UNITED STATES DISTRICT COURT

DISTRICT OF CONNECTICUT

FILED

IN RE CONNECTICUT PRISON OVERCROWDING AND AIDS CASES	MASTER FILE NO. H80-506 (JAC)
DAVID DOE, et al., Plaintiffs	
v.	CIVIL NO. H88-562 (PCD) (JGM)
LARRY R. MEACHUM, et al., Defendants	NOVEMBER 2, 1990

CONSENT JUDGMENT ON
HEALTH CARE FOR HIV-INFECTED INMATES AND
CONFIDENTIALITY OF HIV-RELATED INFORMATION

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EXHIBITS

FORMS

I. BACKGROUND

1. This action was filed on August 15, 1988. It challenges certain policies and practices of the defendant officials of the Connecticut Department of Correction which pertain to education concerning the Human Immunodeficiency Virus ("HIV"), counselling prior and subsequent to testing for HIV-infection, medical and mental health care provided to inmates with HIV-infection, and protections for the confidentiality of the identities of inmates with HIV-infection.

2. This action was certified as a class action on February 10, 1989 by Order of the United States District Judge Peter C. Dorsey, accepting and adopting Magistrate Joan Margolis' January 20, 1989 Recommended Ruling on Plaintiffs' Motion for Class Certification.

3. After extensive motion practice, discovery, and several weeks of trial, the parties met to discuss and negotiate settlement of the issues raised by plaintiffs' March 3, 1989 Motion for Preliminary Injunction, which pressed certain of plaintiffs' claims regarding inmate AIDS education and pre- and post-HIV test counselling.

4. On May 16, 1989 the parties entered into a Consent Judgment on Inmate AIDS Education and Pre- and Post-HIV Test Counselling which, after appropriate notice to the class and a hearing, was approved by the Court.

5. Since May, 1989, discovery has continued regarding the remaining issues in this action. The provisions of this Consent Judgment are the result of several discussions and careful negotiation among all parties after this additional discovery. They have been agreed to solely as a means to put a reasonable end to the parties' dispute over the issues of confidentiality and medical and mental health care for HIV-infected inmates and to avoid the costs, time, and risks which would be involved for both parties in further litigation. This Consent Judgment embodies a compromise of the issues involved and, while its provisions are binding on the parties herein, its provisions are not to be construed to be statements, ruling, or precedents with respect to the constitutional and other legal rights of persons who are parties or nonparties to this litigation in this or any other action.

6. As used in this Judgment, the following terms shall have the following meanings unless specifically stated otherwise:

a. "AIDS" shall mean Acquired Immune Deficiency Syndrome, as defined by the Centers for Disease Control of the United States Public Health Service.

b. "AZT" means Zidovudine, Azidothymidine or Retrovir.

c. "CDC" shall mean the Centers for Disease Control of the United States Public Health Service.

d. "Commissioner of Correction" or "Commissioner" shall mean the Commissioner of the Connecticut Department of Correction or his/her designee.

e. "DOC" shall mean the Connecticut Department of Correction.

f. "DOC's medical complexes" shall refer to the current groupings of DOC facilities, which at the time of the signing of this Judgment are six in number: Somers, Niantic, Cheshire, Hartford, New Haven, and Bridgeport. Should this term cease to be used by DOC to designate the current configuration of health care delivery, the term shall be interpreted to mean those groupings of DOC facilities currently in operation which are in the same general area of the state and which serve approximately the same number of inmates as the current complexes serve.

g. "DOHS" shall mean the Connecticut Department of Health Services.

h. "DOHS-certified HIV counsellor" shall mean persons who are certified by DOHS to do HIV-test counselling.

i. "Infectious Disease Specialist" as used in this Judgment shall mean a person meeting the qualifications specified in Section II.A, infra.

j. "Inmate" shall mean any and all persons committed to the care and custody of the defendant Commissioner of Correction now or in the future, whether in pretrial or sentenced status.

k. "FDA" shall mean the United States Food and Drug Administration.

l. "HIV" and "HIV-infection" shall mean infection with the human immunodeficiency virus, or any other related virus identified as the probable causative agent of AIDS.

m. "HIV test" shall mean any laboratory test or series of tests for any virus, antibody, antigen or etiologic agents whatsoever thought to cause or to indicate the presence of HIV-infection.

n. "NIAID" shall mean the National Institute of Allergy and Infectious Diseases.

o. "Inmates at risk of having HIV-infection" shall mean all inmates with a health history indicative of possible HIV-infection, including without limitation intravenous drug use, transfusions, male homosexual contact, sexual promiscuity and/or other types of blood to blood contact with persons with HIV-infection.

p. "Physician's assistant" shall mean a graduate of an approved Physician's Assistant program who is licensed to practice as a physician's assistant in this State.

q. "Accepted professional standards" shall mean those standards in effect on the date of the signing of this Judgment.

II. HIV-RELATED SPECIALTY SERVICES

A. Specialist Services

7. Within 120 days of judicial approval of this Consent Judgment, the Commissioner of DOC shall establish Infectious Disease Specialist services in or for each DOC Complex (except in the New Haven Correctional Center and the Bridgeport Correctional Center where such services shall be established in July, 1991), to which particular inmates with HIV-infection, as specified in this Judgment, §§IV.A.15, IV.C.24, and D.27., infra, shall be referred for health care related to their HIV-infection. These specialist services shall be provided by physicians who either are Infectious Disease Specialists, Infectious Disease Fellows, or physicians who are Board-certified in internal medicine, family practice or preventive medicine and who have two years of experience in in- and out-patient management of persons with HIV infection. The total number of hours of Infectious Disease Specialist service provided by DOC shall be determined by the number of referrals and the clinical need for the services, as measured by the criteria set forth in this Judgment. The specialist services shall be provided as necessary to fulfill the terms of this Judgment and to meet the clinical need for such services, as defined in this Judgment. It is anticipated that there will generally be a weekly clinic at each Complex. Inmates who need to be seen by an Infectious Disease Specialist may be transported to another Complex in the event of the unavailability

of the specialist assigned to their Complex or in the event that there are too few inmates to justify a separate clinic at that Complex. In addition, DOC shall provide for telephone consultation services and, as medically necessary, for non-regularly scheduled visits to the facility on an on-call basis by physicians with equivalent qualifications and experience.

8. Until such time as Infectious Disease Specialist services are established at the New Haven Correctional Center and the Bridgeport Correctional Center, DOC shall ensure that the HIV-related treatment plans of HIV-infected inmates within said facilities are reviewed by an Infectious Disease Specialist and shall transfer HIV-infected inmates to Complexes which have Infectious Disease Specialist services whenever medically-necessary.

B. AIDS Coordinator

9. Within sixty days of judicial approval of this Consent Judgment, the Commissioner of DOC shall designate for each DOC facility the medical staff person responsible for ensuring compliance with the terms of this Judgment (including the maintenance of necessary tickler systems) and otherwise acting as a liaison with the DOC Director of Health Services for purposes of ensuring quality of care for HIV infected inmates. This staff person shall be either the Medical Director of the facility, CHNS or acting CHNS for the facility or Complex, or a

Registered Nurse assigned to the facility who is thoroughly trained in the management of HIV disease.

III. IMPLEMENTATION OF POLICY MANUAL

10. A written comprehensive policy and procedure manual setting forth the standards for health care treatment of inmates with HIV-infection as summarized in the pertinent elements of this Judgment and as incorporated in DOC's HIV-related protocols and forms shall be submitted to the Monitoring Panel described herein within sixty days of judicial approval of this Consent Judgment for the Panel's review and comment, and fully implemented within sixty days thereafter. The forms attached to this Consent Judgment may be modified as needed to improve upon the efficiency of the form and to accommodate changes in medical knowledge and standards, provided that the Monitoring Panel, before new forms are implemented, shall have opportunity to review and comment on any changes in the forms to ensure that they conform to then-current accepted professional standards.

IV. INTAKE AND ASSESSMENT

A. Health Screening

11. Within twelve hours of admission to a DOC facility from any place other than another DOC facility, each inmate shall receive a health screening examination. This screening examination must be performed in private by a correctional medical attendant, licensed nurse, nurse clinician, physician assistant, or physician. Within sixty days after judicial approval of this

Consent Judgment, all correctional medical attendants and licensed practical nurses ["LPNs"] performing the medical screening examination will have received a six hour training course specifically dealing with medical screening procedures and important clinical aspects of HIV infection with the appropriate referral criteria.

12. One aspect of this health screening shall be to assess whether the inmate has or may have HIV infection, including by inquiring of the inmate if s/he is infected, assessing the inmate's past behaviors which pose a risk of transmission, and making a preliminary determination of any clinical indications of infection, including fever, night sweats, fatigue, dysphagia, cough, shortness of breath, lymph node enlargement, diarrhea, new skin lesions, pruritus, visual changes, headache, memory changes, weakness, numbness, paresthesias/dysesthesias, and recent weight loss. The health screening also shall be used to determine if the inmate is in need of immediate further evaluation, next-day physician referral, and/or other appropriate followup.

13. Inmates who have not tested positive in the past and who describe risk behaviors in the past related to, and/or who have significant findings suggestive of, HIV-infection shall be advised of the medical benefits of being tested to assess if they are HIV infected. HIV tests shall be available in all DOC facilities, but can only be ordered by a physician. No inmate

may be tested for HIV-infection unless the HIV-test counselling mandated by the 1989 Consent Judgment on AIDS Education and Pre- and Post-HIV Test Counselling in this action is provided. Except as otherwise specified in P.A. 89-246, no inmate shall be tested for HIV infection unless the inmate has consented to the performance of the test, in such manner as required by P. A. 89-246.

