamidine was not prescribed until June, 1989, and even after it was ordered by an outside specialists, DOCS did not offer it to plaintiff for weeks.

c. Plaintiff Three has been denied proper treatment for his opportunistic infections, including a painful mouth condition that interferes with his ability to eat. DOCS has failed to order appropriate tests to confirm or rule out various life threatening illnesses, such as CT-scans to diagnose a variety of opportunistic infections. Throughout his incarceration he has experienced delays in obtaining outside specialty appointments. Since his AZT therapy began in 1989, his blood levels have not been consistently monitored biweekly as ordered by his infectious disease specialist. He does not consistently receive medications prescribed by outside specialty providers, and often the outside providers' consultation sheets, containing clinical observations, orders and plans, have been lost by DOCS employees.

d. Despite Plaintiff Three's compromised immune system, he is unable to secure adequate outside winter clothing. Despite the clear need and medical orders, he does not receive adequate dietary supplements. Frequently, in lieu of a proper dietary supplement, he has been given commercial "breakfast drinks," which due to their dairy content exacerbate his chronic diarrhea.

e. Plaintiff Three has never received any meaningful counselling from DOCS personnel about his seropositive status. He has also been unable to secure mental health counselling despite his repeated requests, including one request made the same week that he learned that his brother died from AIDS.

f. Plaintiff Three has been subjected to numerous breaches of confidentiality, and he has often forgone crucial medical attention and treatments for fear of continued breaches. For months he has refused the administration of aerosolized pentamidine because Auburn Correctional Facility insisted that it be inhaled in a corridor open to the view of passing inmates. On at least one occasion he refused to appear for this crucial treatment because a correction officer told another inmate the reason for the treatment and sent him to call Plaintiff Three to the medical clinic. The inmate went to the cell block and announced loudly that the clinic was ready for Plaintiff Three's "breathing treatments." Plaintiff Three's medical chart is labeled "HIV" on the cover in bright green ink. Correction officers routinely handle his chart despite his repeated

complaints—including formal grievances—to DOCS superintendents about this practice.

g. Plaintiff Three's medical treatment has also been compromised by DOCS' security personnel. On one occasion he appeared for emergency treatment with a hemorrhage in his eye. He was admonished and subsequently disciplined for "abusing" emergency sick call, because it was thought that his condition was not emergent. Consequently, he is presently hesitant to seek care for emergent conditions. Although he has a physician order for special medical showers, security staff refused to honor this order for months.

108. PLAINTIFF FOUR is in the custody of DOCS and has been confined since 1985 at Great Meadow, Clinton, Green Haven and Attica Correctional Facilities.

a. In 1986 Plaintiff Four had persistent congestion and a rash over much of his body but no efforts were made to determine whether he was immunocompromised, despite a history of intravenous drug use, hepatitis and exposure to tuberculosis.

b. By March of 1987, after his rash had persisted for a year, Plaintiff Four was finally suspected of being immunocompromised. He also had developed oral infections, an enlarged lymph node on his neck and high fever. His skin lesions were biopsied and found to be consistent with the opportunistic infection Kaposi's sarcoma. Nevertheless, defendants delayed an HIV test for another two months.

c. From April through October, 1987, Plaintiff Four suffered repeatedly high fevers (103-104 degrees) and a continuation of his other symptoms, but the prison did not do necessary diagnostic tests or prescribe appropriate treatment. They failed to hospitalize him in August, 1987, although he clearly needed in-patient care. Finally, in October, 1987, when his temperature spiked to 105.4 degrees, he was rushed by stretcher to St. Francis Hospital Emergency Room and was diagnosed as suffering from extrapulmonary tuberculosis after a biopsy of the enlarged glands that had been evident for the past six months.

d. Although aware of his HIV infection since May of 1987, the prison failed promptly to consider Plaintiff Four for AZT treatment. He was not evaluated for such therapy until November, 1987, when he was seen by an infectious disease specialist; at that time his T4 count had deterio-

rated to 144 and the specialist recommended AZT treatment. This critical therapy, however, was not started until the end of January, 1988.

