UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

CIVIL ACTION
NO. 10-cv-12013-RWZ

RICHARD NUNES, et al,

Plaintiffs,

v.

UMASS CORRECTIONAL HEALTH, et al.,

Defendants.

DEPARTMENT OF CORRECTION AND PETER HEFFERNAN'S MOTION FOR SUMMARY JUDGMENT

Defendants, the Massachusetts Department of Correction and Peter Heffernan, hereby move, pursuant to Fed. R. Civ. P. 56, for summary judgment in their favor on all counts. Wherefore, for the reasons in the accompanying memorandum of law, this motion should be allowed.

Respectfully submitted,

NANCY ANKERS WHITE
Special Assistant Attorney General

Dated: December 14, 2012

/s/ Sheryl F. Grant

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CERTIFICATE OF SERVICE

I hereby certify that this document 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 the NEF this date.

Date: December 14, 2012

/s/ Sheryl F. Grant

Sheryl F. Grant, Counsel

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DEPARTMENT OF CORRECTION'S AND PETER HEFFERNAN'S MEMORANDUM OF LAW IN SUPPORT OF THEIR MOTION FOR SUMMARY JUDGMENT

Defendants, the Massachusetts Department of Correction ("Department" or "DOC') and Peter Heffernan, submit this memorandum of law in support of their Motion for Summary Judgment.

INTRODUCTION

Plaintiffs, Richard Nunes, Carl Coe, John Doe, Peter Poe and Richard Roe,[1] all inmates presently confined in DOC correctional facilities, have brought the instant Complaint against the Department and defendant Heffernan, as well as UMASS Correctional Health ("UMCH") and various UMCH defendants, wherein plaintiffs seek injunctive/declaratory relief. See Complaint. The relief the plaintiffs seek pertains to a DOC/UMCH policy change that took effect on February, 2, 2009, wherein HIV medications were no longer approved as Keep on Person ("KOP") medications. See Complaint.

[1] With the exception of plaintiff Nunes, who is identified in the Complaint, pseudonyms from the Complaint are utilized for the other plaintiffs in accordance with the Protective Order entered in this case.

With the KOP program, inmates periodically go to the Health Services Unit ("HSU") to request refills of their KOP medication and later return to the HSU and wait in a KOP medication line to receive the refills. [DOC Facts[2] ¶¶ 30-34]. Inmates then bring the KOP medications back to their cells, where it is up to the inmates to administer the medications themselves. [DOC Facts ¶¶ 34-35]. As of February 2, 2009, this policy was changed so that inmates in general population units attend daily medication lines ("med lines") at the HSU to receive their HIV medications via Directly Observed Therapy ("DOT"), where, as the name suggests, staff directly observes the inmates ingest their medications. [DOC Facts ¶¶ 24-27, 96].

The plaintiffs allege that this change: 1) constitutes cruel and unusual punishment, in violation of the Eighth and Fourteenth Amendments to the United States Constitution; 2) violates their Equal Protection rights under the Fourteenth Amendment to the United States Constitution; 3) violates Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (hereafter "Rehab Act"); and 4) violates the Americans with Disabilities Act, 42 U.S. C. § 12132 ("ADA"). Plaintiffs Coe, Doe, Poe and Roe further allege that their constitutional right to privacy under the Fourteenth Amendment has been violated. Plaintiffs seek declarations that these aforementioned rights have been violated and seek a permanent injunction ordering the defendants to restore all HIV medications to the KOP program. Complaint, pp. 31-36.

STATEMENT OF MATERIAL FACTS

Defendants refer the Court to, and incorporate by reference, DOC defendants' statement of undisputed material facts, drafted pursuant to Local Rule 56.1, being filed, under seal, this same day.

[2] The Department of Correction's and Peter Heffernan's Statement of Undisputed Material Facts will be cited herein as "DOC Facts."

