UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

RICHARD NUNES, CARL COE, JOHN DOE, PETER POE, and RICHARD ROE, on behalf of themselves and all others similarly situated,	)	
Plaintiffs,	)	
v.	)	CIVIL ACTION NO.1:10-cv-12013-RWZ
UMASS CORRECTIONAL HEALTH, MASSACHUSETTS DEPARTMENT OF CORRECTION, LEONARD MCGUIRE, WARREN FERGUSON, JUDITH STEINBERG, THOMAS GROBLEWSKI, and PETER HEFFERNAN,	)	
Defendants.	)	
LEAVE TO FILE EXCESS PAGES GRANTED ON FEBRUARY 14, 2013	)	

PLAINTIFFS' CONSOLIDATED MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTIONS FOR SUMMARY JUDGMENT

I. INTRODUCTION

Defendants' removal of all HIV medications from the Keep On Person (KOP) program is a discriminatory and harmful policy, one initiated and perpetuated on the basis of flawed and unsupportive data, along with Defendants' resistance to facing the reality that while Plaintiffs and others like them were responsible with their medication, staff were not responsible in following their own policies. The facts more than sufficiently support Plaintiffs' claims, and summary judgment should be denied.

II. BACKGROUND

HIV is a life-threatening viral infection which leads to destruction of the body's immune system. Pls.' SMF ¶ 1-2. Lives are now saved with Highly Active Antiretroviral Therapy

(HAART), which suppresses the patient's viral load, but if such therapy is not taken consistently, the virus may return, promoting rapid disease progression, opportunistic infections, systemic inflammation that leads to cardiovascular complications, and medication resistance, which makes the virus more difficult to treat. *Id.* ¶¶ 3-8.

HIV treatment for prisoners in the Department of Correction has included HAART since the mid-1990s and such medications have always been distributed as KOP medications. *Id.* ¶ 10. HIV specialists from Shattuck Hospital hold clinics at DOC facilities to treat the disease, while infectious disease case managers (ID case managers) employed by UMass Correctional Health follow the HIV patients closely and ensure that their blood work and other treatment is carried out. *Id.* ¶¶ 11-13. This work includes adherence to HIV medications, and these providers employed several tools to ensure patient adherence. The ID case managers reviewed patient Medication Administration Records (MARs), conducted pill counts at patient appointments, and received notice from nursing staff of potential problems with adherence. In addition, UMCH policies called for daily compliance verification of all KOP medications through the MAR, monthly KOP audits of selected prisoners, denial of early medication refills without justification, and monitoring of each patient's viral load and CD4 count. HIV-positive prisoners are some of the most closely monitored prisoners in the DOC. *Id.* ¶¶ 14-25.

The standard of care for HIV treatment includes an individualized plan for medication adherence, and the providers counseled prisoners about compliance. The KOP policy authorized providers to suspend KOP medications if there were problems with adherence. *Id.* ¶¶ 9, 17-18. By and large, however, patients tended to be adherent to their medications; sentenced state prisoners are generally motivated to keep up with treatment and so as not to die in prison. Each of the Plaintiffs was adherent to his HIV medications under the KOP program. *Id.* ¶ 26-28.

In 2008, an underfunded medical contract between the DOC and UMCH, and then state budget cuts, forced Defendants to find ways to reduce costs. *Id.* ¶ 47-51. Medications did not come cheaply to Defendants. By way of an outside section to the annual budget, Defendants must obtain their medications through another agency, the State Office of Pharmacy Services (SOPS). *Id.* ¶¶ 29-31. SOPS in turn contracts with one private entity to negotiate drug prices, another entity to act as the wholesaler, and a third entity to perform the pharmacy services for DOC and other state institutions. The prices paid for drugs obtained through SOPS are little different than those offered by other pharmacy vendors, but administrative costs are higher. *Id.* ¶¶ 32-38.

HIV medications come at a particularly high cost to Defendants. Because of the mandated affiliation with SOPS, Defendants cannot obtain discounted HIV medications through the federal 340B drug pricing program, a program which could save them up to one million dollars per year. A separate federal program, the HIV Drug Assistance Program, pays for the medications for some populations in Massachusetts, including county prisoners, but not DOC prisoners. *Id.* ¶¶ 39-46.

Within this environment, a proposal emerged to remove HIV medications from the KOP program. SOPS operates a reclaim and reuse program, under which medications that are returned unused may be repackaged and redistributed, so long as they have not been in the possession of the patient. SOPS proposed that by removing all HIV medications from the KOP program, all returned HIV medications would be reclaimable. UMCH advised the HIV specialists and ID case managers of the idea, citing the rationale of cost savings. SOPS also presented Defendants with a table showing figures for the value of returned HIV medications, as well as the subset of those medications that were reclaimed. *Id.* ¶¶ 52-60.

Thus began a pattern of UMCH choosing to see what it wanted to see. The SOPS table showed that a number of HIV medications were already reclaimed under the KOP program. It did not show why these medications were being returned. That information was knowable – returned medications could be traced to the patient – but UMCH took no interest in analyzing the source of the returns. The goal was not to address or reduce medication returns, but to maximize potential savings – to find a figure that could be added to a list of other changes that would meet the required budget cuts being imposed. *Id.* ¶¶ 61-66. Defendants knew why medications were returned. Returns are the result of prisoner discharges from DOC custody, transfers to other DOC institutions, duplicate refill orders, and therapy changes (if the previous medication supply is not finished). *Id.* ¶ 67.

The HIV specialists ordered that old medications be finished before new ones were started, so as to avoid medication returns. *Id.* ¶ 68. Discharges should not result in returned medications, because by policy the medications should go with the prisoners being released, but it was known that pretrial prisoners and temporary detox commitments in the DOC, who could be released without warning, led to such returns. *Id.* ¶ 70. Transferred prisoners were supposed to take their medications with them to the next facility, but Defendants were aware that this did not always happen. The sending facility would return the old medications, while the receiving facility had to order new medications early for the newly arrived prisoner. *Id.* ¶¶ 71-72. Duplicate orders were a known phenomenon, but such medications could be reclaimed under the KOP program, since they had not reached the patient. *Id.* ¶ 69.

When the ID case managers volunteered to track the returned HIV medications to ascertain the sources of waste, they found that returns were attributable to pretrial prisoners and to transfers of new prisoners within DOC. *Id.* ¶¶ 79-81. UMCH pushed forward with the

proposal to end all KOP HIV medications anyway, suspending the change briefly when the HIV specialists raised concerns about the impact on patients, but ultimately proceeding with the original proposal. *Id.* ¶¶ 76-78, 82-120. They purported to study several issues first, but Defendants largely do not recall the studies or their results. *Id.* ¶¶ 91-115.

When HIV medications were removed from the KOP program in February 2009, Defendants' written statements rationalizing the change discussed patient adherence and benefits; only later and begrudgingly did Defendants mention cost reduction. *Id.* ¶¶ 121-126. They much preferred to cite certain analyses they had performed – studies which were hopelessly flawed. An analysis of HIV patients who already went to med line, for other medications, was so cursory that it overstated this phenomenon. *Id.* ¶¶ 127-137. A purported "adherence analysis" cherry-picked 19 prisoners (out of over 200 being treated), who all had detectable viral loads; the report studied a small sample of pharmacy claims (refill orders) of dubious reliability, and declared patient adherence a problem for all HIV patients. *Id.* ¶¶ 138-144.

The reliance on faulty analysis has continued unabated since that time. Regular adherence analyses are still performed, using the same pharmacy claims data for all HIV patients on HAART. But the analyses show no statistically significant improvement in adherence since the policy change. In fact, they show a persistent 30% rate of late medication refills, with half of the late refills extending over a week. Such numbers demonstrate significant problems with the medication line administration, creating a significant potential for patient harm in the form of a detectable viral load and its negative effects. *Id.* ¶¶ 145-154. Defendants also point to overall patient viral loads and claim that mandatory med line has been a success, but a closer assessment reveals that viral loads changed very little from the period just before the policy change to the period just after. Defendants cite to improved overall viral loads in 2012, three years later, but

they cannot reliably attribute those numbers to the removal of HIV medications from the KOP program. *Id.* ¶¶ 165-167.

Although UMCH resisted acknowledging to prisoners that this policy was a cost-saving measure, it has been quick to trumpet the purported savings to outside parties, with an eye to attracting more business. *Id.* ¶¶ 168-189. The data on savings from reclaimed medications is misleading, however. It is overinclusive, failing to acknowledge that many HIV medications were also reclaimed under the KOP program and failing to note that savings from transferred prisoners are a mirage, since those prisoners will have to obtain early refills at the new facility. *Id.* ¶¶ 155-164. The reports do not acknowledge that medications for discharged prisoners should not be returned and reclaimed, but given to the prisoner. *Id.* ¶ 162.

