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

ANTHONY FERNANDEZ
666 Walnut Street
Easton PA 18042,

Plaintiff,

-v-

NORTHAMPTON COUNTY
Northampton County Government Center
669 Washington Street
Easton, PA 18042,

PRIME CARE MEDICAL , INC.
3940 Locust Lane
Harrisburg, PA 17109,

DR. WILLIAM SPRAGUE
272 7 106th St. Court NW
Gig Harbor, WA 98332

VICTORIA GESSNER, M.D.
PRIME CARE MEDICAL , INC.
3940 Locust Lane
Harrisburg, PA 17109

TODD HASKINS, RN, CCHP
Individually and in his Official Capacity as
CORRECTIONAL HEALTHCARE
SOLUTIONS DIRECTOR,
NORTHAMPTON COUNTY PRISON
666 Walnut Street
Easton, PA 18042,

TODD BUSKIRK
Individually and in his Official Capacity as
DIRECTOR OF CORRECTIONS,
NORTHAMPTON COUNTY PRISON
666 Walnut Street
Easton, Pennsylvania 18042,

Defendants.

CIVIL ACTION NO.

JURY TRIAL DEMANDED

COMPLAINT

Plaintiff, Anthony Fernandez, by counsel, Gerald J. Williams, Esquire, Williams Cuker Berezofsky, brings this suit to recover for violations of his federal and state civil rights, as follows:

PARTIES

1. Plaintiff, Anthony Fernandez, is a current inmate at the Northampton County Prison (hereinafter, "NCP") in Easton, Northampton County, in the Commonwealth of Pennsylvania; he was incarcerated at NCP on or about December 31, 2006 and remains there at the present time. While incarcerated at NCP, Mr. Fernandez has been and is completely dependent upon Defendants for his care and well-being.

2. Defendant Northampton County is a municipal corporation of the Commonwealth of Pennsylvania.

3. At all relevant times, Defendant, Prime Care Medical, Inc., (hereinafter, "Prime Care"), was and is a Pennsylvania Corporation which has been under contract with Northampton County to provide medical care and services to inmates at the Northampton County Prison, including Mr. Fernandez.

4. Upon information and belief, at all relevant times Defendant, Dr. William Sprague, was a physician who played a role in overseeing Mr. Fernandez' treatment on behalf of PRIME CARE and Northampton County while Mr. Fernandez was incarcerated at Northampton County Prison.

5. Upon information and belief, at all relevant times Defendant, Dr. Victoria Gessner, was a physician who played a role in overseeing Mr. Fernandez' treatment on behalf of

PRIME CARE and Northampton County, while Mr. Fernandez was incarcerated at NCP.

6. At all relevant times, Defendant Todd Haskins, RN, CCHP was and/or is the Correctional Healthcare Solutions Director, who was and is responsible for the overall operation of the prison's healthcare services. He is sued in his individual and official capacities.

7. At all relevant times, Defendant Todd Buskirk served as the Director of Corrections and the former Warden of the Northampton County Prison, and was responsible for the overall operation of the prison. He is sued in his individual and official capacities.

JURISDICTION AND VENUE

8. Jurisdiction in this Court is asserted under the provisions of 28 U.S.C. §§1331 and 1343. This Court has Supplemental Jurisdiction of Plaintiff's state law claims pursuant to 28 U.S.C. § 1367(a).

9. Venue is appropriately laid in this Court pursuant to 28 U.S.C. 1391(b) in that the actions complained of took place within the District, the Defendants have carried on business within the District, and at least one Defendant resides within the District.

FACTUAL ALLEGATIONS ON THE MERITS

10. Northampton County Prison ("NCP") has a history of inhumane conditions and recklessly indifferent administration and staffing.

11. As a result, the prison has become a breeding ground for disease.

12. Due to Defendants' actions and inactions over the past years, the prison has experienced repeated outbreaks of Methicillin-Resistant Staphylococcus Aureus (hereinafter, "MRSA"), a potentially deadly bacterial infection that is resistant to certain antibiotics.

13. According to the United States Department of Health and Human Services, Centers for Disease Control and Prevention, MRSA infections occur in otherwise healthy people.

14. MRSA often first appears as a pimple or boil which can become red, swollen, and extremely painful; as it advances, the boils often have pus or other drainage and result in the formation of a mass below the surface of the skin.

15. Drainage of skin boils or abscesses requires the attention of a healthcare provider.

16. Once a MRSA boil drains and the mass is removed, a hole is left behind and becomes a scar which deforms the affected area.