e. In 1989, Plaintiff Four was denied critical treatment with AZT and aerosolized pentamidine, the latter of which is prescribed to prevent pneumocystis carinii pneumonia, because these items were out of stock in the prison pharmacy. On September 23, 1989, Plaintiff Four was hospitalized with pneumocystis carinii pneumonia and pancreatitis and remained in the hospital for a month with these conditions.

f. Plaintiff Four's treatment remains inadequate. His condition is not appropriately monitored and blood work is not done regularly. Currently, Plaintiff Four is suffering from cloudy vision, but he has been denied a consultation with an ophthalmologist to evaluate this condition. Because many patients with HIV suffer opportunistic infections in the brain, eyes, and optic nerves that lead to blindness, the prison's lack of vigilance to Plaintiff Four's vision complaints is inexcusable.

g. Defendants have not kept proper medical documentation of Plaintiff Four's condition. Nearly a year and one half of ambulatory health records are missing, during which time he was hospitalized twice. The problem list in his chart is outdated and fails to note several of his opportunistic infections, as well as important diagnostic information. Similarly, defendants fail to maintain flow sheets on his condition, blood work, and treatment with AZT and aerosolized pentamidine, thus preventing physicians from following his care closely. His records are disorganized, and pertinent discharge summaries from outside care facilities are missing. These deficiencies seriously impede the proper care and treatment of this patient.

h. Plaintiff Four speaks only Spanish and has great difficulty communicating with medical staff. Since there are almost no providers who speak Spanish, he is often left uninformed as to his condition and treatment. He is frequently forced to choose between no communication at all or the use of other inmates of security staff to translate, with resultant breaches of confidentiality. Rarely has a civilian translator been provided to allow for proper communication with medical staff.

i. Defendants have also violated the confidentiality of Plaintiff Four's condition. In the Fall of 1989, he was

ordered by the security staff to sit in the hallway of the medical department while waiting for treatment. During this time, non-medical persons in the area were informed that he was suffering from AIDS.

109. PLAINTIFF FIVE has been in the custody of DOCS since January, 1986 and has been confined at Auburn, Great Meadow and Attica Correctional Facilities.

a. Plaintiff Five has a history of intravenous drug use and was determined to be seropositive in January, 1989, while at Attica. After diagnosis, he was placed in the infirmary, where he was isolated from other patients 24 hours a day, although such isolation was not medically required. He was denied recreation and had little human contact.

b. While in the infirmary, Plaintiff Five's condition was not properly addressed. He was not seen by an infectious disease specialist, although a blood test showed an abnormal T4 count below 200. Defendants did not properly monitor his abnormal liver function. A chest x-ray and a skin test indicated the possibility of tuberculosis, but this potentially life-threatening condition was not properly evaluated to determine if further treatment was required.

c. In early May, 1989, Plaintiff Five was transferred to disciplinary housing, while under medical orders to take AZT precisely every four hours. Because defendants do not permit inmates in disciplinary segregation to have watches or other timekeeping devices, Plaintiff Five filed a grievance, maintaining that he could not properly time the taking of his medication without a clock. Thereafter, his AZT dosage was changed to every eight hours. This change was ordered even though the medical chart fails to indicate any significant change in his medical condition or other justification for altering the treatment regimen, and the change was inconsistent with then acceptable medical practice. In response to Plaintiff Five's grievance, the prison claimed that, since he could now take medication every eight hours, he could time his doses by the shift changes of correctional officers on the unit. Security staff interfered inappropriately with Plaintiff Five's medical treatment, and medical staff inappropriately acquiesced.

d. The prison has also failed to document his condition properly so that the medical providers can monitor his situation. They do not keep vital information on his weight and temperatures and have not maintained a flow sheet of his blood work to follow his AZT treatment. The problem

list in his medical chart omits important information about his medical condition.

e. Plaintiff Five has not received adequate counseling or even written material about his illness, potential treatments, and means to avoid transmission of the disease to others. Moreover, he has not been permitted to participate in any peer group sessions or to receive appropriate mental health counseling to deal with the distress and depression he has experienced as a result of his illness.