There is little incentive to provide more accurate numbers. An inflated cost savings makes budgeting easier, and makes presentations to prospective clients more appealing. *See id.* ¶¶ 66, 181, 183-188. The harm brought by this policy falls not only on Plaintiffs and other HIV-positive prisoners in the DOC, but on prisoners elsewhere, as UMCH pitches this policy change as a proven good, notwithstanding the questionable methods and results of its analyses.

Still, Plaintiffs and prisoners like them have been harmed the most. Many of them suffer side effects, most notably the high number of prisoners taking Efavirenz, in Atripla or as part of another regiment. The side effects from Efavirenz are significant enough that bedtime administration is indicated, yet bedtime administration is impossible with mandatory med line. Two Plaintiffs suffered the side effects every night, until their regimens were ultimately changed. Changing regimens to accommodate a med line requirement is not defensible. *Id.* ¶¶ 204-211, 248.

Plaintiffs, who were adherent on KOP medications, are now subjected to a med line process that increases the likelihood of missed doses. They have experienced such omissions on multiple occasions, and the HIV providers corroborate these reports. Incomplete doses have also been administered. These interruptions increase the risk of viral loads rising and medication resistance developing. *Id.* ¶¶ 190-203, 249-263. The med line process also leads inevitably to unwanted disclosures of a prisoner's HIV-positive status, and the evidence reflects multiple such episodes. *Id.* ¶¶ 212-227.

The decision to take KOP medications away from all HIV patients ignores the individual treatment histories of Plaintiffs and other prisoners like them. This action was taken only against HIV-positive prisoners, while Defendants simultaneously seek to expand the role of the KOP program in other areas. *Id.* ¶¶ 234-247. The policy change infantilizes Plaintiffs and takes away their investment in their own care. *Id.* ¶¶ 228-233. Whatever the goals sought to be furthered by this blanket policy, they could be furthered under the KOP program with its individualized, case-by-case treatment of HIV-positive prisoners.

III. ARGUMENT

A. Equal Protection Claim (Count II).

Plaintiffs do not oppose summary judgment on Count II of the Complaint, claiming violation of their Equal Protection rights under the Fourteenth Amendment to the Constitution.

B. Summary Judgment Standard.

In order to prevail on summary judgment, the moving party must show that "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed.R.Civ.P. 56. The court must construe the evidence in the light most favorable to the non-moving party and make all reasonable inferences in that party's favor. *Flowers v. Fiore,* 359

F.3d 24, 29 (1st Cir.2004). The function of the court is not "to weigh the evidence and determine the truth of the matter but to determine whether there is a genuine issue for trial." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986).

While the Prison Litigation Reform Act (PLRA) limits the scope of any requested relief to "the least intrusive means necessary to correct the violation of the Federal right," 18 U.S.C. § 3626, this provision is directed at the scope of the prospective relief to be fashioned by the court, not the antecedent determination about whether relief ought to be granted. *See* 18 U.S.C. § 3626(a)(1); cf. *Disability Law Center v. Mass. Dept. of Correction*, No. 07-10463-MLW, 2012 WL1237760, *11 (D. Mass. 2012); *Henderson v. Thomas*, No. 2:11cv224-MHT, 2012 WL 6681773, *39 (M.D.Ala. Dec. 21, 2012) (deciding liability separately, before addressing scope of relief).

C. Plaintiffs Properly Exhausted Their Administrative Remedies.

Defendants contend that Plaintiffs have failed to exhaust with regard to certain claims. As failure to exhaust is an affirmative defense under the PLRA, Defendants have the burden to prove that contention. *Jones v. Bock,* 549 U.S. 199, 216 (2007); *Cruz Berríos v. Gonzáles–Roserio,* 630 F.3d 7, 11 (1st Cir.2010). Dismissal of a claim for failure to exhaust is without prejudice. *Tolbert v. Clarke*, 685 F.Supp.2d 244, 250 (D.Mass. 2010). Accordingly, if any Plaintiffs are deemed to have failed to exhaust, they will re-file their claims challenging Defendants' policy, after exhausting. *See Gartrell v. Ashcroft*, 191 F.Supp.2d 23, 24-25 (D.D.C. 2002) (decision on re-filed challenge to prison grooming policy, after first action dismissed for failure to exhaust).

The PLRA's requirement that prisoners exhaust administrative remedies is intended to afford correctional officials a fair opportunity to address complaints internally before allowing prisoners to initiate litigation, while reducing the quantity and improving the quality of lawsuits

filed. *Woodford v. Ngo*, 548 U.S. 81, 93-94 (2006), citing *Porter v. Nussle,* 534 U.S. 516, 524-25 (2002). The requirement is designed to deal with parties who do not want to exhaust. *Woodford*, 548 U.S. at 90. Nevertheless, the primary purpose of requiring exhaustion is not to put officials on notice that they may be sued, but to alert them of problems. *Mallory v. Marshall*, 659 F.Supp.2d 231, 238 (D.Mass.2009), citing *Jones*, 549 U.S. at 219.

Defendants first argue that Plaintiffs, with the exception of Mr. Nunes, failed to make the requisite requests for accommodations to proceed on ADA and Rehabilitation Act claims. They are misguided. "[I]t is the prison's requirement, and not the PLRA, that define the boundaries of the proper exhaustion." *Jones*, 549 U.S. at 218. Here, the policy governing requests for reasonable accommodations, 103 DOC 207.04, specifies that prisoner requests "may be initiated in either of two ways: (a) by a request to or from medical staff for a medically prescribed accommodation, or (b) by completion of a Request for Reasonable Accommodation of Special Need(s) form." The policy sets forth no specific language or content that must be included in the request. Defs.' Ex. 81.

Each Plaintiff submitted requests to medical staff concerning the policy change excluding them from the KOP program, via the medical grievance process. To the extent that 103 DOC 207 needed to be followed, it was. It is by no means clear that Plaintiffs Coe, Doe, Poe, and Roe are even subject to this policy. While they bring ADA and Rehabilitation Act claims, they claim discrimination, not a failure to accommodate; 103 DOC 207 does not, by its terms, apply to all claims of discrimination, but only to requests for a reasonable accommodation. Defs.' Ex. 81.

Defendants next contend that the Plaintiffs' grievance submissions were not broad enough to encompass all of the legal claims that they have asserted in the Complaint. Defendants overstate the terms of the exhaustion requirement. In general, prisoners must

"provide enough information about the conduct of which they complain to allow prison officials to take appropriate responsive measures." *Beltran v. O'Mara*, 405 F.Supp.2d 140, 151 (D.N.H. 2005) (quoting *Johnson v. Testman,* 380 F.3d 691, 697 (2d Cir.2004)). They "need not lay out the facts, articulate legal theories, or demand particular relief," unless legitimate prison rules require them. *Beltran*, 405 F.Supp.2d at 151 (quoting *Strong v. David,* 297 F.3d 646, 650 (7th Cir.2002)). No grievance process "may demand the prisoner specify each remedy later sought in litigation." *Strong v. David*, 297 F.3d 646, 649-50 (7th Cir. 2002). Proper exhaustion means compliance with the applicable policy, but the medical grievance policy, UMCH Policy 12.00, requires no particular content, no magic words. Defs.' Ex. 83. The fields in the medical grievance form appended to the policy are open-ended, calling for a "Summary of Grievance" and "Remedy Requested." *Id.*

Each Plaintiff grieved the removal of HIV medications from KOP and unfortunate results stemming from that policy change. Plaintiffs were not obliged by UMCH Policy 12.00 or otherwise to spell out every possible legal wrong. *See Beltran*, 405 F.Supp.2d at 151; *Lewis v. Washington,* 197 F.R.D. 611, 614 (N.D.Ill.2000) (prisoners complaining about various aspects of the conditions in their housing unit need only have grieved their placement in the unit, not each alleged unconstitutional condition present; "[o]therwise the defendants could obstruct legal remedies to unconstitutional actions by subdividing the grievances...."); *Aiello v. Litscher*, 104 F.Supp.2d 1068, 1074-75 (W.D.Wis. 2000) (when inmates have filed a grievance regarding a prison policy, they need not file grievances regarding subsequent incidents in which the policy is applied).