STANDARD OF REVIEW

Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. (56); Celotex Corp. v. Catrett, 477 U.S. 317, 322-23 (1986); see also Conward v.Cambridge School Committee, 171 F.3d 12, 18 (1st Cir.1999). "An issue is genuine if 'it may reasonably be resolved in favor of either party' at trial, Garside, 895 F.2d at 48, and material if it 'possess[es] the capacity to sway the outcome of the litigation under the applicable law,' Cadle Co. v. Hayes, 116 F.3d 957, 960 (1st Cir.1997) (citation and internal quotation marks omitted)." Iverson v. City of Boston, 452 F.3d 94, 97 (1st Cir. 2006). To defeat a summary judgment motion, the non-movant must demonstrate, through "submissions of evidentiary quality, that a trialworthy issue persists." Id. "Withal, a measure of factual specificity is required; 'a conglomeration of 'conclusory allegations, improbable inferences, and unsupported speculation' is insufficient to discharge the non-movant's burden.' DePoutot, 424 F.3d at 117 (quoting Medina-Munoz v. R.J. Reynolds Tobacco Co., 896 F.2d 5, 8 (1st Cir.1990))." Id. "When opposing parties tell two different stories, one of which is blatantly contradicted by the record, so that no reasonable jury could believe it, a court should not adopt that version of the facts for purposes of ruling on a motion for summary judgment." Scott v. Harris, 550 U.S. 372, 380 (2007).

To obtain a permanent injunction, the plaintiffs must demonstrate that they would suffer irreparable injury without the injunction, that the harm to the plaintiffs would exceed the harm to the defendants from the imposition of the injunction, and that the public interest would not be adversely served by an injunction. Aponte v. Calderon, 284 F.3d 84, 190 (1st Cir. 2002)

Further, the Prison Litigation Reform Act ("PLRA"), 18 U.S.C. § 3626, limits the scope of prospective relief in prison cases. The PLRA states:

> Prospective relief in any civil action with respect to prison conditions shall extend no further than necessary to correct the violation of the Federal right of a particular plaintiff or plaintiffs. The court shall not grant or approve any prospective relief unless the court finds that such relief is narrowly drawn, extends no further than necessary to correct the violation of the Federal right, and is the least intrusive means necessary to correct the violation of the Federal right. The court shall give substantial weight to any adverse impact on public safety or the operation of a criminal justice system caused by the relief.

18 U.S.C. § 3626(a)(1)(A). The Supreme Court has interpreted this language as meaning that "the scope of the order must be determined with reference to the constitutional violations established by the specific plaintiffs before the court." Brown v. Plata, 131 S.Ct. 1910, 1940 (2011). "In essence, § 3636(a)(1)(A) requires that a court find a violation of a federal right before ordering any prospective relief and then narrowly tailor the remedy ordered to assure that it does no more than correct that violation." Disability Law Center v. Mass. Dept. of Correction, No. 07-10463-MLW, 2012 WL 1237760, *11 (D. Mass. 2012).

I. SOME PLAINTIFFS FAILED TO PROPERLY EXHAUST THEIR ADMINISTRATIVE REMEDIES IN RELATION TO CERTAIN CLAIMS.

The PLRA, 42 U.S.C. §1997e(a), provides, in pertinent part:

> No action shall be brought with respect to prison conditions under section 1983 of this title, or any other Federal law, by a prisoner confined in any jail, prison, or other correctional facility until such administrative remedies as are available are exhausted.

42 U.S.C. § 1997e(a). A plaintiff must properly exhaust his administrative remedies as to *each* claim raised in order to pursue that claim in his Complaint. Jones v. Bock, 127 S.Ct. 910, 923-924 (2007) (no unexhausted claim may be considered); Stokes v. Commissioner of Correction, 26 Mass. App. Ct. 585, 590 (1988). Indeed, plaintiffs constitutional claims as well as those under the ADA and Rehabilitation Act fall under the PLRA as they all purport to relate to prison conditions as well as "other Federal law and thus require exhaustion. See e.g., Pacheco v. Zurlo, 2011 WL 1103102, *2 (N.D.N.Y.) *report and recommendation adopted by,* 2011 WL 1102769 (N.D.N.Y. 2011)(inmate who did not complete DOCS's three-tier grievance process before filing