14. All inmates at the initial screening shall be given written materials in English and Spanish which describe available medical and mental health services for HIV-related care, the confidentiality of these services, and the procedures for gaining access to such services. DOC shall ensure that this information is communicated verbally in a timely manner to illiterate inmates, and by translation to inmates with a native language other than English or Spanish.

15. If the screening examination indicates that an inmate's HIV-related condition may require immediate medical and/or mental health treatment, that inmate shall be referred immediately for such additional care to appropriate DOC medical and/or mental health staff. This staff shall promptly assess the inmate's status, provide appropriate treatment, and make all necessary additional referrals, including, as appropriate, to the Infectious Disease Specialist. Medical findings that would trigger such additional referrals to the Infectious Disease Specialist would include, but would not be limited to, the

following: a) an inmate on AZT, PCP prophylaxis, or any other prescribed medications for HIV disease or its complications; b) fever of 102 F or more in a patient suspected or known to be HIV-infected; c) obvious significant infection in a patient suspected or known to be HIV-infected, including dental abscess, cellulitis, peri-anal ulcerations, etc.; d) signs of respiratory distress, e.g. respiratory rate at rest greater than or equal to 25/minute, intercostal retractions, cyanosis, especially if these signs are associated with a non-productive cough; e) severe persistent headache in a patient suspected or known to be HIV-infected; f) mental status abnormalities that are acute or clinically unexplained, e.g. confusion, poor memory, bizarre or inappropriate behavior; g) visual complaints in a patient suspected or known to be HIV-infected; h) a patient with suspected wasting syndrome (suspected on visual exam or by a documented 10% weight loss over the previous three months without obvious explanation); i) an inmate exhibiting skin lesions suggesting Kaposi's sarcoma, severe HSV or varicella-zoster; j) obvious muscle weakness or ataxia of recent onset in a patient suspected or known to be HIV-infected; k) a patient with a known T4 count below 200/mm3. Access to such specialist services shall not be denied based on custodial concerns or other non-medical issues. The time, date and nature of each referral shall be noted in the inmate's medical record, or, as appropriate, mental health record.

B. Comprehensive Health History and Physical Examination

16. Each newly admitted inmate who is known to DOC to have HIV infection, who demonstrates symptoms suggesting HIV infection, and/or who has notified DOC staff that s/he is HIV infected shall be given a comprehensive health history and physical examination ["CHH"] of all systems by a physician, nurse clinician, or physician assistant with adequate training in the assessment of HIV disease within ninety-six hours of admission, provided that in those DOC facilities in which such staff is present two or fewer times each week or during holiday weeks, the assessment shall be completed within one week of admission. All inmates diagnosed as having HIV infection while within DOC custody shall be given this same examination by the same DOC medical personnel within ninety-six hours of diagnosis.

17. The comprehensive health history and physical examination shall be conducted in private and the results recorded in the inmate's medical record using, as appropriate, the HIV Health Care Summary, Flowsheet, and Rolling Treatment Plan, attached hereto as Forms A-C and incorporated herein by reference. It shall include the following components:

a. a complete physical examination (including a baseline weight, temperature, pulse, blood pressure, and respiratory rate and an examination of the lungs, cardiovascular system and abdomen).

b. a fundoscopic examination.

c. a basic examination of the soft tissues of the mouth, which shall include assessment of abnormalities indicative of HIV-infection (e.g. oral hairy leukoplakia, candida, oral ulcerations, oral Kaposi's Sarcoma, and progressive periodontal disease).

d. a basic neurologic examination, which shall assess any disturbances in gait, cerebellar function, gross and fine motor function, reflexes, and sensory functioning.

e. a basic mental status examination, which shall assess any memory loss, speech difficulties, delusions, symptoms of psychotic or marginal behavior, clinical depression and/or suicidal ideation.

f. an evaluation of lymph node status in various chains including cervical, supraclavicular, axillary and inguinal areas.

g. a basic examination of the skin to assess any HIV-related problems, e.g. with nonspecific rashes/dermatitis, folliculitis, psoriasis, seborrhea, and lesions suggestive of Kaposi's sarcoma.

h. an evaluation of the genitalia and perirectal areas (for men) or a Pap smear, pelvic and perirectal examination (for women). Such evaluations for women performed by a DOC nurse need not be repeated if such an exam was performed within the previous two months, and if the patient denies any gynecological complaints.

18. In addition, the following laboratory tests shall be included as a routine part of the comprehensive health examination for those inmates known to be HIV-antibody positive once the comprehensive health history and physical examination have been completed:

a. a PPD-intermediate (which shall be read forty-eight to seventy-two hours after application), unless the inmate is PPD positive and/or has a past history of TB.

b. a CBC with differential which shall be repeated twice a year at a minimum.

c. a Chem 20 (or similar chemistry profile) which shall be done when the CBC is first done, and thereafter repeated with the CBC.

d. a dipstick urinalysis, which shall be repeated thereafter at the yearly physical examination.

e. VDRL.

f. HBsAg and HBsAb unless the HBSAb is known to be positive.

g. a T cell profile, which shall include an absolute CD4 count and a CD4/CD8 ratio and which shall be repeated twice a year (or more often if there is evidence of clinical deterioration consistent with advancing HIV disease or if the inmate's most recent T4 count was approaching a level for which s/he would qualify, under currently-accepted professional standards, for a treatment that had not yet been offered. Once the T4 count falls

below 200/mm 3, the T cell profile need not be repeated unless medically appropriate.

h. a chest x-ray, to be repeated yearly.

i. if the results of the comprehensive health history and physical examination, as reflected in an entry in the inmate's medical record, indicate that the inmate is not known to be HIV infected, only the tests specified in §IV.B.18.a-e, supra, need be performed.

19. If the medical staff conducting the comprehensive health examination detects any significant clinical findings in an inmate's mental status examination, the neurological examination, the examination of the mouth, and/or the laboratory tests requiring further evaluation, immediate referrals shall be made to specialists in psychiatry, ophthalmology, neurology, dentistry, diagnostic radiology, etc. so that the inmate's condition might be more fully assessed as soon as medically appropriate, subject to review by the Infectious Disease Specialist. Access to such specialist services shall not be denied based on custodial concerns or other non-medical issues. The time, date, and nature of each such referral shall be recorded in the inmate's medical or, when appropriate, mental health record.

20. The comprehensive health examination for new admittees, specified in §§16-18, supra, need not be conducted if, after review of the DOC medical records, it is established that

the inmate has been discharged from the DOC system and subsequently readmitted AND has had a comparable comprehensive health examination within a DOC facility within the previous sixty days AND the initial screening/comprehensive health history at the time of readmission has revealed no acute medical or mental health conditions.

21. A repeat comprehensive health history and physical examination are not required for those inmates who are transferred from one DOC facility to another UNLESS such comprehensive health history and physical examination are medically indicated by the initial medical screening which is done by the receiving DOC facility at admission.

C. HIV Disease Treatment Plan

22. After the physician's review of the HIV-infected inmate's existing medical and mental health records, including those pertaining to the personal examination of the inmate, review of reports of any other specialists, and completion of such other tests and assessments as are determined to be necessary, an individualized, goal-directed and outcome-oriented HIV-disease health care summary, flow sheet, and treatment plan, using the attached Forms A-C as standardized forms, shall be developed and implemented for the medical care of each HIV-infected inmate.

23. The individualized health care summary, flow sheet and treatment plan (Forms A-C) for each HIV-infected inmate shall

be completed by a DOC physician responsible for HIV-related care within that inmate's particular DOC facility.

24. The individualized health care summary, flow sheet and treatment plan for a symptomatic HIV-infected inmate shall be completed within ten days of the inmate's admission to a DOC facility or, for inmates diagnosed while within DOC care, within ten days of diagnosis. If all requisite laboratory reports have not been completed within this period or if the inmate is transferred to a community facility for health care treatment, the plan shall be prepared in draft form, and revised, as necessary, when all laboratory reports are complete or the inmate returns to a DOC facility. The treatment plan for an asymptomatic HIV-infected inmate shall in normal circumstances be completed within ten days of completion of requisite laboratory work, but in no event later than thirty days after admission or diagnosis. The Infectious Disease Specialist shall review the initial treatment plans of all HIV-infected inmates who have not been referred to him/her for in-person evaluation to ensure that the data base is complete, to assess if there are any laboratory or physical abnormalities which require referral to him/her, to assess the need for and timing of examinations by other specialists, and to alert the responsible facility physician as to needed changes in the treatment plan and to provide advice as to how to follow the inmate medically. All significant changes to an HIV treatment plan and the finding of new opportunistic

infections or other new AIDS-defining conditions also shall be reviewed by the Infectious Disease Specialist. This review shall be completed within seven business days of the completion of, or revision to, the treatment plan or new finding.