There is no question of whether Defendants were on notice of complaints about the policy change. Not only did Plaintiffs present concerns in line with the claims asserted in the

Complaint, so did the infectious disease specialists and UMCH staff. Defendants responded by minimizing and discarding these concerns, along with the grievances. They did not conduct interviews with any of the Plaintiffs to gain additional information regarding their grievances, though they could have done so.[1] Pls.' Ex. 12 at ¶ 3; Pls.' Ex. 13 at ¶ 4; Pls.' Ex. 14 at ¶ 14; Pls.' Ex. 15 at ¶ 5; Pls.' Ex. 16 at ¶ 4. In fact, they instructed some Plaintiffs that they wished to hear no more about these issues. *See* Defs.' Ex. 98; Defs.' Ex. 105. They should not now be heard to claim that these grievances were somehow lacking. Plaintiffs address their individual efforts below.

1. Carl Coe.

Defendants inaccurately contend that Carl Coe failed to exhaust administrative remedies concerning a right to privacy claim. Mr. Coe filed a medical grievance on February 9, 2009 concerning the increased side effects, interruptions in treatment, and barriers to medication access created by the removal of HIV medications from the KOP program. Defs.' Ex. 97. He asked that his meds be reinstated as KOP and suggested that health care providers should determine eligibility for KOP on a case-by-case basis. *Id.* His grievance was denied by HSA Kevin Sabourin who indicated that the Pharmacy & Therapeutics Committee determined DOT to be "the best approach for all concerned" and that there were no exceptions. *Id.*

In his grievance dated August 3, 2009, he raised similar complaints, also pointing out that the policy change appeared prejudicial, targeting only HIV-positive individuals. Defs.' Ex. 98. This grievance also documented two additional problems: (1) his PM snack was discontinued, further exacerbating the side effects caused by having to take his HIV medication hours before bedtime; and (2) he had missed getting his HIV medication twice because med line had not been announced in the unit. Mr. Coe requested reinstatement of his PM snack and of KOP for his

[1] UMCH Policy 12.00(3)(f) indicates that, upon review of a grievance, a face to face interviews may be conducted.

HIV medications. *Id.* In a response to the grievance dated August 7, 2009, Mr. Coe was informed by HSA Russell Phelps that the issues he raised were non-grievable as "matters of medical judgment" and "[t]herefore, administration may not interfere with clinical decisions." Mr. Phelps' response also stated: "The issue of KOP HIV medication has been previously addressed and is a duplicative grievance. I will not address or respond to duplicative grievances." *Id.* Mr. Coe's subsequent appeals were denied. *Id*. In response to his second level appeal, Assistant Deputy Commissioner of Clinical Services Terre Marshall affirmed that HIV medications are not available KOP and stated that her decision denying his grievance appeal "is final." *Id.*

In his grievances, Mr. Coe sufficiently raised concerns about the removal of HIV medications from KOP, providing Defendants enough information to allow them to take appropriate investigative and responsive measures. *See Beltran*, 405 F.Supp.2d at 151. Moreover, in light of the response to his August 3, 2009 grievance, Defendants cannot now claim that Mr. Coe failed to grieve implications of the policy change on his right to privacy. Mr. Coe was explicitly instructed that this matter was not grievable, per UMCH Policy 12.00(3)(c) and 103 DOC 610.01(2). That ruling rendered administrative remedies no longer available. Mr. Coe exhausted the administrative remedies available to him, challenging the policy change.

2. <u>John Doe.</u>

Defendants acknowledge that Mr. Doe completed the grievance process for an April 7, 2009 grievance concerning a breach of privacy by a nurse at med line. Defs.' Ex.103. Defendants then contend that he only exhausted administrative remedies for the right to privacy claim. This is incorrect.

Mr. Doe filed a medical grievance on February 13, 2009 concerning the fact that his medication was not available when he attended med line, explaining that he "went without meds again." He expressed concern about missing doses because his infectious disease clinicians "tell me that Im at the end of my med's cause there is nothing else for me to take." Defs.' Ex.101. HSA Donna Jurdak responded to Mr. Doe's grievance late, on April 10, 2009, indicating only that UMCH was tracking and addressing "issues with the pharmacy and medication delivery" as they occurred. *Id.* Dissatisfied with this response, Mr. Doe appealed on April 17, 2009, asking to have his HIV medications returned to KOP while asserting that the policy change was enacted despite longstanding problems of this nature with med line. *Id*. After receiving no response to the appeal, Mr. Doe filed a second level appeal on June 5, 2009.[2] Pls.' Ex. 17. Mr. Doe had not received Dyana Nickl's response dated June 3, 2009 denying his first level appeal. Pls. Ex. 14 at ¶ 12. Defendants did not respond to the second level appeal Mr. Doe filed. Defendants' lack of response was a failure to comply with the grievance procedure. At that point, Mr. Doe exhausted all available administrative remedies. *See Braxton v. Ross*, 2010 WL 1713614, *1 (D.Mass. 2010) (deeming prisoner to have exhausted administrative remedies when prison failed to respond to his grievance, giving him "nothing from which to appeal").

There were more. On May 20, 2009, Mr. Doe filed three grievances regarding events of that day. Defs.' Ex. 104. Mr. Doe had attempted to get his medication at the 12:30pm med line because was unable to take it on an empty stomach at 8:00am, but his request was denied. He then overheard a nurse speaking to a correctional officer about him and his medication near other prisoners before he was sent back to his unit. He requested the following relief in his three

[2] The second level appeal to this grievance was filed simultaneously with the second level appeal for Mr. Doe's grievance from April 7, 2009 regarding his privacy concerns. Both appeals were mailed directly to Terre Marshall by Attorney Joel Thompson with a letter dated June 8, 2009. Pls.' Ex. 17. Defendants failed to respond to the second level appeal to the April 7th grievance as well.

grievances: (1) to change his med line times to 12:30pm and the night med line or to return his medications to KOP; (2) to allow prisoners who miss med line to get their HIV medications at the next available line; and (3) to retrain the nurse who disclosed his confidential medical information. *Id*. He received no responses.

Instead, Mr. Doe received a notification from Dyana Nickl dated July 21, 2009. Defs.' Ex. 105. Mr. Doe had been deemed "an abuser of the grievance process" and his ability to submit medical grievances was suspended until August 21, 2009. Defs.' Ex. 105. The reasons for the suspension were: (1) "[f]iling five or more grievances in a week or twenty or more grievances in any 180 consecutive days"; (2) "[c]ontinuing to file grievances after an issue has been resolved through all levels of the grievance and appeals process"; and (3) "[i]ntentionally disregarding the proper grievance and appeal procedure resulting in disruption of the normal business of UMass Correctional Health." *Id*.

As his problems with missing doses continued, Mr. Doe filed a grievance on July 1, 2010 stating that he has missed doses of his HIV medication at least once a month since their removal from the KOP program. Defs.' Ex. 106. His grievance was denied in a response dated 7/12/10. Mr. Doe, with the assistance of counsel, mailed his appeal to DOC Health Services Division. *Id*. He did not receive a response.

Mr. Doe repeatedly grieved the fact that the removal of HIV medications from KOP had deleterious effects, providing Defendants enough information to allow them to take appropriate investigative and responsive measures. See *Beltran*, 405 F.Supp.2d at 151. Furthermore, after failing to respond to Mr. Doe's grievances and appeals and prohibiting him from submitting additional grievances, Defendants cannot now legitimately claim that Mr. Doe failed to exhaust

administrative remedies as to each claim in the Complaint. *See Braxton*, 2010 WL 1713614 at *1.

3. Peter Poe.

The Correctional Defendants do not challenge the fact that Mr. Poe completed the medical grievance process as to every claim; the Medical Defendants do, incorrectly.

Mr. Poe filed a medical grievance on May 17, 2009 indicating that the removal of HIV medications from the KOP program impedes his access causing missed doses, causes him to miss work, creates privacy problems, and violates his rights under the 8th and 14th amendments, the ADA and the Rehabilitation Act, among other things. Defs.' 109. He requested that HIV medications be distributed as KOP. *Id*. Mr. Poe's grievance was denied by HSA Donna Jurdak in a response dated June 2, 2009. Mr. Poe filed a timely appeal, which was denied by Diana Nickl in a response dated August 31, 2009. *Id.* He filed a second level appeal on September 21, 2009; he received a response dated September 29, 2009 denying his appeal. *Id.*

Mr. Poe filed another grievance on March 9, 2010 reporting that he was turned away from the work call morning med line by a correctional officer and, as a result of having to go to work, missed taking his HIV medications on fourteen dates listed in the grievance. Defs.' Ex. 111. He indicated that he had never missed a dose when he had KOP and asked that he be allowed to get his medications in the afternoon line if he is not able to get them in the morning. Mr. Poe received a response dated March 11, 2010 indicating that his was not a grievable issue but that, if he was told to leave the 8 a.m. med line, he could come back to the noon med line. *Id.* Mr. Poe appealed on March 15, 2010 and received a final decision dated April 2, 2010 from Terre Marshall.