110. PLAINTIFF SIX has been in defendants' custody since November of 1987 and has been incarcerated at Downstate, Orleans, Attica, Wende, Shawangunk, Auburn, and Clinton Correctional Facilities. He has also been hospitalized at Central New York Psychiatric Center.

a. When Plaintiff Six was tested positive for HIV late in 1987 at Orleans Correctional Facility, the confidentiality of his diagnosis was breached almost immediately by security officers who began to harass and taunt him. When he attempted to speak with his counselor about his anxiety and difficulties with staff, this patient was told "we all have to go sometime."

b. Plaintiff Six was thereafter transferred to Attica, whereupon the escorting security staff informed security staff at Attica about his diagnosis. Harassment continued, including the officers' wearing of unnecessary protective gear, such as surgical gowns. Although he was seen by mental health staff, they dismissed his anxiety as based on "alleged medical problems." This pattern continued through successive transfers. Meanwhile, Plaintiff Six was provided with little or no information about the nature of his illness or what he might expect to be its course. Although he continued to have difficulty coping with his illness, he remained for the most part in solitary confinement and received little or no mental health support.

c. Plaintiff Six's physical health was similarly neglected. Although he was known to be HIV positive since at least December of 1987, he was not even referred to an infectious disease specialist until September of 1988, and it was almost another year until his first appointment occurred in August of 1989. Meanwhile, his T4 count fell by more than half and his platelet count dropped so low that physicians were considering removal of his spleen. Despite the need for earlier treatment, he was not started on AZT or given medication for his low platelet count until specialists

intervened in August of 1989. Even this medication and food supplements that had been ordered for his weight loss were not regularly received, because of lack of supplies and interference by security staff with delivery of the items in the segregation unit.

d. Plaintiff Six continued to lose weight and to become increasingly more disturbed in segregation. By Fall of 1989, he was engaging in obviously unbalanced conduct and self-destructive behaviors, including self-mutilation. As he became more and more disturbed, security staff subjected him to ever increasing isolation, often by force. At one point prior to his transfer to Central New York Psychiatric Center, he was handcuffed and placed in a plexiglass cell. He has permanent numbness from compression injury due to the tightness of the handcuffs.

e. On November 14, 1989, he was psychiatrically hospitalized. The commitment papers stated that coping with his illness in the restrictive setting of segregation intolerably weighed upon him, and he became overwhelmed by depression. The mental health services he received prior to his hospitalization were profoundly inadequate.

f. When the patient was transferred to Central New York Psychiatric Center, he was awaiting a specialist appointment with a hematologist. He was sent six weeks late, and then only after he threatened legal action.

g. Plaintiff Six has received little or no education concerning HIV since his diagnosis—a fact noted in his admission evaluation at Central New York Psychiatric Center.

111. PLAINTIFF SEVEN has been incarcerated since 1987 at Elmira, Coxsackie, Otisville, Fishkill and Clinton Correctional Facilities. He has also been hospitalized at Central New York Psychiatric Center and has a history of psychiatric disorders.

a. Plaintiff Seven tested positive for HIV antibodies in February, 1989, while at Fishkill. Aside from brief pre- and post-test counselling, Plaintiff Seven has received no education or counselling about the course of the illness, his current medical condition, his treatment options, information about nutrition, or guidance on ways to prevent the transmission of the infection, despite his requests for such services. Since h e is functionally illiterate, Plaintiff Seven is unable to gather this information from written material on his own. DOCS refuses to permit HIV counsellors, not

employed by DOCS, into the prisons where Plaintiff Seven has been confined.

b. Defendants' failure to provide Plaintiff Seven with necessary educational services or to permit qualified HIV counsellors into the prisons where he has been detained, has effectively denied him the ability to make informed decisions about his course of treatment. It has also caused him unnecessary anxiety, with a resultant deterioration in his already fragile psychiatric condition.

c. Plaintiff Seven tested positive for exposure to tuberculosis in August, 1987, upon his entry into state prison. This test result is reflected on his medical chart, along with orders that he immediately undergo preventative treatment by taking INH medication continuously for one year. Entries in his medical chart ten months later show that INH treatments were never begun, and to date he has not received this needed medication. This failure places this HIV-infected individual at grave risk of contracting a highly infectious disease with potentially life-threatening consequences.