17. More serious infections may cause pneumonia, bloodstream infections, surgical wound infections, and death.

18. Factors associated with the spread of MRSA skin infections include exposure to contaminated items and surfaces, crowded living conditions, exposure to dirty and unsanitary living environments, and openings in the skin such as cuts and abrasions.

Prison Conditions

19. At all relevant times, the conditions of the prison have been filthy and overcrowded, creating a breeding ground for diseases such as MRSA.

20. As discussed herein, Defendants have knowingly failed to maintain sanitary conditions throughout the prison, including the medical unit, causing the MRSA outbreaks and Plaintiff's associated injuries.

21. Defendants did not clean the inmates' cells or blankets, did not allow adequate flow of fresh or clean air, did not provide adequate medical isolation facilities, and did not protect inmates from the spread of life-threatening infections.

22. There have been roof leaks that were never fixed.

23. The leaks were patched on the inside, not the outside, and buckets caught the water.

24. The leaking water ran down into the walls, ruined the sheetrock and left holes in the walls. Inmates were not given enough food resulting in substantial weight loss in many inmates.

25. Food from previous meals was left on trays.

26. Food was not handled properly and sometimes smelled.

27. Food that should have been served hot was often served cold.

28. Food often was stored in refrigerators that were not cold enough to safely store and preserve food for human consumption.

29. The drinking water was a dirty brown color.

30. The kitchen was infested with cockroaches and fruit flies.

31. On at least one occasion, the prison was locked down for a time due to sewage coming up through a grease trap in the kitchen.

32. A sewage pipe in the cafeteria ceiling leaked raw sewage into the cafeteria.

33. Cafeteria ceiling tiles were replaced regularly, but the sewage pipe was never fixed.

34. Due to the sewage leak, the cafeteria smelled like urine.

35. Showers which the inmates use were rarely cleaned, and when/if they were cleaned, they were never cleaned properly.

36. Showers were moldy, dirty and had hair on the floors.

37. C-Tier and K-Tier showers were merely rinsed with a hose to wash the hair down the drain.

38. Some showers had pipes coming out of the walls, missing tiles and feces on the walls.

39. The shower water was dirty.

40. Many showers had no hot water, did not work properly and had too many inmates using them at one time (i.e. seven [7] to thirteen [13] inmates used a six [6] man shower all at the same time).

41. The inmates were not required to shower, therefore, some did not creating further risk of the development and/or spread of infection(s).

42. Inmates could usually take only one shower per day.

43. After recreational activities, inmates had to remain sweaty and dirty until, and if, the guards allowed them to shower.

44. Even if permitted to shower, inmates often did not have enough soap to shower properly.

45. Once, after a flood had occurred in the prison, inmates were unable to shower for about a week.

46. Inmates were not always allowed to shower on time, and showers were often limited in time to about five (5) minutes per inmate.

47. Many inmates were refused showers for various reasons, such as when corrections officers would wrongly claim that an inmate had already showered, when there were alleged emergencies in other areas of the prison, and sometimes for no reason at all.

48. When inmates pressed the issue of wanting to shower, they faced being written up and taken to lock down (the "Hole") by the guards or commanding officer.

49. Many inmates were afraid to use the toilets because of the unsanitary conditions.

50. Many toilets leaked.

51. Due to overcrowding, thirty (30) inmates at a time, sleeping on the floor in plastic

"boats", were housed in the "Gym" with access to only one (1) toilet and two (2) showers, and eight (8) inmates were in one (1) cell with one (1) toilet and one (1) small sink.

52. It was common practice to have overcrowded cells with inmates sleeping on dirty floors on mattresses, in plastic "boats" or simply on the floor.

53. Inmates were made to sleep on the floor for extended periods of time.

54. Many inmates slept on the floor next to toilets with feces rings.

55. The general population and medical cells were dirty and had severe mold and mildew issues.

56. The cells were rarely cleaned and had holes, open concrete, paint peeling, cables and bare wires hanging and/or sticking out, and spit and other unhealthy things on the surfaces.

57. Basically, the cells were filthy and coming apart.

58. Inmates requesting to clean their cells were usually denied or ignored altogether.

59. When given time to clean their cells, inmates used a mop and dirty water that had been passed from cell to cell and left a foul odor.

60. Any supplies given to the inmates for cleaning were limited, heavily diluted with water and ran out.

61. Cells were not disinfected between inmates.

62. In general population, linens and towels were usually taken weekly to be washed but were washed together with the laundry of inmates who were suffering from MRSA.

63. Changing linens, towels and washing laundry were not mandatory.

64. The inmates blankets were virtually never washed.

65. Laundry was taken to be washed weekly, but it came back wet and with the same stains as before it was washed.

66. Mattresses that had been defecated and urinated on were not cleaned or changed between inmates, and instead, were quite often left in place for the next inmate's use.