25. The individualized HIV health care summary, flow sheet and treatment plan shall follow the standardized format of the attached Forms A-C, and may refer to and incorporate by reference any pertinent DOC protocols for HIV-related care. The treatment plan shall include at least the following:

a. a record of the inmate's current T-cell level.

b. a schedule according to which appropriate T-cell and other laboratory studies will be performed -- starting immediately.

c. a determination of toxoplasmosis titer for those HIV-infected patients whose T4 count is below 250/mm3. Once a toxoplasmosis titer has been obtained in the past and the results recorded, it need not be repeated.

d. a schedule for follow-up check-ups to review past and current symptomatology, to repeat and to review T-cell and other laboratory results, and to order medication as appropriate.

e. Referrals to appropriate specialists, including but not limited to neurology, ophthalmology, psychiatry, diagnostic radiology.

f. nutrition and diet restrictions or recommendations.

g. evaluation for and, when medically-appropriate, initiation of anti-retroviral therapy (with AZT, DDI, etc.).

h. evaluation for and, when medically-appropriate, initiation of primary and secondary opportunistic infection prophylaxis (e.g. for PCP, toxoplasmosis, cytomegalovirus, cryptococcus).

i. evaluation for, and, when medically-appropriate, initiation of anti-viral therapies (for CMV, herpes simplex, varicella-Zoster infections, etc.).

j. evaluation for and, when medically-appropriate, initiation of anti-fungal therapies (for candida, cryptococcus, etc.).

k. evaluation for and, when medically-appropriate, initiation of treatment for M. tuberculosis and atypical TB infections.

l. evaluation for and, when medically-appropriate, provision of vaccination (for influenza, pneumococci).

m. evaluation for and, when medically-appropriate, initiation of treatment for Kaposi's sarcoma (alpha-interferon, chemotherapy, radiation therapy etc.).

n. evaluation for and, when medically-appropriate, initiation of treatment for other neoplasms.

o. a schedule for regular evaluation (by laboratory tests, inmate interviews and/or physical examinations) of the

toxic side effects of each medication administered when medically appropriate.

p. a determination of the frequency with which a complete repeat physical shall be done on that inmate.

q. a list of all consultations requested for the inmate, including the date the request was made, the type of consultation requested, the date of any followup calls, the date on which the consultation occurred, and any summary of the outcome of the consultation, provided that any summary of a mental health consultation shall be recorded in the inmate's mental health record.

26. A CHH shall be conducted and an individualized treatment plan and flowsheet as described above shall be completed within 120 days of judicial approval of this Consent Judgment for each inmate who has been diagnosed as having HIV-infection and who is in DOC custody at the time of the approval of this Judgment. If inmate has had the CHH specified in §IV.B.17-18, supra, in last six months, this exam need not be repeated.

D. Referrals to Infectious Disease Specialists

27. The following categories of inmates shall immediately be referred to the Infectious Disease Specialist, to be seen within the response time noted after each basis for referral outlined below:

a. HIV-infected inmates on AZT, DDI, PCP prophylaxis, and other HIV-related medications shall be seen within two weeks of referral;

b. HIV-infected inmates who are identified as having a T4 count under 400/mm3 shall be seen within two weeks of referral;

c. inmates who upon the initial health screening and/or physical examination, or subsequent to this initial examination, are found to exhibit symptoms suggestive of the following HIV-related conditions:

- thrush not related to concomitant or recent antibiotic therapy. Such inmates shall be seen within two weeks of referral;

- skin lesions consistent with Kaposi's sarcoma, Herpes zoster, severe Herpes simplex infection. Such inmates shall be seen within one week of referral;

- unexplained dysphagia in a patient suspected or known to be HIV-infected. Such inmates shall be seen within one week of referral;

- persistent periodic fever of 102 F or more in a patient suspected or known to be HIV-infected. Such inmates shall be seen within one week of referral;

- persistent non-productive cough but negative chest x-ray for an acute infiltrate in a patient suspected or

known to be HIV-infected. Such inmates shall be seen within one week of referral;

- other localized infections including cellulitis, infected wounds or ulcers, etc. in a patient suspected or known to be HIV-infected. Such inmates shall be seen within one week of referral.

d. HIV-infected inmates with a clinically-significant deterioration in an HIV-related condition. Such inmates shall be either evaluated by the Infectious Disease Specialist within twelve hours or less of the referral or they shall be referred to an emergency room attached to an accredited community hospital within this timeframe. Conditions requiring such medical disposition would include, but would not be limited to, the following:

- respiratory distress with a respiratory rate greater than or equal to 25/minute at rest not related to a known chronic respiratory disorder, e.g. asthma, COPD. The presence of cyanosis or mental status changes thought to be related to hypoxemia would require immediate transfer to a hospital emergency room as above.

- signs and symptoms compatible with encephalopathy due to HIV itself, toxoplasmosis, or other HIV-associated CNS disease including lymphoma and cryptococcal meningitis. Such signs and symptoms would include severe unrelenting headache, neurological changes such as the sudden

appearance of a focal neurologic deficit or sudden ataxia, and mental status changes (confusion, personality change, unexplained sudden alterations in consciousness, etc.).

- visual complaints compatible with retinal disease (suspected CMV or toxoplasmosis retinitis).

- clinically significant hemorrhagic episodes, e.g. documented acute GI blood loss.

e. HIV-infected inmates with an unintended weight loss of 10% of body weight or more within the past six months. Such inmates shall be seen within two weeks of referral.

f. HIV-infected inmates experiencing vomiting and/or diarrhea of more than three days duration notwithstanding dietary adjustments. Such inmates shall be seen within one week of referral.

g. HIV-infected inmates with progressive gingivitis, obvious dental abscess, unexplained oral lesion, or hairy leukoplakia. Such inmates shall be seen within one week of referral.

h. inmates housed in an infirmary setting specifically because of their HIV-related condition. These patients shall be evaluated at least weekly by an Infectious Disease Specialist, though they shall also be seen several times a week by the DOC physician assigned to this area.

i. HIV-infected inmates with a documented new infiltrate on chest X-ray. Such inmates shall be seen within one week of referral.

j. Inmates with a newly documented white cell count between 1000/mm3 and 3500/mm3. Such inmates shall be seen within two weeks of referral. Inmates with a newly documented white cell count under 1000/mm3 shall be seen within one week of referral.

k. Inmates with a newly-documented platelet count between 50,000 and 100,000 shall be seen within two weeks of referral. Inmates with a platelet count under 50,000 shall be seen within one week of referral. Those inmates with physical signs of internal hemorrhage (many petechiae, large, scattered purpura and ecchymoses, especially if associated with GI blood loss) may require immediate referral to a local emergency room following phone consultation with the Infectious Disease Specialist.

l. Inmates with a hematocrit less than 27% who shall be seen within one week.

m. Inmates with such additional symptoms and conditions as the DOC Director of Health Services, in consultation with the Infectious Disease Specialists, determines to be medically-appropriate bases for referral in light of new medical developments. The time and reason for referral shall be noted in the inmate's health care record.

V. DELIVERY OF ROUTINE HEALTH SERVICES TO HIV-INFECTED INMATES.

28. All HIV-infected inmates shall be routinely scheduled for follow-up health examinations at a frequency consistent with current professional standards.

29. All HIV-infected inmates shall be routinely scheduled for all laboratory tests as are determined to be medically-necessary by the treating physician in consultation with the Infectious Disease Specialist in accordance with accepted professional standards.

30. DOC shall institute a "tickler system" and such other procedures as are necessary to ensure that the examinations and laboratory work are scheduled for, and provided to, HIV-infected inmates at the intervals consistent with §V.28. to V.29, supra. These procedures shall include, but are not limited to, the use of the standardized form attached hereto as Form C and a requirement that if an inmate is transferred from one DOC facility to another without his/her medical file, the receiving facility shall promptly call the sending facility and/or the Health Services Division in Central Office for all information about that inmate on their tickler files, and shall promptly include said information on the receiving institution's tickler file. This system and its accompanying procedures shall also ensure that all necessary treatment identified in an inmate's HIV treatment plan is provided at the time(s) identified in the plan. Any "tickler system" and other procedures for ensuring ongoing

care for infected inmates shall maintain the confidentiality of an inmate's HIV status by limiting disclosures regarding HIV status only to the health care personnel involved in providing HIV-related health care to that inmate.

31. DOC shall establish a system for preventive health care maintenance for HIV-infected inmates which ensures that inmates are apprised of treatments and vaccines deemed medically necessary and appropriate for them. HIV-infected inmates shall receive, in accordance with current recommendations of CDC or NIAID:

a. pneumococcal vaccine.

b. influenza vaccine.

c. PCP prophylaxis.

32. DOC shall incorporate into the introductory AIDS education program for inmates mandated by the May 16, 1989 Partial Consent Judgment in this action information about AZT, DDI, PCP prophylaxis, and any other advances in HIV-related therapies deemed appropriate for inclusion in such program by the DOC Director of Health Services as well as an explanation that Consent Judgments relating to AIDS-related care have been entered and where, within the institution, a copy of these Judgments is maintained for an interested inmate to read. Defendants shall maintain within each DOC facility, either in the medical unit or another appropriate site, a copy of the two Consent Judgments entered in this action and shall establish a procedure whereby

inmates interested in reading one or both Judgments have opportunity to do so within a reasonable time of their request.

33. Because of the relationship between HIV-infection and TB, DOC shall continue to implement policies and procedures for the identification, management and treatment of TB that meet accepted professional standards.

VI. ACCESS TO MEDICAL CARE FOR ACUTE ILLNESSES.

34. Each DOC facility shall institute a system for sick call by which inmates, including those with HIV-disease, who seek medical attention shall be allowed to place their requests into a locked box or other equivalent confidential container or location which shall be checked at least daily when health care staff are present in the facility and access to which shall be limited to health care personnel. The collection schedule shall be posted on or near the box (or container).

35. Absent an emergency, any HIV-infected inmate who requests medical attention shall be placed on the next routine sick call. Any HIV-infected inmate identified by DOC medical staff as having an unresolved, clinically-significant acute illness or condition which has lasted for three consecutive days, or with a clinically-significant deterioration in neurological and/or respiratory status which has lasted for six hours, shall immediately and automatically be referred to the on-call Infectious Disease Consultant or the Complex's Infectious Disease Specialist for immediate attention. If this physician determines

that further evaluation is required, s/he shall either come promptly to the facility to examine the inmate or the inmate shall be transported promptly to a hospital emergency room. If this physician decides that no further action should be taken or treatment administered, he/she shall note the rationale therefore in the inmate's medical record and the inmate shall be informed of the decision by DOC medical staff. Inmates shall be afforded the opportunity to review their medical records and shall be informed of the procedure by which they can raise questions regarding the medical care being provided to them.

36. When an HIV-infected inmate develops fever or other sign of infection and when any physician (or registered nurse, if the physician is not available) believes that the inmate is in need of a transfer to an outside hospital, that inmate shall immediately be transferred to such an outside hospital.