112. PLAINTIFF EIGHT has been incarcerated at Bedford Hills, Albion, and Bayview Correctional Facilities since February, 1989.

a. Plaintiff Eight was being followed by an infectious disease specialist in Rochester, New York, when she was transferred from Albion to Bayview Correctional Facilities. The specialist noted that she had a history of intravenous drug use and a positive HIV test; he prescribed AZT and aerosolized pentamidine. He also noted that she reported a bout of "presumed" pneumocystis carinii pneumonia prior to her incarceration.

b. The specialist recommended in a letter to Bayview that she continue taking AZT to slow the progress of the virus and aerosolized pentamidine to prevent recurrence of the pneumonia. He also wrote that, although she recently had a negative HIV test, he believed that the test result was inaccurate, noting her abnormal T4 count and her other symptoms and history.

c. Plaintiff Eight's medications were discontinued after her transfer. This action was taken without bothering to obtain her pre-incarceration medical records to verify her history of pneumocystis carinii pneumonia—a determination that would have shed critical light on her condition and helped dictate an appropriate course of treatment—

and despite the specialist's finding and recommendations and the voluminous records he forwarded. Two months later, her AZT and aerosolized pentamidine were reinstated, but only after her T4 count dipped to 199.

d. Plaintiff Eight was not given a choice about these crucial clinical decisions or an explanation of the treatment options available to her. Defendants' reckless disregard of the specialist's recommendations, and their failure to obtain pertinent medical records, placed her at great risk for serious opportunistic infections.

113. PLAINTIFF NINE has been in DOCS' custody since April, 1987 and has been confined at Downstate and Shawangunk Correctional Facilities.

a. Upon entry into the state prison system, Plaintiff Nine had a history of intravenous drug use, plus oral infections and swollen lymph nodes. Notwithstanding these hallmarks of HIV infection, he was neither offered the HIV antibody test nor counseled about taking it.

b. During February and March of 1988, he exhibited signs of HIV-related illness, including chest pain, fevers, headaches, weight loss, night sweats, and generalized aches and pains. Notwithstanding these symptoms, defendants failed to treat his condition aggressively. Finally, in March of 1988, he was rushed to a hospital emergency room and was admitted with a diagnosis of pneumocystis carinii pneumonia. Only at this point was he tested for HIV antibodies.

c. fter his discharge from the hospital, Plaintiff Nine was seen by an infectious disease specialist who ordered that he begin treatments to prevent recurrence of his pneumonia. Defendants waited five months to implement these orders, thereby subjecting Plaintiff Nine to the unnecessary risk of a recurrence of the deadly pneumonia.

d. Throughout his treatment, Plaintiff Nine has received little or no information concerning his illness, his prognosis, and the course and nature of his treatment. On at least one occasion, he has refused a medical trip outside the prison because of a misunderstanding as to its purpose.

114. PLAINTIFF TEN has been incarcerated since June, 1987, at Downstate, Attica and Wende Correctional Facilities.

a. Upon admission to state prison, Plaintiff Ten had an abnormally low white blood count, accompanied by night sweats, shortness of breath, and a weight loss of fifty

pounds in the previous three years. At that time this 5'11" man weighed 130 pounds. Nevertheless, the comprehensive blood work-up ordered by the reception prison was not done for over sixteen weeks.

b. By October of 1987, Plaintiff Ten complained of continued shortness of breath, night sweats, and weight loss, and additional symptoms of fatigue, malaise, loss of appetite, and a chest cold that persisted for two months; but the prison medical staff failed to respond adequately. Although he had a history of exposure to tuberculosis, the prison failed timely to x-ray his chest or to perform other diagnostic tests to determine the cause of his respiratory problems. While his symptoms continued for months, defendants provided only minimal treatment, despite his deteriorating condition. When his blood was tested in the late Fall, his T4 count had dipped to 112, but the medical staff did not react. Defendants did not even begin AZT therapy until late January of 1988, months after the need was apparent.

c. Although Plaintiff Ten had obvious indications of HIV infection and a history of intravenous drug use, this man with a seventh grade education was never counseled about taking an HIV antibody test until he was seen by an infectious disease doctor in early 1988—a referral that was long overdue.

d. In 1989, Plaintiff Ten received continued inadequate care. The prison failed to respond properly to his repeated high fevers, which sometimes spiked to 104.6 degrees, nor to his respiratory problems. The prison did not take x-rays when needed or perform necessary physical exams or other diagnostic tests. They treated potentially life-threatening conditions with medications that acted only to mask the symptoms without identifying the cause of the infections and treating them specifically.