Mr. Poe clearly exhausted administrative remedies as to each claim. Indeed, he far exceeded any grievance policy requirements by explicitly making reference to legal theories later advanced in the Complaint.[3]

4. Richard Roe.

Defendants contend that Richard Roe only properly exhausted administrative remedies concerning a right to privacy claim as well.

Mr. Roe filed a medical grievance on May 11, 2009 citing the policy change and requesting that KOP for his life sustaining HIV medication be returned to avoid invasions of privacy at med line. Defs.' Ex. 113. In response to his grievance and his two appeals, Mr. Roe was informed that HIV medication is no longer available KOP and must be taken at med line. *Id.* Terre Marshall's response to his second level appeal also stated that UMCH is offering medical services as clinically indicated and her decision denying his grievance appeal is final. *Id.*

Mr. Roe sufficiently raised concerns that the removal of HIV medications from the KOP program was problematic. He need not have stated every way in which it was problematic, nor every potential cause of action that might arise from the policy. *See Beltran*, 405 F.Supp.2d at 151. He gave sufficient information to allow Defendants to investigate or to take responsive measures. *Id.* Instead, the responses that he received from Defendants upholding the propriety of the policy change were cursory and clearly conveyed that filing more grievances on this subject would be fruitless.

[3] Mr. Poe also sought relief through the DOC grievance process. Defs.' Ex.108. Specifically, Mr. Poe filed DOC Grievance No.40597 on May 16, 2009 explaining that, since HIV medications were removed from the KOP program, he missed doses, missed work waiting in the medication line, and had his HIV status exposed to the general population in violation of the 14th and 8th amendments as well as the ADA and Rehabilitation Act. He noted that he was submitting the DOC grievance because his infectious disease clinician had stated that his preference was to deliver HIV medication as KOP. Mr. Poe requested that KOP status be restored immediately for HIV medications. *Id.* Mr. Poe's grievance and appeal were denied as medical decisions non-grievable through the DOC process. *Id.*

D. The ADA's Comprehensive Remedial Scheme Does Not Bar Plaintiffs' §1983 Claims.

The Correctional Defendants contend that the ADA's comprehensive remedial scheme precludes any of Plaintiffs' claims under 42 U.S.C. § 1983. The law does not support this contention. Courts have held that Section 1983 claims *for violation of the ADA* are precluded. *See Meara v. Bennett*, 27 F.Supp.2d 288, 291-92 (D.Mass. 1998) (dismissing plaintiff's Section 1983 claim of employment discrimination on the basis of disability as precluded by her identical claim under the ADA); *Murphy v. Magnusson*, 1999 WL 1995203, *3 (D.Me. 1999) ("Section 1983 is not available when the only rights alleged to have been violated were created by these two statutes."); *Alsbrook v. City of Maumelle*, 184 F.3d 999, 1010-11 (8th Cir. 1999) (ADA's detailed remedial scheme barred plaintiff from maintaining a Section 1983 action against defendants in their individual capacities for violations of the ADA); *Holbrook v. City of Alpharetta*, 112 F.3d 1522, 1531 (11th Cir.1997) (plaintiff may not maintain a Section 1983 claim if the only alleged deprivation is of employee's rights created by the ADA).

In this case, Plaintiffs assert their ADA claims under the ADA, not under Section 1983. Plaintiffs do also claim, pursuant to Section 1983, that Defendants' policies, practices, and acts violate the privacy rights of prisoners with HIV and their right to be free from cruel and unusual punishment, as protected by the Fourteenth Amendment and Eighth Amendment, respectively. These claims are not barred.[4]

E. Defendants Are Not Entitled to Judgment as a Matter of Law on the Claims Under the ADA and Rehabilitation Act.

Defendants' blanket exclusion of HIV medications from the KOP program represents discrimination in violation of the ADA and the Rehabilitation Act. Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded

[4] As Plaintiffs are only seeking declaratory and injunctive relief, there can be no implication that Plaintiffs are using Section 1983 to circumvent the ADA, in order to seek individual liability against Defendants.

from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. Prisons are public entities under the statute. *See Pennsylvania Dept. of Corrections v. Yeskey*, 524 U.S. 206, 210 (1998).

To prevail on a Title II claim, "a plaintiff must establish: (1) that he is a qualified individual with a disability; (2) that he was either excluded from participation in or denied the benefits of some public entity's services, programs, or activities or was otherwise discriminated against; and (3) that such exclusion, denial of benefits, or discrimination was by reason of the plaintiff's disability." *Parker v. Universidad de Puerto Rico*, 225 F.3d 1, 5 (1st Cir. 2000); *Bibbo v. Massachusetts Dept. of Correction*, No. 08-cv-10746-RWZ, 2010 WL 2991668, *1 (D.Mass. July 26, 2010). Liability standards for the Rehabilitation Act are the same as those for Title II of the ADA. *Quiles-Quiles v. Henderson*, 439 F.3d 1, 5 (1st Cir. 2006).

Defendants question whether HIV is a disability under the ADA, but Congress has provided the answer. HIV is specifically listed as a physical impairment under the Act's implementing regulations. 28 C.F.R. § 35.104 ("physical impairment" includes HIV disease, whether symptomatic or not). The ADA Amendments Act of 2008, Pub. L. 110-325, rejected a narrow definition of disability and left no doubt as to the ADA's broad protection. The Act "clarifies that 'major life activities' includes 'the operation of a major bodily function, including ...functions of the immune system.'" *Henderson v. Thomas*, 2012 WL 6681773 at *11 n. 15 (citing 42 U.S.C. § 12102(2)(B)). HIV is a disability under the ADA, since it "critically impacts the immune system." *Id.*

The KOP program is a program or service, subject to Title II. Defendants refer to it as a program, Defs.' Ex. 31 ("Keep On Person (KOP) Medication Distribution Program"), and the

provision of prescription drugs for HIV treatment has previously been found to be a program or service. *McNally v. Prison Health Services*, 46 F.Supp.2d 49, 58 (D.Me. 1999). Plaintiffs are otherwise qualified for the KOP program. They were successful participants in the program for years, taking their HIV medications through the program. Pls.' SMF ¶ 28, 234. Plaintiffs and all HIV-positive prisoners are excluded from the KOP program regardless of circumstance. It matters not which HIV medications they take, or what their individual histories are, *i.e.* whether they have proven themselves capable of taking their own medications under the KOP program.

Such discrimination resembles that of Prison Health Services in *McNally*, which had "one policy for detainees taking HIV medication and one for detainees on medication for maladies other than HIV." *McNally*, 46 F.Supp.2d at 58-59. In that case, a new detainee reporting his HIV-positive status and medication regimen was denied those medications, even though medications for other conditions were provided to new detainees. The District Court denied summary judgment, finding that a jury could infer that PHS policy denied HIV-positive prisoners access to its prescription drug program. *Id.* at 59. Similarly, the facts here demonstrate that Defendants took the KOP program away only from the HIV-positive prisoners. Defendants maintain a blanket policy of excluding all HIV-positive prisoners from the KOP program, regardless of their individual circumstances. *See Henderson*, 2012 WL 6681773 at *18. "That policy denies plaintiffs the individualized determinations to which they are entitled under the ADA." *Id.*

Defendants declare that KOP medications are a privilege, not a right, and that individual prisoners may be excluded from the KOP program. They miss the point. These HIV patients do not challenge Defendants' ability to apply the KOP program's criteria to individual patients. What they challenge is the decision to take an entire category of patients with KOP medications

– those who are HIV-positive – and remove them from the program, without any individualized assessment of their qualifications for the program, including their history *in* the program. Plaintiffs seek only not to be automatically excluded from the KOP program "on account of their HIV status." *See Henderson*, 2012 WL 6681773 at *22 n. 30. To the extent that Defendants claim they excluded only the HIV medications, not the HIV patients, this is not a principled distinction. The ADA prohibits them from imposing eligibility criteria that tend to screen out a class of individuals with disabilities from fully and equally enjoying a service, program, or activity. 28 C.F.R. § 35.130(b)(8); *see Henderson*, 2012 WL 6681773 at *32.

Defendants claim that they were justified in removing HIV medications from the KOP program, in order to improve patient adherence. Their evidence shows just the opposite. At the time they changed the policies, Defendants pointed to a self-serving study of nineteen patients who were cherry-picked out of the 232 prisoners receiving treatment, because they all had detectable viral loads. Pls.' SMF ¶¶ 138-140. That analysis revealed that seven of the nineteen patients were adherent to medications. This study was hardly a clarion call for change. The adherence analyses that followed the policy change have only proved that taking away KOP medications had *no* impact on overall patient adherence. Thirty percent of all refills remain late, and half of those late refills last long enough to pose a significant risk of harm in the form of detectable viral load. If the goal of requiring med line for all HIV patients was to improve adherence, then this blanket policy is an abject failure.

