UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
UNITED STATES COURT HOUSE
NEW YORK, N. Y. 10007

CHAMBERS OF
JUDGE MORRIS E. LASKER

May 8, 1990

TO: Dale A. Wilker, Esq.
Marcia Levy, Esq.
Julie E. O'Neill, Esq.
Chlarens Orsland, Esq.

RE: Vega v. Sielaff
82 Civ. 6475(MEL)

Enclosed please find a resume drawn up in these Chambers regarding the statements made at my visit to the "isolation" rooms and C-73 at Rikers Island last week.

Will you please let me know as quickly as possible whether your recollection differs in any substantial manner from this resume and, if so, how? Promptly after my hearing from you, I will be prepared to rule on the pending matter.

Very truly yours,

Morris E. Lasker

Revised 5/22/90

Vega v. Sielaff, 82 Civ. 6475 (MEL): Report of May 3, 1990 Visit by the Court to Rikers Island

On May 3, 1990, the court toured the AIDS patient infirmary housing in Dorm 4 ("the AIDS module") and the Contagious Disease Unit at C-73 ("the C-73 CDU") at Rikers Island.[1] The purpose of the tour was to allow the court to make a visual inspection of the facilities in which AIDS patients are housed and to consult with the physicians who care for the patients. The following constitute the court's observations during the tour.

The city estimates that 20% of the inmate population in the New York City Correction System is infected with the AIDS virus.[2] Of that 20%, a smaller group has been

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[1] The court was accompanied by Dale Wilker of the Legal Aid Society, Julie O'Neill and Chlarens Orsland of the Corporation Counsel's Office, Robert Daly, General Counsel of the Department of Correction, Sharon Keilin, Deputy Commissioner for Capital Planning and Development of the Department of Correction and others. The following physicians were present during the tour: Margaret Grossi, M.D., Deputy Commissioner for Medical Affairs, New York City Department of Health; Jack J. Adler, M.D., Medical Director, New York City Department of Health, Bureau of Tuberculosis; Wallace Rooney, M.D., Medical Director, New York City Department of Health, Prison Health Services; Charles Braslow, M.D., Program Director, Montefiore Rikers Island Health Services; Eran Bellin, M.D., Director of Infectious Diseases, Montefiore Rikers Island Health Services; Dennis Oliver, M.D., Chief Physician, North Infirmary Center, Montefiore Rikers Island Health Services; and Merle Cunningham, M.D., Senior Assistant Vice President for Clinical Affairs, Health and Hospitals Corporation.

[2] The city does not test all inmates for the AIDS virus. City officials derive their estimate of the number of infected inmates from inmate histories taken upon admission which indicate that 40% of the male inmates have

classified as "AIDS patients" based on guidelines issued by the Center for Disease Control ("CDC").[3] All city inmates with AIDS who are in need of infirmary care are housed in the AIDS module at Rikers. In addition, some AIDS patients who are not in need of infirmary care choose to live in the AIDS module for their own protection and support.

AIDS patients at Rikers who exhibit no symptoms of secondary contagious diseases live in dormitory-style housing in the AIDS module. A large open room (labeled "30: WARD RM 2" on the attached map) contains 20 beds for AIDS patients and a smaller room (labeled "28: PRV.HSNG" on the map) adjacent to the large one contains 10 beds for AIDS patients, separated by partitions. The partitions provide patients who are particularly ill with some modicum of privacy but do not prevent the spread of contagious diseases.

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a history of intravenous drug use. Figures from methadone maintenance clinics indicate that 55% of intravenous drug users are infected with the AIDS virus.

[3] Dr. Bellin, Director of Infectious Diseases for Montefiore Rikers Island Health Services, and Dr. Braslow, Program Director of the Montefiore Rikers Island Health Services, indicated that the CDC guidelines set up an "artificial distinction" between AIDS patients and other HIV-positive patients who have not yet exhibited the same symptoms as AIDS patients. The physicians explained that HIV-positive patients are more properly thought of as falling along a spectrum or continuum rather than as two discrete groups of AIDS patients and non-AIDS patients.