e. On at least three occasions between June and August of 1989, Plaintiff Ten's condition compelled immediate hospitalization—in June, when his fever raged to 104.5 degrees; in July, when his laboratory test results were ominous; and in August, when his high fever and abnormal laboratory results were accompanied by severe chest pain—but defendants did not provide it. Instead, they, in effect, merely watched him deteriorate, even though he was then housed in a Special Needs Unit ostensibly designed for enhanced care for HIV patients.

f. When he was finally hospitalized, Plaintiff Ten had developed pneumocystis carinii pneumonia. Plaintiff Ten's course of treatment during these months represents gross inattention to obvious symptoms and an inability or unwillingness to provide even minimally adequate care. Defendants' failures repeatedly placed him at risk of premature death.

Those Who Have Died

115. Since 1981, almost 800 prisoners in defendants' custody have died from HIV-related illness. Each month, the death toll rises, and in the next year, it is estimated that hundreds more will die. In the months preceding the filing of this Complaint, fifteen prisoners investigated for inclusion as named plaintiffs died from HIV-related illness.

116. The medical care (or the lack of it) received by those prisoners who did not survive to become plaintiffs or class members and the other conditions of their confinement hastened their deaths. They suffered unspeakable physical and emotional pain and were subjected to base indignities. Their records provide eloquent, if mute, evidence of the denial of their humanity. Defendants withheld from these terminally ill people in the last days of their lives the compassion expected of a mature society.

Legal Claims

117. *CLAIM I.* Defendants' failures in delivery of medical and mental health services to members of the plaintiff class, as detailed herein at ¶¶ 29-84, subject them under color of state law to deliberate indifference to their serious health care needs, in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

118. *CLAIM II.* Defendants' failure to protect the confidentiality of medical and other personal information about members of the plaintiff class, as detailed herein at ¶¶ 95-103, denies them under color of state law their right to privacy secured by the Ninth and Fourteenth Amendments to the United States Constitution.

119. *CLAIM III.* Defendants' failures to afford plaintiffs educational and preventive services, and protection of their right to privacy, as detailed herein at ¶¶ 85-103, subjects them under color of state law to deliberate indifference to their serious health care needs, in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

120. *CLAIM IV.* Defendants' failures to afford plaintiffs educational and preventive services and protection of their right to privacy, as detailed herein at ¶¶ 85-103, subjects them under color of state law to deliberate indifference to their right to be protected from harm, in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

121. *CLAIM V.* The totality of conditions under which defendants incarcerate the plaintiff class, as detailed herein at ¶¶ 29-103, subjects them under color of state law to cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

122. *CLAIM VI.* The totality of conditions under which defendants incarcerate the plaintiff class, as detailed herein at ¶¶ 29-103, subjects them under color of state law to deprivation of their lives without due process of law in violation of the Fourteenth Amendment to the United States Constitution.

IRREPARABLE INJURY

123. As a result of defendants' policies, practices, procedures, failures, and omissions, plaintiffs have suffered and they will continue to suffer immediate and irreparable injury. Plaintiffs have and will continue to die unnecessarily or prematurely and have suffered and will continue to suffer physical, psychological, and emotional harm. Plaintiffs have no plain, adequate or complete remedy at law to redress the wrongs described herein. They will continue to suffer irreparable injury unless the Court grants the injunctive relief they seek.

PRAYER FOR RELIEF

WHEREFORE, plaintiffs request that the Court grant the following relief:

A. Certify this case as a class action.

B. Declare that defendants' policies, practices, procedures, omissions and failures detailed herein violate plaintiffs rights under the United States Constitution.

C. Permanently enjoin defendants, their officers, agents, employees, and successors in office, as well as those acting in concert with them from subjecting plaintiffs and the class to the illegal and unconstitutional conditions of confinement described in this Complaint.

D. Retain jurisdiction of this matter until the Court's Order has been fully implemented and the Court is satisfied that the illegal and unconstitutional conditions of confinement will not recur.

E. Award plaintiffs their reasonable costs and attorneys' fees.

F. Grant such other relief as may be just and reasonable.

Dated: New York, New York
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