37. A W-10 Transfer Form, attached hereto as Form D, shall be prepared for each HIV-infected inmate who is to be transferred outside DOC for in-patient care. For inmates transported for out-patient care, significant problems and medications shall be documented on a consultation sheet which shall accompany that inmate to the appointment. A copy of the inmate's HIV flow sheet (Form B) shall also accompany the inmate at the time of transfer for inpatient care. The documents shall be updated, as necessary, to include a list of all current medications, doses, dose schedules, and allergies, as well as instructions as to

which medications can and cannot be taken together, a summary of current illnesses including vital signs and relevant physical findings, and the results of all lab tests done in the previous two weeks. In the event of an emergency transfer precluding time for copying the necessary transfer documents, the physician, nurse, or medic shall, concurrent with the inmate's transfer, make direct telephonic contact with the physician or emergency room triage nurse at the outside hospital to relay all information necessary for the inmate's treatment and shall forward the completed and updated W-10 and flow sheet within twelve hours to the hospital.

38. All inmate transfers for medical and mental health care shall be managed so as to protect the confidentiality of the inmate's condition from disclosure to non-medical DOC staff and other non-medical personnel.

VII. DRUG THERAPIES.

39. DOC shall offer to an HIV-infected inmate such drug therapies (including drugs approved by the FDA for "compassionate use" and FDA-approved Treatment Investigational New Drugs) as are determined to be medically necessary for him/her by the treating physician, in consultation with the Infectious Disease Specialist, in accordance with accepted professional standards. Said drugs shall be administered (in dosages and at frequencies) and monitored in accordance with accepted professional standards.

40. Prior to the initiation of any treatment, HIV-infected inmates shall be informed of the nature of the treatment, the possible risks, benefits and side effects of the treatments, and the methods to monitor the efficacy of the treatments. DOC shall prepare a written Informed Consent Form for AZT, DDI, and any treatment IND drug. This form shall be in English and Spanish, and shall detail the requisite components of an informed consent, shall be signed by an inmate prior to receipt of the drug, and shall be included in the inmate's medical record.

41. An inmate receiving AZT, DDI, PCP prophylaxis, and/or other HIV-related medications shall be monitored at medically-indicated frequencies by the Infectious Disease Specialist. This monitoring shall be on an ongoing basis according to accepted professional standards and shall include all requisite lab work at the medically-accepted frequencies.

42. The hematocrit (HCT) of each inmate receiving AZT shall be appropriately monitored by an R.N. or M.D. on an on-going basis. All inmates with a hematocrit (HCT) below twenty (as well as those with a hematocrit above twenty when clinically indicated) will be transferred to an appropriate medical facility for the purpose of receiving transfusions, unless medically contraindicated or the patient refuses transfer.

VIII. HEALTH CARE RECORDS OF HIV-INFECTED INMATES.

43. A uniform, statewide recordkeeping system for maintaining the information about the medical and mental health

status of HIV-infected inmates shall be implemented within 120 days of judicial approval of this Judgment.

44. During the comprehensive, HIV-related health examination, each HIV-infected inmate shall be questioned regarding his/her prior health care providers, and asked to sign Medical and Mental Health Release Forms to obtain all prior medical and mental health records (unless already in DOC possession). Any refusals to sign such release forms shall be recorded in the inmate's health care record. DOC shall request all health care records from the appropriate health care providers within two working days of the inmate signing the release. If there has been no response to a request for records within two weeks, a followup request shall be sent.

45. The medical records of an HIV-infected inmate shall, at a minimum, include:

a. past DOC medical records and those records obtained pursuant to §VIII.44.

b. all inmate health screening forms, documentation pertaining to the comprehensive health examination(s)(including results of intake laboratory tests) and documentation pertaining to any assessment(s) by the Infectious Disease Specialist.

c. current medication records and records of all HIV-related medications and medication allergies.

d. records of any in-patient treatment within DOC, or in community hospitals (to the extent such records have been provided to DOC).

e. reports from all consultants (including the Infectious Disease Specialist).

f. copies of all signed Release of Information forms.

g. the HIV Health Care Summary, Flow Sheet and Treatment Plan (Forms A-C).

h. copies of all W-10s (Form D) and Termination/ Transfer Forms (Form E) and any other discharge summaries.

i. a substantive record of all contacts with medical staff as recorded in progress notes.

46. To ensure that an HIV-infected inmate's current and past medical problems, treatment status, and medication status can be accurately determined, entries (including out-patient clinic and doctor's notes) in DOC medical records pertaining to treatment provided while in DOC custody on an outpatient basis (whether scheduled or sick call) shall include the date of visit and year, purpose of visit and chief complaint, examinations and tests performed, diagnosis, and disposition.

47. DOC shall expand its efforts to increase the number of health care providers at each DOC facility who are fluent in Spanish. These efforts shall include attempting to recruit trained bilingual medical staff (e.g. from Puerto Rico) and offering interested current medical staff Spanish-language tapes.

48. DOC health care staff shall neither examine and question an HIV-infected inmate about HIV-related issues nor discuss the HIV-related health care status of that HIV-infected inmate, without his/her consent, while in the presence or earshot of other inmates, non-medical DOC staff, or other persons who are not DOC health care staff, except to the limited extent currently permitted by P.A. 89-246.

49. Unsealed medical and mental health files of an HIV-infected inmate shall be available only to the DOC medical and mental health staff directly responsible for providing care to that inmate or to a consulting specialist or outside medical provider to whom the inmate is referred for medical/mental health treatment or evaluation, absent the inmate's informed written consent for disclosure of HIV-related records to a specifically-identified individual. The foregoing provision shall not limit access to such files to attorneys for DOC, plaintiffs' counsel, and any Monitoring Panels or quality assurance staff established by this Judgment for the purposes of monitoring compliance with this Judgment and assessing the adequacy of the care being provided by DOC, or anyone else authorized under P.A. 89-246 to review such records. Neither non-medical DOC staff nor inmates, whether they work in the infirmary or not, shall have an opportunity to read any part of the contents of an HIV-infected inmate's medical and mental health record which identifies the inmate as being HIV-infected absent the inmate's informed

written consent (except to the extent permitted by P.A. 89-246). It is understood that there may be certain documents in an inmate's central file which may contain information pertaining to medical and mental health issues about that inmate, however such documents shall not include any confidential HIV-related information as said term is defined in P.A. 89-246.

50. All DOC employees shall receive periodic training as to their obligations, under P.A. 89-246 and the DOC Administrative Directive on AIDS, to maintain the confidentiality of any HIV-infected inmate's condition.

51. The medical and mental health records of an inmate transferred from one DOC facility to another shall accompany that inmate, together with his/her master institutional file. The medical and mental health files shall be sealed by the medical/ mental health unit staff before being delivered to the correctional staff responsible for making inmate transfers. Each DOC facility transferring an inmate to another DOC facility shall ensure that the inmate's health care records are transferred simultaneously with the inmate. The Warden of each DOC facility shall designate staff on each shift who shall be responsible for ensuring that this simultaneous transfer of inmate health records occurs and who shall have access to such records to accomplish this end, provided that non-medical personnel shall not be permitted to look into any inmate's health records, except when necessary for the limited purpose of identifying the file as that

which pertains to the inmate being transferred in instances in which there is a reasonable basis for an error in this regard. Should said non-medical personnel thereupon become aware of confidential HIV-related information about an inmate, as said term is defined in P.A. 89-246, s/he shall be bound by the non-redisclosure provisions of said Act. In the extraordinary circumstance that an inmate's health care records are not transferred together with the inmate: a) the inmate's HIV Health Care Summary, Flow Sheet and Treatment Plan (Forms A-C) shall be faxed (on the next shift health care staff are on duty and in confidence) to the fax machine in the medical unit at the receiving facility; b) the sending facility medical staff shall make telephone contact with the receiving facility medical staff to transmit necessary information about that inmate's care; and c) the health care records shall be delivered to the receiving facility within three to seven days.

52. DOC shall institute a system to ensure that the DOC HIV-Treatment Plan, Health Care Summary, Flow Sheet, and the Progress Notes of any inmate who is released from a DOC facility or transferred to community status are not transferred to a parole office, but are maintained within the releasing DOC facility and/or DOC's Central Office Health Services Office. Whenever an HIV-infected inmate is then readmitted to a DOC facility, the inmate's health care records shall be transported to the medical unit of the facility to which she/he has been

readmitted within three to seven days of the new admission. In those instances in which the health care records do not arrive at the inmate's facility within forty-eight hours of his/her admission, the receiving facility shall promptly contact the DOC Health Services Office and/or the facility in which the inmate was last confined and request all relevant HIV-related medical information maintained by that office and/or facility about that inmate. Such information shall thereafter be faxed by the DOC Health Services Office or facility to the receiving facility within one business day of the request.

53. All lab work, procedures, and tests performed on an HIV-infected inmate shall be recorded in the inmate's medical record, and as appropriate on the HIV Health Care Summary, Flow Sheet and Treatment Plan Forms. Medications ordered also shall be included and maintained in the medical chart and the medications prescribed and administered reflected on the Treatment Plan and Flow Sheet Forms. The Infectious Disease Specialist shall review, at the appropriate and medically-indicated frequencies, the reports of HIV-related lab work, procedures and tests and shall document his/her impressions regarding the results and subsequent course of treatment. Unless medically contraindicated, inmates shall be informed within three business days of the results of abnormal lab work and/or tests, and their significance, provided that in the case that there are test results indicating major abnormalities in renal, liver or

kidney function, major electrolyte disturbance, and/or culture results which require immediate institution of antibiotic therapy, the inmate shall be notified within twenty-four hours of DOC's receipt of the test result, unless medically contraindicated.