The blanket exclusion of all HIV-positive prisoners from the KOP program is not "necessary" in any event. 28 C.F.R. § 35.130(b)(8). HIV patients as a group did not have adherence problems. To the extent that individual patients had adherence problems, the Defendants were already equipped to address them on an individualized basis. The KOP policy,

the daily compliance monitoring and monthly KOP audit policies, and the early refill policy all ensure that patient adherence problems will be detected. Those who do not adhere to their medication will be suspended from the KOP program. Moreover, HIV-positive prisoners were subject to closer monitoring under the KOP program than anyone else. The ID case managers reviewed patient MARs, conducted pill counts at clinic appointments, and were alerted by nurses to possible nonadherence. These measures were supplemented by the quarterly measure of patient viral loads and CD4 counts; worsening counts were another signal of possible nonadherence. For the HIV-positive prisoners more than anyone else, medical staff is able to "differentiat[e] among prisoners on the basis of their behavior," which is exactly what the ADA calls for. *Henderson*, 2012 WL 6681773 at *19, *26 ("adherence should be addressed on an individual-by-individual basis, as the ADA requires, rather than categorically").

The blanket exclusion of all HIV-positive prisoners from the KOP program is no more "necessary" for the sake of saving money. It is not clear that avoiding the destruction of returned medications is a necessary component of the KOP program. Even if it is, though, the exclusion of *all* HIV-positive prisoners from the KOP program is not necessary to reduce waste. Defendants are fully aware of the reasons for medication returns – therapy changes, discharges, transfers, and duplicate orders. The HIV specialists do not change regimens in a way that causes waste. Discharged prisoners should not lead to medication returns, because, by policy, Defendants are to send their medications with them. If there is a problem here, it is one not of waste but of failure to follow policy and ensure continuity of care. Similarly, transferred prisoners should have their medications transferred with them, as dictated by policy. Transfers should not lead to medication returns. Even if they do, no money is saved on a transfer, because the receiving facility must order an early refill to account for the absence of the returned

medications. Whether or not duplicate orders are avoided, they can be returned under the KOP policy anyway because the medications have not yet reached the patient. Defendants have refused to recognize their responsibility for medication returns, most of which are improper, and they have refused to do anything to limit them. *See* Defs.' Ex. 62 (Reclaim and Reuse Data, showing a persistent volume of returned medications).

Reduction of waste can be accomplished without discriminating against all HIV-positive prisoners. Defendants have the information to trace returns to the individual patient and find the cause for the return. The IDCMs performed this task once and advised administrators that returns were caused by the discharge of pretrial prisoners and by transfers of new DOC prisoners. Defendants ignored that finding and have never since cared to know the source of medication returns. There is no evidence that the HIV-positive as a group all cause waste. As such, Defendants cannot meet their "heavy" burden of showing that denying KOP medications to all HIV-positive prisoners is "necessary" to achieve the goal of avoiding waste. *See Henderson*, 2012 WL 6681773 at *32, quoting *Guckenberger v. Boston University*, 974 F.Supp. 106, 139 (D.Mass. 1997).

A blanket policy denying KOP medications to all HIV-positive prisoners, regardless of their individual sentence length, placement, and history, is discrimination. *Henderson*, 2012 WL 6681773 at *33 (finding that the ADA prohibits all discrimination by public entity, and is not limited to exclusion from program or service). Since returned medications are traceable to the individual patient, the Defendants can address any problems on an individual basis. They can address pretrial prisoners or temporary detox commitments separately, if need be. Plaintiffs, and others like them, are in stable sites with long sentences and predictable release dates. They do not cause medication returns. Prohibiting them from having KOP medications is not necessary.

Defendants took an entire population that previously qualified for the KOP program – HIV-positive prisoners – and removed them. They did not remove anyone else, even those with expensive medications like Ribavirin, which is prescribed to a select few Hepatitis C patients at a time. Pls.' SMF ¶ 240. In fact, at the same time that Defendants excluded Plaintiffs from the KOP program, they have looked to expand the KOP program for others. Pls.' SMF ¶ 196. The KOP program is not unreasonably costly for HIV patients, especially given its individual assessment of each patient's adherence or waste. *Henderson*, 2012 WL 6681773 at *35. Problematic patients can be identified and screened out, without disturbing those who are adherent and do not cause waste.

Plaintiffs are not demanding that all HIV-positive prisoners be restored with KOP medications. They merely ask not to be excluded from the KOP program based on their HIV-positive status. Whether Plaintiffs or other HIV-positive prisoners may have KOP medications "must depend on an individual-by-individual assessment of these prisoners that honors each prisoner's rights under the ADA, and…resources are reasonably available to do this." *Henderson*, 2012 WL 6681773 at *40.

F. The Blanket Policy Removing HIV Medications from the KOP Program Violates the Eighth Amendment.

The Eighth Amendment prohibits punishments that are "incompatible with 'the evolving standards of decency that mark the progress of a maturing society,'" and those that "involve the unnecessary and wanton infliction of pain." *Estelle v. Gamble*, 429 U.S. 97, 102-04 (1976) (citations omitted); *see Kosilek v. Spencer*, 2012 WL 3799660, *3 (D.Mass. 2012). "A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society." *Plata v. Brown*, __ U.S.

__, 131 S.Ct. 1910, 1928 (2011). Accordingly, deliberate indifference to a prisoner's serious medical needs violates the Eighth Amendment. *Estelle*, 429 U.S. at 105.

An official is deliberately indifferent if he or she knows of and disregards a substantial risk of serious harm to the prisoner's current or future health. See *Farmer v. Brennan*, 511 U.S. 825, 843 (1994); *Helling v. McKinney*, 509 U.S. 25, 33-35 (1993) ("We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year."). Conscious disregard can be established by the defendant's response to a known need, or by "denial, delay or interference with prescribed health care." *Battista v. Clarke*, 645 F.3d 449, 453 (2011), quoting *DesRosiers v. Moran*, 949 F.2d 15, 19 (1st Cir.1991); *see Estelle*, 429 U.S. at 104-05; *Soneeya v. Spencer*, 851 F.Supp.2d 228, 242 (D.Mass. 2012); *Alexander v. Weiner*, 841 F.Supp.2d 486, 493 (D.Mass 2012). The plaintiff need not show that the prison official believed that harm would actually befall the prisoner, only that the official acted or failed to act despite knowledge of a substantial risk of serious harm. *Id.* at 842; s*ee Battista*, 645 F.3d at 453, citing *Farmer*, 511 U.S. at 835 ("[S]ubjective intent is often inferred from behavior and even in the Eighth Amendment context… a deliberate intent to harm is not required.").

Plaintiffs have a serious medical need. "[A] serious medical need" is one that involves a substantial risk of serious harm if it is not adequately treated. *Kosilek*, 2012 WL 3799660 at *11, citing *McGuckin v. Smith*, 974 F.2d 1050, 1059 (9th Cir.1992) ("A 'serious' medical need exists if the failure to treat a prisoner's condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.'"). "It is obvious that HIV is a serious medical condition, as the condition can be life-threatening if not properly treated." *Leavitt v. Correctional*

Medical Services, Inc., 645 F.3d 484, 500 (1st Cir.2011), citing *Brown v. Johnson*, 387 F.3d 1344, 1351 (11th Cir.2004), *Montgomery v. Pinchak*, 294 F.3d 492, 500 (3d Cir.2002). In addition, the risk of harm faced by Plaintiffs due to Defendants' actions, which include both painful side-effects and missed doses that leave Plaintiffs susceptible to drug resistance and the resulting complications, plainly constitutes a serious medical need. *See Leavitt*, 645 F.3d at 500-01; *McNally v. Prison Health Services*, 46 F.Supp.2d 49, 54-55 (D.Me.1999).

Defendants' blanket removal of HIV medications from the KOP program amounts to conscious disregard of Plaintiffs' serious medical need. This policy change puts Plaintiffs and others at substantial risk of serious harm. First, Defendants are all well aware that mandatory DOT forces some prisoners to endure side effects from their medications unnecessarily. This is particularly so with respect to Atripla and other medications containing Efavirenz; over half of the DOC's HIV patients are treated with Efavirenz-based regimens. Pls.' SMF ¶ 207. Efavirenz is indicated to be taken at bedtime because of its neurological effects, causing dizziness and flulike symptoms. Pls.' SMF ¶ 245. Forcing a prisoner to take this medication hours before bedtime is not the standard. Pls.' Ex. 3 at ¶ 18. Both Mr. Coe and Mr. Doe have experienced these side effects first hand, every night, as have many others. These effects are substantial enough to constitute harm under the Eighth Amendment. *See Roe*, 631 F.3d at 864-65 (symptoms that "included stomach distention, nose bleeds, rashes and bowel irregularity" that a prisoner experienced during and shortly after his nine-month incarceration when his HCV was left untreated constituted sufficient injury); *Gil v. Reed*, 381 F.3d 649, 662 (7th Cir.2004) (testimony from which a jury could infer that an overnight delay in providing antibiotic treatment for an inmate's infection caused "many more hours of needless suffering" was sufficient to withstand summary judgment).