While the issue of AIDS patient classification is not currently before the court, it may become relevant at some later time if medical experience reveals that HIV-positive patients who are not currently classified as AIDS patients are also at high risk of contracting infectious diseases from other inmates.

AIDS patients who exhibit definite symptoms of secondary infectious diseases such as tuberculosis ("high suspicion" patients) are removed from the AIDS module and sent to one of the New York City Health and Hospitals Corporation facilities (Bellevue or Kings County Hospital, collectively "HHC") for evaluation and treatment.[4] Those patients who, in the opinion of the house staff at HHC, are in need of hospitalization, remain at HHC. Some high suspicion patients are returned to Rikers without being admitted to HHC because, in the opinion of the HHC staff, they do not require hospitalization. Once the high suspicion patients return to Rikers, they are housed in the C-73 CDU until the physicians at Rikers determine that they are no longer contagious to others.

C-73 CDU

Dr. Bellin explained that the C-73 CDU was not built to contain respiratory diseases and does not have adequate ventilation to do so. Although an attempt is made to prevent patients with different contagious diseases from infecting each other in the C-73 CDU by cohorting the patients and housing different disease groups in separate rooms, the rooms are not effectively sealed off from each other and air circulating throughout the unit can carry

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[4] Dr. Braslow estimated that approximately one new patient per week moves into the "high suspicion" category and there are approximately 4-5 "high suspicion" patients at any given time.

diseases between disease groups. As evidence of this phenomenon, Dr. Bellin cited the fact that chicken pox had been transmitted within the unit between rooms that share a common hallway. Dr. Bellin also stated that on previous occasions, he has felt the wind blowing through the unit from the room where patients with tuberculosis are housed.

The city has been exploring the possibility of retrofitting the C-73 CDU to achieve isolation conditions. However, Sharon Keilin, Deputy Commissioner for Capital Planning and Development for the Department of Corrections, indicated that an attempt to upgrade the exhaust system by installing new fans had failed to produce negative air pressure. The situation is complicated by the presence of asbestos above the ceiling.

Dr. Bellin explained that true respiratory isolation would require that tuberculosis patients be housed in individual rooms where they would remain during a two week course of treatment which would render them non-infectious to others.[5] The area within the C-73 CDU where tuberculosis patients are currently housed contains several individual rooms. However, the ventilation in those rooms is inadequate and difficult to improve. The installation of ultraviolet

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[5] Dr. Adler stated that a two week period for treatment is not a uniformly agreed-upon time period for rendering a tuberculosis patient non-infectious. He noted that many clinicians feel that a few days of effective anti-tuberculosis medications render the patient non-infectious and therefore that one week in isolation would be adequate.

lights in the individual rooms would kill some airborne bacteria, but would not be sufficient alone to produce the equivalent of isolation conditions. Dr. Braslow pointed out that the windows would need to be sealed to achieve isolation and because the C-73 CDU, like the AIDS module, is often uncomfortably hot, sealing is not currently a workable possibility. The city has considered installing individual air conditioners in the rooms and opening wall areas for new exhaust fans through the walls. However, it could take a long time to acquire the necessary equipment and there is no guarantee that these changes would produce medically appropriate ventilation.

The absence of true respiratory isolation in the C-73 CDU presents a serious current health hazard for AIDS patients who are housed there. For example, an AIDS patient who is moved to the C-73 CDU because he has chicken pox might contract tuberculosis through his exposure to infected patients there. Dr. Bellin eloquently expressed the grave danger which the AIDS patients housed in the C-73 CDU face when he said that the lives of those patients are "forfeit."[6]

HHC

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[6] Ms. O'Neill indicated that the Nursery Beacon Jail, currently scheduled to open in September, will contain isolation rooms which will be appropriate for both high and low suspicion patients. Mr. Wilker expressed concern about whether Nursery Beacon will be ready to open on time and stressed the need to find medically appropriate housing for contagious patients immediately.

Drs. Braslow and Bellin stated that from their point of view, it would be better for contagious patients to remain at HHC because although perfect isolation may not be available at HHC, the number of patients exposed at Rikers is much higher than at HHC and many of the patients exposed are particularly susceptible because they have AIDS.