IX. PRESCRIPTION AND ADMINISTRATION OF MEDICATIONS FOR HIV-INFECTED INMATES.

54. Other than "over-the-counter" medications, medications shall be administered to HIV-infected inmates only by a physician, physician assistant, registered nurse, licensed practical nurse, or other medical staff who have completed the DOC medication training curricula and who otherwise meet state statutory requirements for administration of medication within a DOC facility.

55. The inmate's medical records shall be maintained in such a way that it can be determined what drugs have been ordered for an inmate, by whom, for what purpose, when and in what manner they have been administered and/or offered and refused, the inmate's subjective symptoms or complaints, and any adverse reaction (or lack of response) to the medication.

56. Patient drug profiles and medication administration records shall be maintained for so long as medication is being dispensed and, when not active, shall be kept in the inmate's medical record.

57. No prescription medication may be administered to an HIV-infected inmate without a physician's order. If a physician

is not present at the DOC facility, a registered nurse, LPN, or medic (but only if no RN or LPN is on duty), may relay information to the physician by telephone regarding the inmate's symptoms and condition. If medication is consequently initiated, or changed, by a physician by telephone, a physician must sign the telephone order recorded by the registered nurse, LPN, or medic on the physician's next working day, but in no event later than forty-eight hours after the verbal order. Telephone orders may not be used to initiate AZT and other medications with potentially deleterious side effects for HIV-infected inmates, except when the inmate arrives in custody while currently receiving such medication (as evidenced either by the inmate's possession of the medication itself or by a current prescription).

58. An HIV-infected inmate shall not be barred from receiving medication solely by reason of the inmate being unavailable to request and/or obtain the medication at the specified time. Only a member of the medical staff may make the necessary medication dosage adjustments due to a delay in the administration of such medications.

X. EMERGENCY KITS

59. The defendant Commissioner shall secure for each DOC facility a standard emergency response kit, which shall include the items described in the attached Exhibit "1", and shall ensure that all standard updates to the kits are secured in a timely

manner. The kits shall be readily available to medical staff but not to inmates, i.e., they must be stored in a locked room or area. Emergency drug cassettes in the kit, as well as other kit contents, shall be inspected after each use of the kit, and at least monthly by medical staff, to remove deteriorated and outdated drugs and to ensure the completeness of the kit's contents. A list of the kit's contents, and instructions for use as deemed appropriate by the DOC Medical Director, shall be kept in close proximity to the kit.

60. Medical staff shall be appropriately trained in the use of the kits and their contents.

XI. DIET FOR HIV-INFECTED INMATES.

61. A nutritional assessment shall be part of the initial comprehensive health assessment specified herein in Section IV.B., supra. All appropriate orders to implement any special dietary plan for the HIV-infected inmate shall be signed by the physician, placed in the inmate's medical record, and transmitted to the kitchen staff. DOC staff shall refer all inmate complaints of noncompliance with special dietary orders to the kitchen staff. Facility kitchen staff shall investigate all such complaints and act promptly to remedy any noncompliance. Complaints about noncompliance about which medical staff becomes aware shall be noted by such staff in the inmate's medical record.

62. Monitoring for special nutritional and dietary needs shall be incorporated in the regular follow-up examinations of each HIV-infected inmate, as specified in §IV.C.25.d and 25.p., supra. As a part of these regular follow-up examinations, the inmate's weight shall be measured, the inmate shall be asked about any loss of appetite and any other change in status which alters the inmate's ability to eat.

63. Medical staff shall inform all HIV-infected inmates (orally and/or in writing) about the importance of a balanced diet and provide them with information about basic nutrition and weight maintenance.

64. If any member of the medical staff learns that an HIV-infected inmate has failed to eat three successive meals for whatever reason, that fact shall be noted in the inmate's medical record and brought to the attention of the physician of the facility and, when medically necessary in the judgment of that physician, the Infectious Disease Specialist.

65. HIV-infected inmates shall be provided with a daily multivitamin pill if medically-indicated.

66. If an HIV-infected inmate develops wasting syndrome or experiences an unintended weight loss of 10% of body weight or more within six months or less, his/her weight shall be monitored with increased frequency and s/he shall be provided with high caloric dietary supplements to the regular institutional diet, if

medically necessary, such as two to three cans of Ensure, Sustacal or comparable supplements.

67. Whenever nutritional supplements and multivitamins have been specially selected to meet the individualized dietary needs of an HIV-infected inmate, they shall be distributed and administered in such a manner as to ensure that the inmate receives such supplements and vitamins. Where determined to be appropriate by the facility physician and/or Infectious Disease Specialist, inmates may be provided with multiple doses of such supplements and/or vitamins for self-administration.

68. If DOC medical staff become aware, through inmate report or a report on an inmate's behalf by non-medical staff, that an HIV-infected inmate is experiencing vomiting and/or diarrhea, that inmate shall be evaluated by medical staff within twenty-four hours of the report to determine the cause of the condition and to make any appropriate adjustments in the inmate's diet. If serious vomiting and/or diarrhea persists for more than three days, notwithstanding the change in diet, a referral shall be made to the physician on call or the Infectious Disease Specialist to be examined at the next regularly scheduled visit, or sooner if medically-necessary.

69. Regardless of the manner in which food is delivered to inmates within an particular DOC facility, DOC shall ensure that specialized diets (including low fat, low fiber, bland, diabetic, soft) are made available to all inmates for whom they are

ordered, including, as needed, nutritionally-equivalent substitutions for those items in the standard inmate diet which are not permitted in any particular specialized diet.

XII. MENTAL HEALTH CARE FOR HIV-INFECTED INMATES.

70. All HIV-infected inmates shall be made aware of the availability of mental health services by DOC staff, including those persons who do HIV test counselling, and, upon request, shall be referred to a mental health staff person for further assessment. Mental health services shall be offered to all HIV-infected inmates, who, following assessment by DOC mental health professionals (psychiatrists, psychologists, correctional psychiatric treatment workers and psychiatric nurses) are determined to be in need of such services. HIV-related mental health services shall be provided only by appropriate mental health staff who possess that level of professional training and competence which meets the particular inmate's need for treatment (including psychiatrists, psychologists, Correctional Psychiatric Treatment Workers, psychiatric nurse practitioners, psychiatric nurses, Correctional Treatment Officers, thanatologists, recreation therapists and/or supervised and trained volunteers). A designated facility mental health coordinator shall assign appropriately trained staff to all referrals.

71. The initial comprehensive health history and physical examination of an HIV-infected inmate shall include a basic neurological examination and mental status examination as

required in §IV.B.17, supra, and the findings shall be noted on the examination forms. The medical staff person conducting the comprehensive health history and physical examination shall encourage the inmate to be seen by facility mental health staff for further mental health assessment if such referral is deemed medically necessary. Upon receipt of a referral for mental health assessment, a member of the mental health staff expressly authorized by §XII.70, supra to perform such assessment shall conduct the assessment within five business days of the referral. In the event of any emergency, on-call mental health services shall be available at all times.

72. An individualized written mental health treatment plan shall be developed for each HIV-infected inmate who, after assessment, is determined to be in need of ongoing mental health care. This treatment plan shall be reviewed, approved, and signed by the facility mental health coordinator. The plan shall be reviewed and updated on a regular basis. It shall be maintained as part of the inmate's mental health record.

73. The protocols for the general components of the mental health assessments and mental health treatment plans used with HIV-infected inmates shall be as set forth in Forms F-G, attached hereto and incorporated herein.

74. Mental health staff treating an HIV-infected inmate shall document his/her findings and assessment in the inmate's mental health record, which shall be maintained in such a way as

to protect the confidentiality of the records and as is consistent with the requirements of Conn. Gen. Stat. §§52-146d to 52-146i. All findings relevant to the inmate's medical care shall be reported promptly to the responsible facility physician and, when medically-indicated, to the Infectious Disease Specialist.

75. At least every two weeks, mental health staff for each DOC facility shall review with facility medical staff the status of HIV-infected inmates receiving on-going mental health treatment to ensure the coordination of medical/mental health treatment. A notation that the review took place along with a listing of any recommendations resulting from the review shall be entered in the inmate's medical and mental health files.

76. The DOC has permitted some HIV-infected inmates to participate in HIV support groups in certain facilities. The decision whether and to what extent to permit inmates to participate in such groups depends upon several factors, including the number of inmates requesting participation, the size of the facility, the space limitations of the facility, classification status of the inmate, security concerns of the facility, availability of staff to monitor the meetings, frequency of the meetings, behavior of inmates at the meetings, etc. The DOC will continue to try and accommodate requests for participation in HIV-support groups whenever it is practical to do so upon consideration of the many factors involved. HIV-

infected inmates shall be advised of the existence of any and all peer support groups within their facility and how to become a part of them. The time and place of any support group's meetings shall be set in such a manner as to protect the privacy rights of the inmates involved in the group.

77. Each HIV-infected inmate shall be assessed for the presence of AIDS dementia at the time of each follow-up health status examination, see §IV.C.25., supra.

XIII. DENTAL CARE FOR HIV-INFECTED INMATES.

78. Dental staff in each DOC institution shall follow universal infection control procedures for all inmates. These procedures shall be consistent with the current infection control procedures for dental treatment established by the CDC, the American Dental Association, and/or the National Institute for Dental Health. There shall be no postponement or delay of dental appointments for HIV-infected inmates solely in order to fulfill special infection control procedures, though appointments may be delayed for valid medical reasons.