With no relief forthcoming from Defendants, ultimately the HIV specialists changed these Plaintiffs' regimens. Dr. Stone and Dr. Quirk recounted changing therapies to less optimal regimens, as a result of the policy change. For Defendants to needlessly force such changes is deliberate indifference, as it is essentially the imposition of "an easier and less efficacious" treatment plan made for non-medical reasons. *Chance v. Armstrong*, 143 F.3d 698, 703 (2d Cir. 1998) (citations omitted); see *Estelle*, 429 U.S. at 104 n. 10; *Waldrop v. Evans,* 871 F.2d 1030, 1035 (11th Cir.1989); *Soneeya,* 851 F.Supp.2d at 242, 248; *Kosilek v. Maloney*, 221 F.Supp.2d 156, 183, 185, 189 (D.Mass. 2002).

Second, Defendants are aware that their policy has resulted in some patients, including Plaintiffs, missing *more* doses of their medication than they did under the KOP program. Plaintiffs have detailed occasions of missed medications, under circumstances that would not have led to a missed dose when the medications were KOP. Plaintiff Nunes, fearing the development of drug resistance from missed doses, does not take medications at all, unless he is in segregation where medications are delivered to each cell. The HIV specialists and ID case managers have recounted problems and complaints from their patients. Although Defendants trumpet some of the warm words in the DPH audit of HIV treatment from 2011, they overlook the Audit's finding that twelve prisoners were having adherence problems *because of* the med line policy. Defendants' actions are creating problems, not solving them.

Defendants would have the prisoners believe otherwise – that they removed HIV medications from the KOP program for their benefit, to improve their care. The record belies this assertion. This blanket policy was implemented first and foremost to reduce costs through reclaim of returned medications. Patient care was an afterthought, until the prisoners' providers spoke up. At that point Defendants began addressing these concerns – by accusing the HIV

population of nonadherence. They suspended the policy change temporarily and ordered several studies. That the Defendants cannot recall the results of these studies, or whether they even happened, is telling. Defendants were going to push this policy through regardless of what they found. The one study they do have, and cite as supporting the policy, is an ill-defined analysis of nineteen patients who all had detectable viral loads, using a limited data set of pharmacy claims, the reliability of which is suspect. Even that biased sample contained seven adherent patients. Nevertheless, Defendants point to this study as justifying a policy affecting over 200 other prisoners, regardless of their individual histories.

Defendants forge ahead with their reliance on adherence figures as justifying the blanket policy change. They do so using the same questionable pharmacy claims data and the results are an indictment of Defendants' actions, not an endorsement. After all medications were removed from the KOP program, with staff fully responsible for ordering refills, thirty percent of such refills have been late, persistently. Half of those late refills have been a week late or more; such long interruptions in medication dramatically increase the risk of viral rebound, which can have disastrous effects. This rate of late refills marked no improvement over the period before the change.

The same can be said for viral loads. A fair comparison of pre-change and post-change viral loads shows no statistically significant difference between the two. Defendants proclaim success based on fewer detectable viral loads in 2012, but there is no way to link those figures to the removal of HIV medications from the KOP program, as too many other factors that contribute to viral loads cannot be controlled for. *See Henderson*, 2012 WL 6681773 at *17 (finding that the link between prison policy and lower HIV transmission rates amounts to "*post*

hoc ergo propter hoc"). In particular, newer medications with higher potency are the most likely reason for the improvement in viral loads.

UMCH apparently believes that it can prevail by pushing out a few graphs, no matter what the numbers actually say or mean. This practice may suffice for promoting their business, but it does not entitle them to summary judgment. Nonadherent patients are accountable under the KOP program. They can lose the privilege. The HIV-positive prisoners are closely monitored. Plaintiffs did not have adherence problems under the KOP program; they took their medications. Now, having lost any control of their medications, they are definitively worse off. They need not wait until medication resistance or other horribles develop, in order to sustain the Eighth Amendment claim; the risk of such harm is enough. *See Farmer v. Brennan,* 511 U.S. 825, 843 (1994); *Helling v. McKinney,* 509 U.S. 25, 33-35 (1993); *Leavitt*, 645 F.3d at 500-01; *Roe v. Elyea*, 631 F.3d 843, 858 (7th Cir. 2011); *McNally*, 46 F.Supp.2d at 54-55. Blanket policies such as the one imposed here are vulnerable if they take no account of individual patient circumstances. *Johnson v. Wright*, 412 F.3d 398, 404-06 (2d Cir. 2005) (vacating granting of summary judgment finding that blanket Hepatitis C policy may be unconstitutional). The Eighth Amendment obligates Defendants to provide adequate care, *Kosilek*, 2012 WL 3799660 at *33, and adequate care "requires an individualized assessment of a patient's medical needs." *Kosilek*, 2012 WL 3799660 at *35, citing *Roe v. Elyea*, 631 F.3d 843, 862-63 (7th Cir. 2011), *Soneeya v. Spencer*, 851 F.Supp.2d 228, 242 (D.Mass. 2012).

Cost is not a defense. "[T]he cost of adequate medical care is not a legitimate reason for not providing such care to a prisoner." *Kosilek*, 2012 WL 3799660 at *18, *15; *see Chance,* 143 F.3d at 704; *Harris v. Thigpen,* 941 F.2d 1495, 1509 (11th Cir.1991); *Ancata v. Prison Health Servs., Inc.,* 769 F.2d 700, 705 (11th Cir.1985); *Soneeya,* 851 F.Supp.2d at 243 ("Cost of

treatment, however, may not be used as a reason to deny an inmate medically necessary care.").

Even if cost were a relevant consideration, however, Defendants incur no additional cost by providing KOP medications to Plaintiffs. No waste is attributable to Plaintiffs, who were at stable sites, were not transferred frequently, and were not going to be discharged without warning. Defendants know, yet continue to ignore the reality, that returned medications arise from sudden discharges of pretrial prisoners and temporary detox commitments and from transfers where staff did not transport the medications or forward them. No practical constraints prevent restoration of the Plaintiffs to the KOP program, which they had followed for years. Defendants are not entitled to summary judgment on the Eighth Amendment claim.

G. The Policy Change Violates Privacy Rights Preserved by the Fourteenth Amendment.

1. Plaintiffs Have a Constitutional Right to Privacy with Regard to Their HIV Status.

Individuals have a constitutional right to privacy that protects "the individual interest in avoiding disclosure of personal matters." *Whalen v. Roe*, 429 U.S. 589, 599 (1977); *see generally Houchins v. KQED, Inc*., 438 U.S. 1, 5 n. 2 (1978) ("Inmates in jails, prisons, or mental institutions retain certain fundamental rights of privacy; they are not like animals in a zoo to be filmed and photographed at will by the public or by media reporters, however "educational" the process may be for others."). This right has been found to encompass a right to nondisclosure of prisoners' sensitive medical information. *Klein v. MHM Correctional Services, Inc*., 2010 WL 3245291, *4 (D.Mass. 2010) (assuming prisoners enjoy a constitutional right of privacy with respect to medical information). A prisoner's HIV-positive status has been deemed to be sufficiently sensitive to trigger the right. *See, e.g., Moore v. Prevo*, 379 Fed.Appx. 425, 428 (6th Cir. 2010); *Powell v. Schriver*, 175 F.3d 107, 112 (2d Cir.1999); *Doe v. Delie*, 257 F.3d 309, 317 (3d Cir. 2001); *Doe v. Magnusson*, 2005 WL 758454, *10-11 (D.Me. 2005); *Nolley v. County of*

Erie, 776 F.Supp. 715, 728-32 (W.D.N.Y.1991); *Rodriguez v. Coughlin,* 1989 WL 59607, * 3 (W.D.N.Y. 1989); *Woods v. White,* 689 F.Supp. 874, 876 (W.D.Wis.1988), *aff'd*. 899 F.2d 17 (7th Cir.1990); *Doe v. Coughlin*, 697 F.Supp. 1234, 1237-38 (N.D.N.Y. 1988); *see also Alfred v. Corrections Corp. of America*, 437 Fed.Appx. 281, 285-286 (5th Cir. 2011); *Harris v. Thigpen,* 941 F.2d 1495, 1513 (11th Cir.1991) (assuming, arguendo, a constitutionally protected privacy interest in nonconsensual disclosure of HIV status).