Dr. Cunningham, Senior Assistant Vice President for Clinical Affairs of the Health and Hospitals Corporation, indicated that some patients with contagious diseases are returned to Rikers because they do not need acute hospital care and the crowding at HHC is so serious that it does not have room to keep such patients. He explained that on any given day, there may be as many as 15-20 critically ill patients waiting in the emergency room at an HHC hospital for a bed to become available.[7]

Dr. Braslow stated that sometimes contagious patients who are sent to HHC are returned to Rikers sooner than the physicians at Rikers believe is appropriate. For example, the normal medication period for patients with tuberculosis is two weeks. However, HHC sometimes sends such patients back to Rikers after only five days of medication when they might still be highly contagious. Dr. Braslow also mentioned that sometimes the physicians at HHC disagree with

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[7] Dr. Bellin also indicated that if Rikers had better accomodations for isolating infectious patients, HHC would "decompress," i.e., release more Rikers patients sooner, thereby freeing up space for other, presumably sicker, patients.

the diagnosis made by the physicians at Rikers. For example, the physicians at Rikers might send a particular patient to HHC because they believe he has pneumonia. The physicians at HHC might disagree and send the patient back to Rikers. If the physicians at Rikers still believe the patient has pneumonia, that patient will be sent to the C-73 CDU.

Dr. Bellin indicated that the release of contagious patients from HCC might well be medically appropriate if the patients were being sent home where their families had already been exposed to them. However, when the patients are returned to jail, they endanger AIDS patients and patients who are HIV-positive with immunodeficiency, many of whom may not have been previously exposed to them.

The "Isolation" Rooms

Under the circumstances, the physicians who care for the AIDS patients are reluctant to send them to the C-73 CDU unless absolutely necessary. In response to these exigencies, a practice has arisen of placing AIDS patients who exhibit non-specific, ambiguous symptoms which might or might not indicate the presence of secondary contagious disease ("low suspicion" patients)[8] in six "isolation" rooms

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[8] Dr. Bellin offered the following example to illustrate the difference between "high suspicion" patients who are sent to HHC and the C-73 CDU and "low suspicion" patients who are placed in the "isolation" rooms. A patient who suddenly develops an abnormal chest X-ray, a cough and a fever would be classified as "high suspicion" for tuberculosis. By contrast, if a patient who has an abnormal chest X-ray because of some pre-existing condition (i.e., not tuberculosis) develops a cough, the physicians evaluating

(labelled "16-21 ISOLATION" on the map) adjacent to the dormitories in which the rest of the AIDS patients are housed.

At the present time, these six "isolation" rooms are not equipped to provide total isolation between the patients who are housed in them and the rest of the patients in the AIDS module. "Low suspicion" patients spend approximately two weeks in the "isolation" rooms before a definite diagnosis is made. If the patient is diagnosed as having a contagious disease through testing or moves into the high suspicion category through the development of more definite symptoms, he is sent to HHC. If the physicians determines that the patient does not have a contagious disease, he is returned to the regular AIDS dormitories. Dr. Oliver, Chief Physician of the North Infirmary Center of Montefiore Rikers Island Health Services, explained that some of the "low suspicion" patients who have been placed in the "isolation" rooms in the past six months to a year that the rooms have been in use have later been found to have contagious diseases such as tuberculosis. According to the physicians, there has been no obvious spread of tuberculosis as a result of the use of the isolation cells, although some patients who previously had negative skin tests have later

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that patient have less reason to believe that the patient has tuberculosis and therefore that patient is classified as "low suspicion."

developed positive skin tests.[9]

City officials hope that certain capital improvements will effectively eliminate any risk of transmission of disease from the patients in the six "isolation" rooms to the other AIDS patients. Thus the ventilation system has been adjusted to achieve negative air pressure in each of the six rooms[10] and plans exist to construct walls at both ends of the corridor off of which the "isolation" rooms are located. Dr. Adler, Medical Director of the New York City Department of Health, Bureau of Tuberculosis, explained (and it was unanimously agreed) that a properly functioning and maintained negative air pressure system can effectively prevent the spread of respiratory illness if it achieves six air exchanges per hour, as

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[9] Some AIDS patients with tuberculosis may have falsely negative skin test reactions because of immunosuppression.