79. If the initial health screening and/or comprehensive health examination reveal that an HIV-infected inmate has a painful severe dental condition, including extensive dental caries, severe periodontal disease and/or dental abscess, that inmate shall be referred to and examined by the facility dentist within seventy-two hours. If this screening and/or examination reveal such a condition but the inmate is not experiencing pain,

the inmate shall be referred to and examined by the facility dentist within one week, unless a sooner consultation is medically-necessary. In all other cases, the dentist assigned to each DOC facility shall, within ten weeks of an HIV-infected inmate's admission and/or diagnosis of HIV infection, examine that inmate. The dentist's examination of the inmate's hard and soft tissues shall include charting the status of each tooth and recording any restorations or dental caries, examining periodontal conditions, looking for abnormalities indicative of HIV infection (e.g. oral hairy leukoplakia, candida, oral ulcers, oral Kaposi's Sarcoma, and progressive periodontal disease), and conducting panoramic and individual film x-ray examinations as needed.

80. At the conclusion of the dental examination, the dentist shall devise a dental treatment plan for each HIV-infected inmate. The timing of subsequent visits to the dentist shall be determined by that plan. In addition, each HIV-infected inmate with an HIV-related oral condition which is more appropriately treated by the Infectious Disease Specialist shall immediately be referred to him/her, to be seen at the next regularly scheduled Clinic, or earlier if medically appropriate.

81. A platelet count shall be obtained before tooth extraction, periodontal curettage or surgery and biopsy on HIV-infected inmates. HIV-infected inmates upon whom oral surgery is performed shall be instructed on how to handle the gauze used to

stop bleeding to avert transmission of the virus. When feasible, the inmate shall be held in the medical unit until the wound(s) stop bleeding.

XIV. EYE CARE FOR HIV-INFECTED INMATES.

82. HIV-infected inmates for whom chorioretinitis and/or other HIV-related ophthalmologic complications (e.g. cotton wool spots, CMV retinitis) are suspected shall immediately be referred for an ophthalmology consultation and, if confirmed, shall be provided with treatment (including gancyclovir therapy for retinitis) in accordance with current professional standards for persons with similar ophthalmological complications related to HIV-disease within seven days, or earlier if medically-necessary.

XV. ADDITIONAL CRITERIA FOR THE CARE OF HIV-INFECTED WOMEN.

83. HIV-infected female inmates shall be provided with a PAP smear at least once a year. Any abnormal PAP smears shall be investigated aggressively, including with cervical biopsy and appropriate therapy.

84. Cultures for gonorrhea and serology for syphilis shall be taken at the comprehensive health examination, and syphilis serology annually thereafter.

85. HIV-infected inmates who are pregnant shall have absolute CD4 cell counts each trimester. If the absolute count falls to a range associated with a substantial risk of opportunistic infection, consultation shall be obtained and professionally-accepted treatments provided as needed. Gonorrhea

cultures and chlamydia antigen tests shall be obtained and syphilis serologies drawn in the first and third trimesters of pregnancy for an HIV-infected inmate. Serologic tests for HBsAg shall be obtained no less than once during the pregnancy. If syphilis is diagnosed, treatment shall be provided consistent with professionally-accepted standards of therapy for HIV-infected pregnant women. Mycobacterium tuberculosis shall be ruled out.

86. HIV-infected pregnant inmates shall be advised of the risk that the fetus may be infected, of the current CDC guidelines regarding breast feeding, and of their rights under P.A. 90-113.

87. HIV-infected inmates shall be advised as a part of any family planning discussion that the intrauterine device is contraindicated and that the latex condom, in conjunction with nonoxyl-9, if used routinely and properly, combines effective contraception with protection against transmission of HIV disease to sexual partners.

XVI. DISCHARGE PLANNING.

88. When release or community transfer planning commences for an inmate, the inmate's counsellor shall notify facility medical staff of the anticipated release or transfer date.

89. Facility medical staff shall prepare a Discharge Packet for each HIV-infected inmate who has a medical complication requiring ongoing medical care or follow-up which shall include a

copy of the Inter-Agency Patient Referral Report Form ("W10") (Form D), the Termination/Transfer Summary Form (Form E) and the Authorization for Release of Information Form (Form H). The information which is provided in this Discharge Packet includes all current diagnoses, current problems, the treatments which have been provided and the inmate's response to treatment, complications noted, allergies noted, description of condition on discharge, and any followup instructions.

90. If given at least five to ten days notice of the inmate's discharge from a DOC institution, facility medical staff will schedule an exit interview with any HIV-infected inmates who have a medical condition requiring ongoing medical care or follow-up to discuss health maintenance, complete the Discharge Packet forms and inform the inmate where outside health care can be obtained and how to arrange for it. The name, address, and telephone number of appropriate outside health care providers will be included on the W10 form, and the inmate will be instructed to contact the appropriate community provider upon his/her release.

91. At the time an inmate is discharged from a DOC institution, a copy of the complete Discharge Packet forms will be placed in the inmate's medical file, a copy shall be offered to the inmate, and a copy shall be forwarded to the DOC Director of Community Health Services. If the inmate gives appropriate

authorization, a copy shall be sent to the inmate's outside medical provider.

92. If an HIV-infected inmate is on prescribed medication(s), the remaining portion of the prescription, up to a fourteen day supply, will be dispensed to the inmate at the time of discharge from a DOC institution. The inmate will be encouraged to apply immediately for any appropriate medical benefits available in the community.

93. If the facility medical staff believe that an HIV-infected inmate will require home health care upon discharge, the local Visiting Nurse Association or community home care agency will be listed on the W10 form. In such cases, with the inmate's authorization, the DOC medical staff will notify the agency of the inmate's discharge and provide the agency with a copy of the Discharge Packet forms.

94. When the inmate authorizes release of HIV related information to his/her family and the inmate's medical condition upon discharge requires family involvement, the DOC medical staff shall make reasonable efforts to make contact with the inmate's family to assist in the discharge planning process.

95. In the event that an HIV-infected inmate who has a medical condition requiring ongoing medical care or followup is discharged from a DOC institution with less than five to ten days notice to DOC medical staff, the facility medical staff shall be notified of the inmate's discharge within two business days of

the discharge. In such cases, the facility medical staff shall complete the Discharge Packet forms and forward them to the DOC Director of Community Health Services within two days of the date they were notified of the inmate's discharge. The DOC Community Health Services staff shall make all reasonable efforts to contact the inmate to discuss health maintenance, inform the inmate where outside health care can be obtained and offer the inmate a copy of the Discharge Packet forms and the inmate's HIV treatment plan.

96. The provisions of this Section XVI do not apply to pretrial detainees, with the very limited exception that those persons confined within DOC as detainees for a sufficient period of time to complete the HIV assessment and receive an HIV treatment plan shall be mailed or otherwise provided with, upon their request and within three business days of it, a completed W10 and a copy of their HIV treatment plan.

97. When an HIV-infected inmate's medical condition renders him/her unable to participate in medical discharge planning, facility medical staff shall arrange an initial medical consultation in the community and notify the inmate (and, with his/her authorization, notify his/her family) of the time and place of said consultation.

98. Medical providers supplying health care to HIV-infected persons who have been in DOC custody shall be provided with copies of those portions of the DOC health care records which

they request of DOC within seven working days of the providers' request, provided that the inmate has signed an appropriate release of information form.

99. Upon diagnosis of HIV disease within DOC, an inmate shall be offered a list of community resources for HIV-infected persons so that the inmate may initiate contact with them in anticipation of his/her release.

XVII. HOUSING OF SYMPTOMATIC HIV-INFECTED INMATES.

A. Chronic Care Ward at Connecticut Correctional Institution at Niantic.

100. Female HIV-infected inmates, including those currently housed at the Connecticut Correctional Center at Niantic, who are experiencing a level of chronic disease which requires continuous medical observation, supervision, and/or care which, if they were male inmates, would warrant their being housed in the Chronic Care Ward at the Connecticut Correctional Institution at Somers (or a like facility), shall be provided--either within the medical unit at CCIN or any other woman's DOC facility or at an outside in-patient facility -- with health care comparable in its quality to that now provided to male inmates with comparable medical conditions housed on Somers' Chronic Care Ward as a result of the Consent Judgment entered in Smith v. Meachum, Civ. No. H87-221 (JAC). The term "health care of comparable quality" as used in this section shall not be interpreted to require identical medical charting procedures for male and female inmates.

B. Skilled Nursing Facility and Health Related Facility Beds.

101. In the event that the Connecticut Department of Health Services or any other state agency should conduct a study to determine the Skilled Nursing Facility and/or hospice bed needs of HIV-infected persons in the State of Connecticut, DOC agrees to cooperate with such a study so that the needs of the DOC inmate population can be included in projections regarding the need for skilled nursing facility beds and/or hospice beds.

C. Medical Unit Beds.

102. HIV-infected inmates shall be housed in a setting which meets their medical needs. For example, if inmates with HIV- infection do not require hospitalization but require frequent observation by a RN and/or are unable to walk to meals, they shall be housed, depending on their level of medical need, in an infirmary setting which meets the standards established by DOC for Transitional Units or Infirmary I, in its April 1989 "Proposal for the Reorganization of Health Services Within the DOC." Receipt of AZT and other HIV-related medications is not sufficient cause alone for placement in a facility infirmary/medical unit. The numbers of inmates in the facility's infirmary/medical unit shall not be so numerous as to compromise the medical care provided to the HIV-infected inmates housed therein.

103. HIV-infected inmates housed in an infirmary setting shall be visited by the facility physician three to four

times each week, or more frequently if medically-indicated, for an interval history and examination and, when needed, for ordering additional laboratory tests and changes in medication. The physician shall write a note about each visit in the inmate's medical record.

104. HIV-infected inmates housed in an infirmary setting shall be visited no less than once each shift by nursing staff, who, if the inmate is awake, shall take the inmate's vital signs and speak with the inmate about the inmate's condition. Appropriate notes shall be made in the inmate's medical record.

105. HIV-infected inmates housed in an infirmary setting shall be examined by the Infectious Disease Specialist weekly, or more frequently if medically-indicated. Appropriate notes shall be made in the inmate's medical record regarding the examination.