complaint under the ADA failed to exhaust administrative remedies).; Alster v. Goord, 745 F. Supp. 2d 317, 322 (S.D. N.Y. 2010); Arc v. O'Connell, 427 F. Supp. 2d 435, 440 (S.D. N.Y. 2006). Further, proper exhaustion is required. Woodford v. Ngo, 548 U.S. 81, 126 S.Ct. 2378, 2385-2386 (2006). "[T]o properly exhaust administrative remedies, prisoners must 'complete the administrative review process in accordance with the applicable procedural rules,' Woodford, 548 U.S., at ---(slip op., at 5)-rules that are defined . . . by the prison grievance process itself. Compliance with prison grievance procedures, therefore, is ... required...." Jones v. Bock, 127 S.Ct. at 922-923. Thus, "[t]o exhaust remedies, a prisoner must file complaints and appeals in the place, and at the time, the prison's administrative rules require." Pozo v. McCaughtry, 286 F.3d 1022, 1025 (7th Cir. 2002). Failure to exhaust the administrative review process mandates dismissal of the claims. Jones, 127 S.Ct. at 922-923; Casanova v. DuBois, 289 F.3d 142, 147 (1st Cir. 2002).

A. Requests for Reasonable Accommodations

The Department has a policy in effect that requires inmates to submit requests for reasonable accommodation in accordance with the procedures outlined in 103 DOC 207, Requests for Reasonable Accommodations. [DOC Facts ¶¶ 177-181]. Plaintiffs Coe, Doe, Poe and Roe's failure to follow this process requires dismissal of their ADA/Rehab Act claims as set forth herein.

To the extent the Complaint could be construed as encompassing claims under the ADA and Rehab Act that the defendants did not provide reasonable accommodations for them in relation to the policy change by providing them their HIV medications KOP, such claims must be dismissed as to plaintiffs ***Coe, Doe, Poe and Roe*** because they made no request for reasonable

accommodation seeking this relief. Nor did ***Coe, Poe or Roe*** submit a request for reasonable accommodation seeking any other type of relief.

Carl Coe, Peter Poe and Richard Roe did not submit any requests for reasonable accommodation in connection with the policy change for HIV medications to DOT, whether to have their HIV medications KOP or for any other accommodation to attend the med line. [DOC Facts ¶¶ 186, 196, 197].

John Doe did not submit a request for reasonable accommodation to allow him to have his HIV medications KOP. [DOC Facts ¶¶ 188-195]. The only accommodation request submitted by John Doe was made in August 2009 to allow him to go to an early medication line in the evening. [Id.]. From August 25, 2009 through the end of July 2010, Doe was allowed to go to the front of the evening medication line until UMCH determined that the accommodation was no longer medically required. [DOC Facts ¶¶ 191-193]. Per his doctor's order, Mr. Doe now takes his HIV medications once a day in the morning. [DOC Facts ¶ 326].

B. Grievances

In accordance with 103 DOC 630.02(10), UMCH has established an administrative procedure for resolving inmate medical issues, informally called the medical grievance process; UMCH's procedures are outlined in UMCH Policy 12.00. [DOC Facts ¶¶ 182-183]. To properly grieve a medical matter, an inmate must first file a grievance with UMCH and, if dissatisfied with that result, appeal to UMCH; if dissatisfied with the UMCH appeal response, the inmate must appeal to DOC. [DOC Facts ¶ 184]. Inmates are responsible for maintaining copies of their medical grievance files. [DOC Facts ¶ 185].

Carl Coe – As delineated in the DOC Facts, Carl Coe never filed any grievance in which he claimed that his right to privacy was violated due to the change in policy. [DOC Facts ¶¶ 207-218]. As such, any right to privacy claim by Coe should be dismissed.

John Doe – As delineated in the DOC Facts, as pertains to the change in policy, John Doe only *properly* completed the grievance process with regard to one grievance, which dealt with an allegation of violation of privacy. [DOC Facts ¶¶ 222-239]. In other instances, Doe failed to pursue all appellate avenues, wrote letters, not grievances, and/or produced no evidence that he filed them with UMCH in the first instance. [Id.]. In the one grievance in which Mr. Doe properly followed all the required procedures, he complained of a single instance where a nurse purportedly asked him if he was on HIV medications within earshot of another inmate; he did not allege this other inmate actually heard what was said. [DOC Facts ¶¶ 229-233].[3] As such, with the exception of the claim relating to the right to privacy, Mr. Doe failed to properly exhaust his administrative remedies. All of Mr. Doe's other claims should be dismissed.