67. Several inmates were working in the kitchen when they contracted MRSA.

68. Even after the prison experienced MRSA outbreaks, many inmates remained working in the kitchen with clear MRSA symptoms.

69. Inmates found to have, or suspected of having, MRSA were usually placed in a "MRSA cell," which was any cell with other inmates who had or were suspected of having MRSA.

70. Many different cells, both in general population and medical, were used as MRSA cells.

71. MRSA cells were often in general population and very near, if not next to, cells with inmates that did not have and were not suspected of having MRSA.

72. Inmates awaiting culture results for MRSA were typically placed in MRSA cells and started on antibiotics, but they were often housed with MRSA positive inmates until their results came back.

73. When in a MRSA cell, the inmates' linens and laundry were quite often not washed at all, and they would only change their jumpsuits.

74. MRSA cells were especially filthy and effectively locked down with no visits, no recreation, no phone calls and being let out only to shower occasionally.

75. If an inmate's culture results were negative for MRSA, antibiotic treatment was often ended, and the inmate was returned to general population after being housed with MRSA infected inmates.

76. Staff at the prison would often tease or taunt infected inmates, calling them

"MRSA-naries", among other names, and acting as though they were less than human.

77. At times, inmates in MRSA cells were only able to shower every other day.

78. Sometimes inmates in MRSA cells had to use general population showers.

79. Each of the individually named defendants were aware of and responsible for the conditions described above, and have allowed these conditions to continue.

Allegations Specific to Mr. Fernandez

80. Based upon records provided by defendants on or about April 4, 2007 Mr. Fernandez notified medical staff that a finger of his right hand was swollen and painful.

81. Based upon records produced by defendants, a doctor or medical staff member wrote a physician order on April 9, 2007 directing that Mr. Fernandez be placed in isolation until further notice and to house him alone.

82. However, despite the physician's written order, Mr. Fernandez was placed in cell on H-Tier, the "flats", with a MRSA positive inmate, where he remained for approximately four (4) days, exposed to an inmate suffering from MRSA.

83. Mr. Fernandez was given antibiotics while he was in the cell with the MRSA positive inmate..

84. The area on Mr. Fernandez' finger was cultured and reported as positive for "heavy growth of staphylococcus aureus."

85. The cell that Mr. Fernandez occupied with the MRSA positive inmate was filthy as were the bed linens and towels that he was given to use there.

86. Based upon records provided by Defendants, on or about July 4, 2008 , and contrary to the medical notes provided, Mr. Fernandez developed a painful, swollen bump on the left side of his jaw which he reported to the medical unit staff.

87. At the time that this bump developed Mr. Fernandez was in BHU-4, known among the prison population as "The Hole," as it is the area where inmates are placed if they have been found to have committed an infraction of prison rules.

88. Mr. Fernandez asked the medical staff to leave him in the "Hole"rather than return to the dirty, unsanitary conditions that he had experienced in the H-Tier Isolation cell in April 2007.

89. The medical staff put Mr. Fernandez on antibiotics, cultured the wound on his jawline and left him in "The Hole."

90. On July 10, 2008 a laboratory report on the culture came back reading positive for MRSA.

91. Based upon records provided by Defendants, Mr. Fernandez reported the discovery of a boil under his left armpit to medical staff on or about September 18, 2008.

92. Based upon records provided by Defendants, while they suspected that Mr. Fernandez had a recurrence of MRSA the medical staff prescribed Bactrim, did not culture the boil and did not isolate Mr. Fernandez.

93. During November 2008 the prison was locked down for 6 consecutive days, during which Mr. Fernandez, along with the other inmates he was housed with in the B Unit, were not permitted to shower or change their bed sheets at all.

94. Based on information and belief, Mr. Fernandez developed a boil on his right check, popped the boil, and he reported to medical staff on or about December 5, 2008.

96. Based on information and belief, Mr. Fernandez showed the popped boil to the medical staff on or about December 5, 2008 at which time a nurse told him he had MRSA, did not culture the area, did not provide proper wound care, prescribed antibiotics for him and

isolated him in cell H-13 alone.

97. Mr. Fernandez remained in H-13 for approximately 3 days.

99. When he was discharged from isolation and returned to B-2, Mr. Fernandez still did not receive proper wound care, the affected area oozed and discharged blood and pus on to his pillow when he slept, and the pillow case was not changed until he asked several times for a clean one.

100. Mr. Fernandez has grave fears about reoccurrences and infecting his loved ones with the diseases he contracted while at Northampton County Prison.