106. A call button system (or alternative, comparably effective device or procedure for notifying medical staff of the need for care) shall be implemented in all medical unit/infirmary rooms in which symptomatic HIV-infected inmates are housed. When the patient is non-ambulatory, access to the call button or alternative system shall be provided. Nothing in this paragraph shall be construed as prohibiting the restriction or removal of the call button for individual security reasons or because of misuse by the inmate, provided that if the call button is removed

or restricted, an alternative, comparable means of access to medical care shall be provided to the inmate.

107. HIV-infected inmates who are in respiratory distress, but not in need of in-patient hospitalization in a community hospital, shall be housed in an appropriate room or facility, where the temperature can be maintained at between sixty-eight and eighty degrees Fahrenheit. Temperature charts shall be maintained daily for this room or facility.

108. Non-ambulatory HIV-infected inmates will be provided access to the visiting area by wheelchair or stretcher or allowed visitation in a private room.

109. HIV-infected inmates housed in an infirmary/ medical unit shall be afforded opportunities for visitation, institutional programs, and activities comparable to that afforded to other inmates in the same infirmary/medical unit, unless participation is contraindicated for medical reasons or for legitimate security concerns unrelated to HIV status. Restrictions on participation in visitation programs and other activities may not be based solely on the fact that an inmate is HIV-infected or on unfounded fears of transmission of HIV among other inmates.

XVIII. STAFF EDUCATION.

110. The Department of Correction will provide to all of its employees a minimum of one hour of training annually on HIV-related subjects. This training will be provided by health

services personnel or by others (teachers, counselors, training officers, etc.) with specific training in HIV-related subjects. This training will be reviewed no less than annually and revisions will be made as appropriate based on new medical and epidemiological information. Additionally, the basic orientation training for correctional officers and correctional treatment officers who are not responsible for providing mental health care will address at least the following issues:

a. a description of the various health and counseling services available for HIV-infected inmates at the facility and in the community;

b. a summary of information needed to access services in the facility;

c. what HIV is, and how it is and is not transmitted;

d. the various diseases, infections, and physical and behavioral conditions for which HIV-infected persons are at increased risk;

e. a description of the HIV antibody test and its limitations;

f. infection control practices, including the use of mouthpieces for CPR;

g. the need to avoid disclosure of confidential HIV related information as required by Public Act 89-246.

111. All medical and mental health staff (including correctional treatment officers providing mental health services)

in DOC facilities shall receive in-service training for at least six hours every year regarding medical/mental health issues affecting HIV-infected inmates. The term "in-service training" as used herein shall not be construed to include training provided through staff meetings and supervision. This training shall be designed to update and supplement the prior training and experience of DOC medical and mental health staff persons and will include new medical and mental health information in the areas of cause, symptoms, assessments, treatments, nutrition, etc. These training sessions shall be conducted by persons with particular experience and/or training in the management of HIV-disease including physicians, RNs, psychologists, psychiatrists, social workers, nutritionists, etc. Further supplementary training shall be conducted whenever it is deemed necessary by the DOC Director of Health Services. The provisions of this section do not apply to medical and mental health professionals under contract with DOC to provide specialized services (e.g. radiology, surgery, neurology, etc) to the inmate population.

112. Newly hired medical and mental health staff shall be provided with eight hours of introductory training on the medical and mental health implications of HIV disease and the requirements of this Judgment to ensure that they possess an understanding of the disease, its manifestations, and medically-appropriate responses to it. Depending upon the immediacy of the medical staffing needs of a particular facility, DOC shall make

its best efforts to complete this training within two months of the date of hire, but in no event shall training be completed later than four months after the date of hire.

113. DOC shall maintain a record of compliance with the training requirements of this Judgment which shall document, for each member of the DOC staff, the date and number of hours of HIV-related training, the subject of the training and the name of trainer. These training records shall be available for review by plaintiffs' counsel and the Agreement Monitoring Panel.

XIX. STAFFING

114. The Department of Correction shall make good faith efforts to provide for one or more Infectious Disease Specialists to be available "on call" for twenty-four hour telephone consultation. The DOC shall maintain sufficient medical and mental health staff (including Infectious Disease Specialists as defined in II.A, supra) to carry out all of the provisions of this Judgment.

XX. QUALITY ASSURANCE

115. Within three months after judicial approval of this Consent Judgment, the Director of Health Services of DOC shall designate a medical department staff member and a mental health department staff member as a Quality Assurance Unit to implement an Infectious Disease Quality Assurance Program. These staff persons will have training and experience in the management of HIV disease and receive special training on the requirements of

this Judgment. The Quality Assurance Program will include a random review of the health care records of HIV-infected inmates, a review of the Medical Incident Report (Form I) and Mortality Review Form (Form K) for HIV-infected inmates, and site visits in order to ensure that the medical and mental health care provided to HIV-infected inmates is adequate. The Program shall conduct focused, outcome-oriented longitudinal reviews, using appropriate samplings of inmate records, regarding specific disease complications of AIDS, such as, but not limited to, reviews of the length of time inmates remain alive after diagnosis and the treatment outcomes of inmates who have HIV-related opportunistic infections.

116. The Quality Assurance Unit will randomly select and review each month the medical/mental health records of no fewer than thirty HIV-infected inmates, pursuant to the criteria enumerated in a Comprehensive Chart Review Screening Criteria Form (Form L). The Comprehensive Chart Review Screening Criteria Form shall be developed by the DOC Director of Health Services within thirty days of the approval of this Judgment, submitted to plaintiffs' counsel for review and comment, and thereafter implemented within thirty days and made a part of this Judgment as Form L. The Comprehensive Chart Review Screening Criteria Form will be dated and signed by the medical and mental health members of the Quality Assurance Unit upon their completion of the review of each set of records.

117. The members of the Quality Assurance Unit shall schedule their site visits to assure that each facility is visited at least once every three months. The site visits shall include the record review specified in §XX.116, supra and a review of the tickler system specified in §V.30, supra.

118. Either or both members of the Quality Assurance Unit shall discuss any problems or inadequacies noted during the course of these site visits and record reviews with the medical/ mental health department staff members involved, and shall devise a plan of correction, which may include referral of the issue to the DOC Director of Health Services.

119. The Director of Health Services of DOC shall complete a Mortality Review Form, attached hereto as Form K, whenever an HIV-infected inmate dies while in the custody of DOC, either in a DOC correctional facility or at an outside hospital. This review shall be based on the DOC health care records as well as on available hospital medical records. The Director of Health Services may consult with members of the facility's medical or mental health staff, if necessary, and shall make specific comments and document all action taken on the form. The Director of Health Services shall discuss any problems noted with appropriate staff members.

120. A Medical Incident Report Form, attached hereto as Form I, shall be completed by each medical department staff person involved in or witnessing an incident of omission or

commission which results in the administration of health care that deviates in any way from the accepted professional standards of care required for HIV-infected inmates. The Medical Incident Report shall be signed by the person preparing the report, and shall be sent to the Medical Director of the facility. Action taken in response to the incident shall be documented and retained, as well as documentation regarding any follow-up indicated by the Medical Director. The Medical Director shall review each report, and when indicated, will fill out the Follow-up to Medical Incident Report, attached hereto as Form J.

122. The Mortality Review Forms shall be retained by the Director of Health Services for DOC. The Medical Incident Report Forms shall be retained by the medical directors of the various DOC facilities. The Comprehensive Chart Review Screening Criteria Forms shall be retained by the Quality Assurance Unit.

XXI. CONFIDENTIALITY

123. DOC staff, and inmates whose job responsibilities potentially expose them to HIV-infection, shall follow universal blood and body fluid precaution standards as established by the DOHS, CDC, and the Occupational Safety and Health Administration (OSHA), and shall be provided with all necessary materials to do so.

124. DOC staff shall conform their conduct to the various requirements of P.A. 89-246, including its non-disclosure provisions. In the event that Public Act 89-246 is repealed or

amended, the plaintiffs shall be permitted, as a part of this action, to challenge whatever actions DOC staff might take in response to such repeal or amendment.

XXII. MONITORING OF CONSENT JUDGMENT

125. An Agreement Monitoring Panel ("AMP") shall be established to monitor the provisions of this Consent Judgment.

126. The AMP shall consist of three persons who shall be appointed by the Court within three weeks of judicial approval of this Judgment: a physician with an expertise in infectious disease chosen by the defendants, a physician with an expertise in infectious disease chosen by the plaintiffs, and a mental health expert with experience with HIV-infection chosen by a consensus of those persons already selected. Should one or more of the originally-designated members of the AMP be unable to serve the full duration of the AMP, replacements shall be made in the same manner as the original members were chosen. Either party may replace its AMP member with judicial approval.

127. The members of the AMP shall submit on a monthly basis to defendants' counsel (with a copy to plaintiffs' counsel) their requests for payment of fees and expenses incurred in monitoring this Consent Judgment. Defendants' counsel shall review said requests within ten days of receipt and promptly submit an Order for Payment of all non-disputed portions of the requests to the Court. The members of the AMP shall be paid by the State of Connecticut for all non-disputed portions of their request for

payment within thirty days of their receipt of the Court Order. Disputed portions of any requests shall be referred to the Court for resolution in whatever fashion the Court deems appropriate. The fee shall not exceed $20,000.00 per panel member per year for any and all services rendered, excepting for any payments which may be ordered by the Court for services rendered for their participation in contempt and other proceedings related to non-compliance. The hourly rate of each member of the AMP shall be reasonable and set by a separate Court Order. The expenses incurred by the AMP shall be only those reasonable necessary to carry out their functions under this Judgment. If the Panel remains in operation for longer than three years, Panel members shall be permitted to make application to the Court for an appropriate cost of living increase in the fees awarded. Defendants agree to represent and to hold harmless to the same extent as State employees the members of the AMP in any litigation initiated by third parties involving the AMP in its performance of its duties under this Judgment.