Richard Roe

Richard Roe properly filed and appealed one medical grievance, in which he claimed the change in policy invaded his right to privacy. [DOC Facts ¶¶ 256-260]. He did not file any other medical grievances complaining about any other allegations in the Complaint. [DOC Facts¶¶ 256-262]. During the pendency of this case, Mr. Roe filed a DOC grievance, pursuant to 103 CMR 491, in which he complained of one correction officer firing him from his job, purportedly because he somehow found out that Mr. Roe was HIV positive. [DOC Facts ¶ 261]. Mr. Roe has not filed any other grievances regarding the claims set forth in the Complaint. [DOC Facts ¶¶ 256-262]. As such, with the exception of the claim relating to the right to pri-

[3] The only other grievance brought to the attention of DOC was one in which Mr. Doe alleged that he had missed dosages of HIV medications due to an institutional emergency or officers "not calling meds loud enough." [DOC Facts ¶¶ 237-239]. However, in this latter grievance, Mr. Doe never filed an appeal with UMCH as required. [Id.].

vacy, Mr. Roe failed to properly exhaust his administrative remedies. All of Mr. Roe's other claims should be dismissed.

Regardless, even if all plaintiffs had properly exhausted all administrative remedies, defendants are still entitled to summary judgment.

II. THE ADA'S COMPREHENSIVE REMEDIAL SCHEME BARS § 1983 CLAIMS.

It is well settled that § 1983 may be used to enforce rights contained in the Constitution as well as rights contained in federal statutes. Maine v. Thiboutot, 448 U.S. 1, 4-8 (1980). However, an exception exists when a federal statute contains a comprehensive remedial scheme. The Supreme Court has held that, "[w]hen the remedial devices provided in a particular Act are sufficiently comprehensive, they may suffice to demonstrate congressional intent to preclude the remedy of suits under § 1983." Middlesex County Sewerage Authority v. National Sea Clammers Association, 453 U.S. 1, 20 (1981). A number of federal courts, including this one, have concluded that the ADA provides a comprehensive remedial scheme which precludes § 1983 actions. See Davis v. Francis Howell School Dist., 104 F.3d 204, 206 (8th Cir. 1997); Pona v. Cecil Whittacker's Inc., 155 F.3d 1034, 1038 (8th Cir. 1997); Meara v. Bennett, 27 F. Supp.2d 288, 291-292 (D. Mass. 1998); Holbrook v. City of Alpharetta, 112 F.3d 1522, 1531 (11th Cir. 1997); Coffey v. County of Hennepin, 23 F. Supp. 2d 1081, 1089 (D. Minn. 1998); Houck v. City of Prairie Village, 978 F. Supp 1397, 1405 (D. Kan. 1997); Metzger v. Lehigh Valley Housing Authority, 1999 WL 562756 (E.D. Pa. 1999); Krocka v. Bransfield, 969 F. Supp. 1073, 1090 (D. Kan. 1997). The Eighth Circuit, in Pona, supra, explained that the ADA's "detailed" enforcement provisions were "imported" from Title VII of the Civil Rights Act of 1964 and, as such, it too was deemed to preclude § 1983 actions. Pona, 155 F.3d at 1038.

In the instant case, plaintiffs' claims under § 1983 mirror the issues raised under the ADA and Rehab Act and they rely on the same set of facts to support all theories of liability. Accordingly, since the ADA and Rehab Act provide comprehensive remedial schemes, and plaintiffs' §1983 claims directly relate to their claims under the ADA and RA, the defendants are entitled to judgment on the § 1983 claims as a matter of law. See Meara v. Bennett, supra. In any event, even if each claim were considered on its merits, defendants are entitled to judgment in their favor.

III. THE DEFENDANTS ARE ENTITLED TO SUMMARY JUDGMENT ON THE EIGHTH AMENDMENT CLAIM.

The plaintiffs allege that the change in policy constitutes cruel and unusual punishment because the defendants supposedly enacted this policy "knowing it would reduce, rather than improve, adherence" and that it would discourage HIV inmates from taking their HIV medications altogether, resulting in a cost savings to DOC and UMCH. Complaint ¶¶ 192. Plaintiffs assert that defendants enacted the change supposedly knowing that it would result in impaired access to the med lines, due to various issues, such as delays, conflicts with med line times, breaches of privacy and increased risk of illness from attending the med line. Complaint ¶¶ 189-191.