[10] Each pair of isolation rooms shares an individual heating/air conditioning intake unit that provides air at the appropriate temperature for those two rooms. Each individual room has an exhaust to the outside. The adjustments to the ventilation units necessary to achieve negative air pressure and the correct exhanges of air were completed prior to the court's visit. The adjustments to regulate temperature control were still in progress at that time.

The subcontractor who completed the work on the ventilation system advised the Department of Correction that on April 20, 1990, the subcontractor tested the air pressure in each room and found that there was an intake of 325 cubic feet per minute ("cfm") into each room and an exhaust of 350 cfm. The Department of Correction used these figures to conclude that there were 22 changes of air per hour.

recommended by the Center for Disease Control.[11]

Once the renovations are complete, the city plans to retain an independent air balancer (other than the subcontractor which performed the renovations) to determine whether adequate negative air pressure has been achieved. The staff of the facility will continuously monitor the air pressure on a daily basis using a velometer and will be instructed to record their measurements in a log book kept for that purpose.

Three major concerns surfaced with regard to the city's ability to maintain the negative air pressure: 1) the possibility of mechanical breakdown in the ventilation system; 2) the possibility that inmates or others will open windows, thereby destroying the negative pressure; and 3) the problem of traffic in and out of the "isolation" area.

Ms. O'Neill explained that in the event of a mechanical breakdown in the ventilation system, the patients in the "isolation" unit would be immediately relocated to an as yet undetermined section of the facility.

Currently, inmates open windows in their "isolation" rooms because the rooms are frequently too warm. Ms. O'Neill explained that city officials are hopeful that when adjustments to the air conditioning system are

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[11] Dr. Adler expressed the opinion that when all the renovations are completed and the new walls provide an anteroom to the individual rooms, the isolation rooms will be "state of the art" in New York City.

completed, the temperature problem will be resolved. The windows will then be sealed so that they cannot be opened.

The problem of traffic flow in and out of the isolation unit is not susceptible to easy resolution. Currently, patients in the "isolation" rooms are "locked in" their rooms for 23 hours each day and allowed to circulate freely throughout the AIDS module for one hour each day. The physicians explained that such a practice effectively destroys any respiratory isolation that might otherwise have been achieved and that their warnings in this regard have not been heeded by staff. Ms. O'Neill indicated that the physicians could order that the patients be confined to their "isolation" rooms at all times. However, there is no law library in the "isolation" area and therefore patients must leave that area to use the law library.[12]

Even if the patients were confined in their rooms all the time, nurses, physicians and food service workers (among others) must travel between the "isolation" area and the dormitory area within the AIDS module. Opening doors will disrupt the negative air pressure and staff may carry contagious diseases out of the isolation area and into the

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[12] Patients in the AIDS module use the law library located off the main corridor in the North Infirmary Building (the building to which the AIDS module is attached). Patients in C-73 CDU (located on the second floor of C-73) use the law library on the first floor of C-73.

The court observed that even if the low suspicion patients were housed in a separate building, they might need to leave that building to use a law library.

AIDS dormitory area.

Although only "low suspicion" patients are currently being placed in the "isolation" rooms, Dr. Bellin indicated that if the physicians are permitted to house "low suspicion" patients in the six "isolation" rooms and no medically acceptable alternative is found for the "high suspicion" patients, their definition of "low suspicion" is likely to expand to include some patients who are currently classified as "high suspicion." Dr. Bellin explained that his ethical responsibility towards those patients who are currently classified as "high suspicion" would require him to at least consider the possibility of housing them in the "isolation" rooms rather than in the C-73 CDU where they would be at high risk of contracting other infectious diseases. Dr. Bellin emphasized that he would strongly prefer to have a medically appropriate alternative to housing "high suspicion" patients in the C-73 CDU so that he would not have to consider using the isolation rooms for that purpose.