128. The AMP shall devise procedures for the monitoring of this Judgment which shall include on-site inspections of the facilities. Defendant's representative may, at his election, give two days prior notice to defendants of any intended inspection. During their inspections, the panel shall have access to all medical and mental health records of HIV-infected inmates, including, without limitation, such records when obtained from

third parties such as outside hospital records. All quality assurance forms specified in this Judgment shall be made available.

129. The AMP shall provide its first monitoring report four months after judicial approval of this Consent Judgment. The second and third reports shall be provided four and eight months later, respectively. In the second year of the Judgment, the AMP shall provide a monitoring report every six months, and in subsequent years once yearly on the anniversary date of the approval of the Judgment. AMP monitoring reports shall be provided to the Commissioner of DOC, counsel for the parties, and the Court. In preparing for these reports, the members of the AMP shall conduct such on-site inspections and review of records as they deem necessary in order to perform their monitoring function.

130. In monitoring this Judgment, the AMP shall focus on patterns of compliance and noncompliance, as well as on individual cases of substantial deviation from the standard of care provided herein.

131. Upon request, the AMP shall have access within two days to all policies, records, procedures and files at each institution relevant to medical and mental health treatment of HIV-infected inmates, as well as access to all staff and consulting physicians with respect to such medical and mental health treatment. During their inspection, the panel shall be

permitted to conduct interviews with HIV-infected inmates, provided each inmate consents. The AMP shall be provided with copies of any new and/or revised DOC written protocols and policies pertaining to the delivery of medical and mental health care to HIV-infected inmates.

132. The DOC shall file written compliance reports on the same schedule as the AMP, as set forth in §XXII.129, supra. These written Compliance Reports shall list and include all blank forms and protocols developed pursuant to this Judgment since the preceding such Compliance Report, to the extent they have not already been provided to the AMP under the preceding section. A description of HIV-related activities undertaken by DOC, including staff training, shall also be included in these reports. The first of the reports shall include staffing summaries (name, position, shifts worked) for DOC's health care staff who perform tasks under this Judgment and the names, professional degrees and licenses of physicians. These reports shall be provided to the Court and counsel for the parties.

133. Nothing contained in this "Monitoring" section shall be deemed to interfere with or alter any monitoring arrangements made pursuant to judicial rulings or decrees in other actions; rather, these provisions are in addition to any other such monitoring arrangements.

134. When the defendants believe in good faith that they have fully and faithfully implemented the provisions of this

Consent Judgment in their entirety and have been in substantial compliance for a period of one year, defendants may move that some or all of the monitoring and reporting requirements of this Judgment be discontinued; provided that no such motion may be filed prior to twenty-four months from the date this Consent Judgment is judicially approved and defendants must give ninety days advance notice of their intention to file such a motion. Discontinuance of the monitoring and reporting requirements of this Judgment will be granted unless, within thirty days after receipt of defendants' motion, plaintiffs file an objection. If such objection is filed, the Court shall hold a hearing on the motion, and the burden will be on the defendants to demonstrate that they have faithfully implemented all provisions of this Consent Judgment and maintained substantial compliance with them. Nothing in this section shall be construed to preclude the reinstitution of some or all of the monitoring and reporting requirements of this Judgment upon a subsequent showing by plaintiffs of noncompliance with this Judgment and plaintiffs' counsel shall be allowed to investigate allegations of non-compliance.

XXIII. GENERAL PROVISIONS

135. Should two or more members of the AMP assert a claim of noncompliance with the terms of this Judgment, the AMP shall make a report to the parties concerning the claim(s) of noncompliance and recommendations to remedy it (with, if necessary, a minority report). In the event a dispute should

arise concerning compliance with this Judgment and appropriate remedial action which cannot be resolved between the AMP or the parties in a timely fashion, a party may request a status hearing with a Settlement Judge or Magistrate. If neither is available, the Chief Judge shall appoint another Judge or Magistrate to resolve the dispute. If any dispute, issue or matter is not resolved by the Settlement Judge or Magistrate, that issue or matter shall be referred to the Trial Judge for adjudication pursuant to any proceeding which the Trial Judge shall deem feasible. At any such proceeding, the members of the AMP may be called as a witness by a party or the Judge.

136. This Consent Judgment satisfies and resolves the claims of the plaintiffs and the plaintiffs' class for injunctive and declaratory relief in the above-entitled case as of the date of judicial approval of this Consent Judgment. Plaintiffs and members of their class shall be permitted to opt out of the class for purposes of preserving their claims for monetary relief only.

137. The parties recognize that this Consent Judgment does not address future changes in recommendations and standards regarding medical/mental health care for HIV-infected persons. The plaintiffs reserve the right as a part of this litigation to initiate judicial proceedings to alter the provisions of this Judgment in light of such changed recommendations and/or standards for HIV care. Should the plaintiffs at any time

initiate such further proceedings seeking to have the defendants comply with what they perceive to be changed accepted professional standards, the burden shall be on the plaintiffs to show that the defendants' failure to adopt such changes constitutes a violation of the plaintiffs' constitutional rights. In the event of any such future judicial proceedings, neither party waives their right to appeal any final ruling or order of the Court, nor do plaintiffs waive their right to seek their costs and attorneys' fees in connection with such proceedings. The plaintiffs shall give the defendants thirty days notice prior to initiating any such proceedings.

138. This Consent Judgment may be modified by the mutual agreement of all parties. The AMP may not, without the express consent of all parties to the Judgment, alter, amend or change the provisions of the Judgment. The Court shall be notified in writing of all such modifications, but need not approve such modifications.

139. The provisions of this Consent Judgment may be suspended or modified in part or in its entirety if the Commissioner, Warden, or person next in command in his/her absence, determines that a "genuine emergency" exists at a specific DOC facility or any portion thereof. Genuine emergency means any special circumstances, or combination thereof, under which it is reasonable to conclude that there is any actual or presumptive threat to (a) either the security and order of the

specific DOC facility or any portion thereof, or to (b) the safety of the staff, inmates, or other person within that facility. If a "genuine emergency" lasts longer than twelve hours or recurs once or more in a one week period, defendants shall report to plaintiffs' counsel, within forty-eight hours except for good cause, the date of the emergency, the nature of the emergency, and what provisions of the Consent Judgment were suspended and/or modified and how they were suspended and/or modified. Current population levels and population increases alone shall not constitute a "genuine emergency". Plaintiffs may contest the emergency action by motion for relief directed to the Court.

140. Nothing contained in this Judgment shall be deemed to reduce the requirements and obligations imposed on DOC by the terms of prior judicial rulings, decrees, and consent judgments in other actions.

XXIV. NOTICE TO CLASS

141. Notice to the plaintiff class members of this Consent Judgment shall issue pursuant to the notice provisions approved by the Court, and shall inform plaintiffs and members of their class of their opportunity to opt out for purposes of preserving their claims for damages.

XXV. COSTS AND ATTORNEYS' FEES

142. Plaintiffs' counsel shall submit their request for costs and attorneys' fees within thirty days of the signing of

this Judgment. Said request shall not exceed $130,000. Any disputes concerning this request shall be submitted to the Court for a final ruling. Payment of plaintiffs' request shall constitute full and complete satisfaction of any and all costs, fees and expenses, including experts' and attorneys' fees, of any kind up to and including the date of the signing of this Judgment by counsel.

WHEREFORE, in consideration of the foregoing provisions the parties respectfully request that the Court approve and adopt the Consent Judgment as being fair, reasonable, and adequate.

THE DEFENDANTS
Larry Meachum, et al.

BY: _____
Larry Meachum, Commissioner
Connecticut Department of
Correction
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Hartford, CT 06106

CLARINE NARDI RIDDLE
ATTORNEY GENERAL

BY: _____
Richard Couture
Assistant Attorney General
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BY: _____
Steven Strom
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THE PLAINTIFFS
David Doe, et al.

BY: _____
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Connecticut Civil Liberties
Union Foundation
32 Grand Street
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BY: _____
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Jerome N. Frank Legal
Services Organization
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BY: _____
Martha Stone
Connecticut Civil Liberties
Union Foundation
32 Grand Street
Hartford, CT 06106

Dated at New Haven, Connecticut, this day of December, 1990.

_____
Joan Glazer Margolis
United States Magistrate

So Ordered and Approved:

_____
Jose A. Cabranes
United States District Judge

UNITED STATES DISTRICT COURT
DISTRICT OF CONNECTICUT

FILED

DEC 3 12 PM '90

U.S. DISTRICT COURT
NEW HAVEN, CONN

IN RE CONNECTICUT PRISON OVERCROWDING AND AIDS CASES	Master File No. H-90-606 (JAC)
DAVID DOE, ET AL.	
v.	Civil No. H-88-562 (PCD) (JGM)
LARRY R. MEACHUM, ET AL.	

ORDER

The Consent Judgment on Health Care for HIV-Infected Inmates and Confidentiality of HIV-Related Information (filed Nov. 2, 1990) ("Consent Judgment") having been approved by United States Magistrate Joan Glazer Margolis, following notice to interested parties, an evidentiary hearing held on December 4, 1990, and a review of the comments of all concerned, and the proposed Consent Judgment having been independently reviewed by me in light of the full record of this case and related cases, the proposed Consent Judgment is hereby approved and entered.

If and when any questions arise between the parties regarding implementation of paragraph 142 (Costs and Attorneys' Fees), those questions shall be, and are hereby, referred to Magistrate Margolis. Any appeal to a district judge from a determination by Magistrate Margolis on any such question (only) shall be referred to Judge Alan H. Nevas, who has consented to this referral if and when it is appropriate or necessary.

It is so ordered.

Dated at New Haven, Connecticut this 6th day of December, 1990.

José A. Cabranes
United States District Judge