101. As a result of Defendants' conduct, Plaintiff suffered the embarrassment, immense pain, bumps and scarring associated with contracting multiple cases of MRSA.

102. Plaintiff was subjected to the unsanitary conditions of the prison and its medical unit, including but not limited to defendants' failures to provide sufficient antibacterial soap for plaintiff's personal use, preventing him from properly cleaning himself to prevent contracting diseases such as MRSA.

103. The prison medical staff, including defendants, knew and/or reasonably should have known that Plaintiff was at risk of contracting a staph infection, but they were deliberately indifferent to this risk, failing to protect Plaintiff by housing him with a MRSA positive inmate, Mr. Rios and/or allowing Plaintiff to determine the location of proper isolation – i.e., "The Hole" – rather than assure that he was isolated and treated in a properly sanitized cell that would provide for a safe environment both for Plaintiff to heal and to prevent him from developing future MRSA outbreaks.

104. The PrimeCare Defendants have engaged in a pattern and practice of failing and/or refusing to generate, maintain, and/or preserve accurate medical records.

105. Defendants have engaged in a pattern and practice of failing and/or refusing to provide adequate and necessary medical treatment to inmates.

106. Defendants have engaged in a pattern and practice of failing to adequately treat inmates who require medical care.

107. Defendants have acted with deliberate indifference toward Plaintiff's medical needs and well-being, in that they knew of the substantial risk of serious harm to Plaintiff and they ignored that risk.

108. Defendants' actions and inactions have amounted to unnecessary and wanton infliction of pain and grief.

109. Defendants' actions and inactions toward Plaintiff have caused him physical and emotional injury, and have created significant and permanent scarring.

110. Defendants have violated Plaintiff's clearly established and well-settled federal and state constitutional rights, including his right to be free from deliberate indifference to his medical needs and well-being.

111. Defendants acted with callous indifference toward Plaintiff's federal and state rights.

112. At all times during the events described above each of the Defendants, upon information and belief, were aware of and acquiesced in the acts of the other Defendants.

113. Upon information and belief, each Defendant advised, assisted, directed, and/or ratified the actions that are at issue herein.

114. Upon information and belief, each of the individual Defendants played a substantial role and provided input which affected the adverse actions against Plaintiff.

115. Defendants County, PrimeCare, Sprague, Gessner, Haskins, and Buskirk have,

with deliberate indifference, failed to adequately train, supervise and discipline personnel at the prison, and the injuries to Plaintiff were caused by, and were a foreseeable consequence of, such failures.

116. Defendants County, PrimeCare, Sprague, Gessner, Haskins, and Buskirk have, with deliberate indifference, failed to provide sanitary and humane conditions in the prison and its medical unit, and the injuries to Plaintiff were caused by, and were a foreseeable consequence of, such failures.

117. Defendants County, PrimeCare, Sprague, Gessner, Haskins, and Buskirk have, with deliberate indifference, failed to adequately train and supervise personnel at the prison concerning the proper sanitation practices to provide for the health and humane treatment of the inmates', and the injuries to Plaintiff were caused by, and were a foreseeable consequence of, such failures.

118. At all times relevant to the allegations herein, Defendants have refused and/or otherwise failed to provide the recommended treatment to individuals with MRSA, including but not limited to, not providing MRSA patients with all doses of antibiotics on the required schedule, and not providing medical attention to the MRSA patients to the extent that some patients' MRSA "boils" or infections have been opened in and under unsanitary conditions by other individuals.

119. Defendants Sprague, Haskins, Gessner and Buskirk knew and/or reasonably should have known that they, the County and PrimeCare had provided inadequate training, supervision and discipline to personnel at the prison, and that this failure of training, supervision and discipline was likely to result in the constitutional violations that caused Plaintiff's injuries.

120. Plaintiff's serious injuries were a foreseeable and direct result of Defendants'

actions and inactions.

121. At all times relevant to the allegations herein, Defendants have refused and/or otherwise failed to follow the protocol recommended by the Department of Health and Human Services, Centers for Disease Control and Prevention, for the prevention and/or treatment of MRSA, and have routinely and continually exposed individuals with MRSA to those who do not have it, allowed filthy and unsanitary conditions to exist.

122. At all times relevant to the allegations herein, Defendants have refused and/or otherwise failed to provide clean, sanitary conditions at Northampton County Prison and thus, have created an environment in which MRSA not only exists, but has thrived to the point of becoming epidemic in proportions.

123. Defendants' conduct shocks the conscience.

124. As a direct and proximate result of the Defendants' wrongful actions and inactions, Plaintiff has incurred significant hardship.