"[T]he interest in the privacy of medical information will vary with the condition." *Powell,* 175 F.3d at 111. Indeed, HIV-positive status has been distinguished from most other medical conditions suffered by prisoners and individuals living in the community alike, given the intensely personal nature of the infection and the stigma accompanying disclosure. *Cortes v. Johnson*, 114 F.Supp. 2d 182, 185-86 (W.D.N.Y. 2000) (finding that leg and neck pain "do not compel the same heightened confidentiality as information about a prisoner's HIV positive status or transsexualism"); *cf. Matson v. Board of Educ. of City School Dist. of New York*, 631 F.3d 57, 67 (2d Cir. 2011) (finding that the constitutional right to privacy of one's medical information does not extend to disclosure of fibromyalgia diagnosis, in contrast to HIV status).

"There are few areas which more closely intimate facts of a personal nature than one's HIV status." *Doe v. Town of Plymouth*, 825 F.Supp. 1102, 1107-08 (D.Mass. 1993), citing *Woods,* 689 F.Supp. at 876. "[T]he privacy interest in information regarding one's HIV status is particularly strong because of the stigma, potential for harassment, and 'risk of much harm from non-consensual dissemination of the information.'" *Delie*, 257 F.3d at 315, quoting *Doe v. Southeastern Pa. Transp. Auth.,* 72 F.3d 1133, 1138 (3d Cir.1995), *cert. denied* 519 U.S. 808 (1996); *see Doe v. City of New York*, 15 F.3d 264, 267 (2d Cir.1994). Though prognoses and

drug treatments have improved, HIV remains a serious medical condition and "social perceptions of HIV have yet to catch up with the modern realities of the illness." *Matson*, 631 F.3d at 64 n.6.

> Undoubtedly exacerbated by the terror that accompanied the disease in its early history, a relentless stigma adheres to HIV. This stigma has at least two plausible sources. First, HIV is most frequently found among historically marginalized populations: particularly, gay men. Prejudice against homosexuals intensifies prejudice against HIV, and prejudice against HIV becomes a proxy for prejudice against members of the gay community. Because HIV is also more common among minorities and the poor, the stigma attached to HIV deeply implicates race and class prejudice, as well as homophobia. A second source of stigma stems from the means of HIV transmission. The plaintiffs' expert, Dr. Frederick Altice, an international authority on HIV and the Director of the HIV in Prisons Program at Yale University School of Medicine, explained: "People make judgments just by the virtue of HIV that you must have done ... something dirty or something awful to have acquired HIV. Being gay. Being a prostitute. Being sexually promiscuous." These impressions build upon negative stereotypes about the groups most commonly affected by HIV.

Henderson v. Thomas, 2012 WL 6681773 at *2-3. Privacy regarding HIV status is even more essential for a prisoner, as a prisoner identified as HIV-positive "will be severely compromised in his ability to maintain whatever dignity and individuality a prison environment allows." *Doe v. Coughlin*, 697 F.Supp. at 1238.

In *Borucki*, the First Circuit Court of Appeals, in weighing a claim that disclosure of the content of psychiatric reports prepared in the course of a criminal matter violated the plaintiff's right to privacy, declined to decide whether a constitutional right to privacy regarding medical records existed. *See Borucki v. Ryan*, 827 F.2d 836, 841-44 (1st Cir. 1987). Instead, the Court conducted a qualified immunity analysis and held only that no clearly established right of privacy protected a former defendant's court-ordered psychiatric report from disclosure after the criminal case had been dismissed. *Id.* Nevertheless, since *Borucki*, several district court decisions in this Circuit have recognized the existence of a right to privacy in one's medical information. *See Flood v. Maine Dept. of Corrections*, 2012 WL 5389533, *26 (2012); *Klein*, 2010 WL 3245291 at *4; *Hodgdon v. Downeast Correctional Facility*, 2010 WL 53504, *4

(2010); *Marchand v. Town of Hamilton,* 2009 WL 3246607, *7 (D.Mass. 2009); *Magnusson*, 2005 WL 758454 at *10-11*; Pouliot v. Town of Fairfield*, 184 F.Supp.2d 38, 50 (D.Me. 2002); *Town of Plymouth*, 825 F.Supp. at 1107. Plaintiffs have a right to avoid unwanted disclosures of their HIV-positive status.

2. Defendants Violate Plaintiffs' Right to Privacy, and This Disclosure Is Not Reasonably Related to a Legitimate Penological Interest.

The removal of all HIV medications from the KOP program has resulted and will continue to result in unauthorized disclosures of HIV status to prisoners and correctional staff. Defendants enacted the policy change in the face of clinicians' objections, which included the privacy problems caused by forcing HIV-positive prisoners to attend med line. Defendants knew that the policy change would result in privacy violations, but they moved forward anyway.

Those problems manifested themselves from the start, as Plaintiffs (and others) suddenly went from not attending med line to attending it every day. Pls.' SMF ¶ 213. Since the policy change, unwanted disclosures have arisen in different contexts. John Doe pointed out the location of a poster showing HIV medications, for all to see and compare to the medications being given to HIV patients. Pls.' SMF ¶ 214. Carl Coe described the prying eyes at med line, where many prisoners are trying to identify the medications that others take. *Id.* ¶ 211-212. Plaintiffs have heard med line nurses announce that it was HIV medication being administered. *Id.* ¶ 215. Medical staff have used different cups for the HIV medications, and given a high sign to the med line CO, who observes all of the goings-on at med line. *See* Defs.' Ex. 6 at pp. 80-81. Plaintiffs have been asked questions that would force them to disclose their own status. Pls.' SMF ¶¶ 216-217, 219. They have had prisoners accost them and ask about their status. Pls.' Ex. 13 at ¶ 12; Pls.' Ex. 14 at ¶ 8; Pls.' Ex. 15 at ¶ 9; Pls.' Ex. 16 at ¶ 8.

Defendants suggest that Plaintiffs suffered from an equal number of unwanted disclosures under the KOP program. The evidence suggests otherwise. If unit officers did have access to information about Plaintiffs' status, they either did not review that information or were discreet about it. Plaintiffs were able to keep their medications hidden in transit between the KOP line and their cells. They were able to maintain privacy from their cellmates, if they chose. Pls.' Ex. 13 at ¶¶ 6-12; Pls.' Ex. 14 at ¶¶ 6-9; Pls.' Ex. 15 at ¶¶ 6-9; Pls.' Ex. 16 at ¶¶ 5-10; *see Henderson*, 2012 WL 6681773 at *34 (finding that voluntary disclosure differs from forced disclosure).

To make matters worse, the procedure Defendants propose to accommodate Plaintiffs when they are too ill to attend daily med line presents more privacy concerns, as it requires that the prisoners disclose their HIV status to an officer in their unit. Experience suggests that the CO will ask the HIV-positive prisoner why his medications are so important, or whether he cannot just skip them. Pls.' SMF ¶ 219. Moreover, other staff and prisoners may overhear the disclosure to the unit officer, or the officer's communications to medical staff. Those who observe this unique process for someone who is not in acute distress will inevitably learn that the process is for prisoners with HIV.

A prisoner's constitutional right may be curtailed by a policy or regulation that is shown to be "reasonably related to legitimate penological interests." *Turner v. Safley,* 482 U.S. 78, 89 (1987). The Supreme Court has set forth several factors relevant in determining the reasonableness of a prisoner regulation or policy: (1) "there must be a 'valid, rational connection' between the [policy] and the legitimate governmental interest put forward to justify it"; (2) "whether there are alternative means of exercising the right that remains open to prison inmates"; (3) "the impact accommodation of the asserted constitutional right will have on guards

and other inmates, and on the allocation of prison resources generally"; and (4) the absence or existence of a ready alternative "that fully accommodates the prisoner's rights at *de minimis* cost to valid penological interests." *Id*. at 89-90. The existence of obvious, easy alternatives may be evidence that the regulation is not reasonable, but is an "exaggerated response" to prison concerns. *Id*. at 91. Defendants contend that the policy change is reasonably related to the goals of medication adherence and medication waste prevention. Even assuming that the penological purpose advanced by Defendants is legitimate, it is clear that Defendants' actions were and are not reasonable.

First, there is no valid, rational connection between the policy that was implemented and the penological interests advanced. Defendants' expressed desire to improve adherence is gainsaid by their own adherence analyses, which depict significant late refills and medication interruptions, many of a duration that threatens serious harm. Medical staff was already evaluating adherence on an individual basis using multiple measures, including the patient MAR and chart. Removing all HIV patients from the KOP program does not further the interest of adherence.