125. As a direct and proximate result of the Defendants' wrongful actions and inactions, Plaintiff has suffered grievously and needlessly, including, without limitation, severe bodily injury, extreme pain and discomfort, and severe emotional distress.

COUNT I - 42 U.S.C. § 1983 - VIOLATION OF EIGHTH AMENDMENT RIGHTS

126. The allegations of all the preceding paragraphs of this Complaint are realleged herein as if fully set forth.

127. Defendants, acting under color of law, denied Plaintiff his rights under the Eighth Amendment to the United States Constitution in violation of the Civil Rights Act of 1866, as amended, 42 U.S.C. § 1983.

128. As a direct and proximate result of the aforesaid, Plaintiff has been damaged as

alleged.

COUNT II - 42 U.S.C. § 1983 - VIOLATION OF FOURTEENTH AMENDMENT RIGHTS

129. The allegations of all the preceding paragraphs of this Complaint are realleged herein as i2 fully set forth.

130. Defendants, acting under color of law, denied Plaintiff his rights under the Fourteenth Amendment to the United States Constitution in violation of the Civil Rights Act of 1866, as amended, 42 U.S.C. § 1983.

131. As a direct and proximate result of the aforesaid, Plaintiff has been damaged as alleged.

COUNT III - 42 U.S.C. § 1983 – DEFENDANT NORTHAMPTON COUNTY

132. The allegations of all the preceding paragraphs of this Complaint are realleged herein as if fully set forth.

133. Prior to the events described herein, Northampton County developed and maintained policies, practices and/or customs exhibiting deliberate indifference to the constitutional rights of persons within the Northampton County Prison, which caused violations of Plaintiff's rights.

134. It was the policy, practice and/or custom of Northampton County to provide unsafe, inhumane and unsanitary conditions in the prison and its medical unit.

135. It was the policy, practice and/or custom of Northampton County and PrimeCare to fail to adequately treat and/or to dump inmates who required extensive and/or expensive medical care.

136. It was the policy, practice and/or custom of Northampton County to inadequately and improperly investigate and scrutinize the backgrounds of administrators and medical service

providers, including those identified herein.

137. As a result, Northampton County retained administrators and medical service providers, including those identified herein, who have deprived the federally and state protected rights of people with whom they have come into contact, including Plaintiff.

138. This deprivation of rights was the plainly obvious consequence of the County's failure to adequately and properly investigate and scrutinize the backgrounds of administrators and medical providers.

139. It was the policy, practice and/or custom of Northampton County to inadequately and improperly investigate complaints regarding constitutional violations at the Prison (including complaints concerning inadequate medical care and inhumane prison conditions), and such violations were instead tolerated by the County.

140. It was the policy, practice and/or custom of Northampton County to inadequately supervise and train its administrators and medical providers, including those identified herein, thereby failing to adequately discourage further constitutional violations on the part of these officials.

141. Northampton County did not provide and/or require appropriate in-service training or re-training to prevent constitutional violations.

142. As a result of the above-described policies, practices and customs, administrators and medical providers of the Northampton County Prison, including those identified herein, believed that their actions would not be investigated or sanctioned, but would be tolerated.

143. The above described policies, practices and customs demonstrated a deliberate indifference on the part of the policymakers of Northampton County to the constitutional rights of persons within the Prison, and were the cause of the violations of Plaintiff's rights as alleged

herein.

144. As a direct and proximate result of the aforesaid, Plaintiff has been damaged as alleged.

COUNT IV - CONSTITUTION OF THE COMMONWEALTH OF PENNSYLVANIA - VIOLATION OF ARTICLE I, SECTION 13

145. The allegations of all the preceding paragraphs of this Complaint are realleged herein as if fully set forth.

146. Defendants have denied Plaintiff his rights under Article I, Section 13 of the Constitution of the Commonwealth of Pennsylvania, including his right to be free from the infliction of cruel punishment.

147. As a direct and proximate result of the aforesaid, Plaintiff has been damaged as alleged.

REQUESTED RELIEF

WHEREFORE, Plaintiff requests that the Court find and determine, after trial by jury as appropriate, that the Plaintiff has suffered substantial and continuing injury as a result of deprivation of his civil and Constitutional rights, and otherwise wrongful conduct, and award the following relief, as appropriate:

a. Declaratory relief;

b. Injunctive relief to eradicate ongoing constitutional violations;

c. Compensatory damages;

d. Prejudgment interest, attorneys' fees and costs;

e. Punitive damages as appropriate;

f. Such other legal and equitable relief as the Court deems just and proper.

Respectfully submitted,

Date: January 19, 2009

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