The connection to medication waste is no more valid or rational. Waste from returned medications is a problem attributable to staff's failure to follow policy, not patient misconduct. Plaintiffs and other long-term, rarely transferred prisoners do not cause waste. Whatever meager benefits this policy change offers, such benefits "are insufficient standing alone to warrant permitting infringement of the prisoner's right to privacy." *Coughlin*, 697 F.Supp. at 1241 (holding that prisoners are entitled to protection against non-consensual disclosure HIV status through involuntary placement in a separate dormitory for HIV-positive prisoners, after

balancing against legitimate penological interests of improved health care for HIV-positive prisoners and reduced costs of transportation to medical appointments).

Second, HIV-positive prisoners have no alternative means to exercise their right to privacy. Once their status has been disclosed, the right "is lost forever." *Nolley*, 776 F.Supp. at 733, 736.

Third, accommodating HIV-positive prisoners' constitutional right to privacy will have a minimal impact on staff and other prisoners, given that for years KOP was available for HIV medications. See *Nolley*, 776 F.Supp. at 733, 736. If anything, removing HIV-positive prisoners from the KOP program actually increased the number of prisoners at med line, creating a greater burden on facility staffing of the medication line.

Fourth, restoring KOP eligibility is an obvious, ready alternative with *de minimis* cost to valid penological interests. Defendants would still be able to ensure adherence and reduce waste, by enforcing the KOP policy to suspend an individual patient's privileges when warranted, and by ensuring that medications actually go with a discharged or transferred prisoner. Removing all HIV medications from KOP eligibility for all prisoners was an exaggerated response to an exaggerated issue.

The privacy violations here are inextricably related to the policy change requiring HIV-positive prisoners to obtain their HIV medications at med line. The policy and procedure give rise to repeated gratuitous disclosures. Such violations of HIV-positive prisoners' right to privacy are not reasonably related to a penological purpose. *See Powell,* 175 F.3d at 109, 112 ("[T]he gratuitous disclosure of an inmate's confidential medical information as humor or gossip-the apparent circumstance of the disclosure in this case-is *not* reasonably related to a legitimate penological interest, and it therefore violates the inmate's constitutional right to

privacy."); *Magnusson,* 2005 WL 758454 at *11. Defendants' policies[5] are laudable but do not prevent these disclosures.

H. Richard Nunes' Accommodation Claim Raises Trial-Worthy Issues.

Along with Plaintiffs' discrimination claim under the ADA and Rehabilitation Act, Richard Nunes asserts a claim under those statutes for failure to accommodate. In its ruling on Richard Nunes' Motion for a Preliminary Injunction, the Court stated that it could not hold, on the limited record before it, that the accommodations being offered to Mr. Nunes were unreasonable. 1:10-CV-12013-RWZ Document No. 66 (September 30, 2011 Order). Defendants' pleas notwithstanding, the failure to obtain a preliminary injunction does not equate to a claim that fails as a matter of law. *See Francisco Sanchez v. Esso Standard Oil Co*., 572 F.3d 1, 14-15 (1st Cir. 2009) (finding that a preliminary injunction is "traditionally viewed as relief of an extraordinary nature and does not purport to be a disposition on the merits"). There are disputed issues as to the severity of Mr. Nunes' conditions and the reasonableness of Defendants' proposed accommodations. These issues should be aired at a trial, where the court can hear from the parties directly.

In particular, Defendants' proposed accommodation for when Mr. Nunes is feeling too ill to attend med line rings hollow. Defendants propose to send a nurse to evaluate Mr. Nunes and determine whether to admit him to the HSU. This is a blunt instrument for symptoms which heretofore have never been deemed worthy of HSU admission. It is intentionally blunt, as the

[5] UMCH Policy 9.00 Privacy of Care: "5. When the presence of security staff is required for the staff safety, every effort will be made to provide auditory and visual privacy."
UMCH Policy 61.00 Confidentiality and Storage of Health Records: "1. The subject of confidentiality of medical records will be included in staff orientation upon hire and will be reviewed periodically thereafter. 2. Non-medical staff that observe or overhear a clinical encounter will be instructed on the requirements of confidentiality.
UMCH Policy 62.02 Release of HIV Information and Test Results: "1. Identifiable information regarding the results of the any HIV test performed on an inmate will not be disclosed to anyone other than the health services staff without prior written consent."

prospect of being removed to the HSU is designed to discourage requests. *See* 1:10-CV-12013-RWZ Document No. 62 (Nunes Affidavit date June 14, 2011).

Of course, a nurse could come to the unit and contest Mr. Nunes' claim of illness. The proposed accommodation does not speak to what happens then. If the nurse does contest Mr. Nunes' claim of illness, given the time it will take for this process to unfold, he will surely miss his medications. In addition, one omission in the proposed accommodation belies its reasonableness – regardless of what the nurse finds, he or she will *not bring Mr. Nunes his medications*. If the nurse is making a special trip out of the HSU to Mr. Nunes' cell, he or she could at least bring his medicine, should the nurse verify his illness. Still, Defendants refuse to make even this common-sense feature part of the accommodation. That the Defendants' plan omits this obvious method of ensuring timely medication access suggests that at least with respect to Mr. Nunes, patient adherence is not of foremost importance to them.

Other pitfalls exist. As Mr. Nunes' disciplinary report for being out of place shows, Mr. Nunes cannot force his unit officers to call the HSU when he feels too ill to go to med line. Officers are trained to call the HSU about emergencies, not mundane illness. The whole process could take so long that the opportunity to take that dose of HIV medication is lost.

It is far from clear that Mr. Nunes is the unreasonable one, despite what Defendants say. Mr. Nunes has proposed other solutions, requesting the ability to line up either first or last at med line so as to avoid the painful standing, and to expedite matters when he has diarrhea or feels ill. Although the Defendants have permitted other HIV-positive inmates with disabilities no more severe than Mr. Nunes' to come to med line early, such as Mr. Doe – *see* Defs.' Ex. 89 (Doe Accommodation Correspondence, Defendants refused Mr. Nunes this option alleging that there is no medical necessity. Although Defendants suggest it impossible to provide the simplest

accommodation to Mr. Nunes – KOP medication – they have exempted one facility, Concord Farm (NECC) from the DOT requirement. Pls.' SMF ¶¶ 224, 246. Mr. Nunes in fact has qualified for reclassification to minimum custody and has requested reclassification to NECC, where he could resume his medications on the KOP program. UMCH has declined to recommend such a placement.

A prison violates the ADA when a prisoner is forced to endure unnecessary hardship, when it could make a reasonable accommodation. *See Shedlock v. Dep't of Correction*, 442 Mass. 844, 856 (2004). Mr. Nunes' claim is fact-intensive and raises issues of each party's credibility. Accordingly, the court should deny summary judgment on Mr. Nunes' ADA claim.

I. <u>The Claims Against the Individual UMCH Defendants Are Not Redundant.</u>

Defendant UMCH moves to dismiss the claims against the individual Medical Defendants (Mr. McGuire, Dr. Ferguson, Dr. Steinberg, Dr. Groblewski) in their official capacities on the ground that these claims are redundant of claims brought against the entity UMCH. UMCH's motion disregards the present reality of this case, one which it brought about. The individual defendants are the *only* defendants for the Fourteenth Amendment and Eighth Amendment claims (Counts I and V) and are not named defendants for the ADA and the Rehabilitation Act claims (Counts III and IV), meaning there is no redundancy.

Initially, Plaintiffs brought suit against both the individual UMCH defendants and UMCH on the constitutional claims. UMCH brought a motion to dismiss all claims against the official entity UMCH, arguing that, as a state entity, it was entitled to immunity under the Eleventh Amendment. Plaintiffs agreed to dismiss the constitutional claims against UMCH, leaving as defendants only the individual Medical Defendants in their official capacities. UMCH remained the defendant on the ADA and Rehabilitation Act claims. In a one-sentence order, the

Court approved this resolution. Their counsel having sought and obtained UMCH's dismissal from the constitutional claims, the individual Medical Defendants cannot now be heard to seek dismissal as well.

IV. CONCLUSION

For the foregoing reasons, Defendants' summary judgment motions should be denied.

Respectfully submitted,
Attorneys for Plaintiffs,

/s/ Joel H. Thompson
Joel H. Thompson, BBO #662164
jthompson@plsma.org
Tatum A. Pritchard, BBO #664502
tpritchard@plsma.org
Prisoners' Legal Services
10 Winthrop Square, 3rd Flr.
Boston, MA 02110
(617) 482-2773

CERTIFICATE OF SERVICE

I hereby certify that this document(s) filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on February 14, 2013.

/s/ Joel H. Thompson
Joel H. Thompson