Plaintiffs have no reasonable expectation of proving the elements necessary to prove this claim. Based on the evidence in this case, no reasonable fact finder could return a verdict for the plaintiffs. Indeed, as described, infra, the evidence undisputedly shows that there was no discriminatory or other improper purpose for the change in policy and, since the change in policy, there has been *improvement* in the clinical outcomes of the inmate population as a whole as pertains to HIV treatment. [DOC Facts ¶¶ 419-420].

A. Legal Standard

"After incarceration, only the unnecessary and wanton infliction of pain constitutes cruel and unusual punishment forbidden by the Eighth Amendment." Whitely v. Albers, 475 U.S. 312, 319 (1986), quoting Ingraham v. Wright, 430 U.S. 651, 670 (1977) (internal quotation marks omitted). In order to sustain an Eighth Amendment claim involving prison medical treatment, an inmate must prove that the prison officials' actions amounted to "deliberate indifference to a serious medical need." DesRosiers v. Moran, 949 F.2d 15, 18 (1st Cir 1991), citing Estelle v. Gamble, 429 U.S. 97, 104-106 (1976). See Layne v. Vinzant, 657 F.2d 468, 474 (1st Cir. 1981). "Deliberate indifference is conduct that offends evolving standards of decency in a civilized society." DesRosiers, 949 F.2d at 18, citing Rhodes v. Chapman, 452 U.S. 337, 347 (1981). In other words, deliberate indifference to serious medical needs amounts to the "unnecessary and wanton infliction of pain." Estelle, 429 U.S. at 104. "A medical need is 'serious' if it is one that has been diagnosed by a physician as mandating treatment, or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." Gaudreault v. Municipality of Salem, 923 F.2d 203, 208 (1st Cir. 1990).

An inmate can prove deliberate indifference by establishing that he has been denied medical treatment as a punishment or that prison medical personnel have made "wanton decisions to deny or delay care." Watson v. Caton, 984 F.2d 537, 540 (1st Cir. 1993). It is well established, however, that mere negligence does not constitute deliberate indifference. DesRosiers, 949 F.2d at 19. Mere disagreement over the course of treatment, or the source of treatment, does not constitute "deliberate indifference." Sires, 834 F.2d at 12-13; Ferranti v. Moran, 618 F.2d 888, 890-891 (1st Cir. 1980). Where the dispute concerns, not the absence of medical care, but

the choice of a certain course of treatment, the plaintiff must prove that the treatment was "so clearly inadequate as to amount to a refusal to provide essential care." Torraco v. Maloney, 923 F.2d 231, 234 (1st Cir. 1991), quoting Miranda v. Munoz, 770 F.2d 255, 259 (1st Cir. 1985).

"In evaluating the quality of medical care in an institutional setting, courts must fairly weigh the practical constraints facing prison officials." DesRosiers, 949 F.2d at 19. In determining whether an inmate has proven the culpable state of mind of a prison official, this is to be assessed by considering "the officials' response to an inmate's known needs or by denial, delay, or interference with prescribed health care." Id. Moreover, when the issues pertain to matters such as medical diagnoses and/or the manner and means of medical treatment, prison officials are entitled to rely upon qualified medical professionals for such assessments. Sires v. Berman, 834 F.2d 9, 13 (1st Cir. 1987) ("prison officials, after proper investigation, learned of and relied upon the recommendations of the doctors and nurses, as they are entitled to do"); Layne , 657 F.2d at 472; Camberos v. Branstad, 73 F.3d 174, 176 (8th Cir. 1995); McCracken v. Jones, 562 F.2d 22, 24 (10th Cir. 1977); Rosen v. Chang, 811 F.Supp. 754, 761 (D.R.I. 1993).

Presuming for purposes of this motion that the plaintiffs' HIV status constitutes a serious medical need, there is simply no evidence to which plaintiffs can point to prove the elements of this claim. Plaintiffs' complaints simply pertain to the *manner* in which they receive their HIV medication. There is no right, constitutional or otherwise, for an inmate to possess any medication as KOP; rather, "the relevant right is plaintiff's right to adequate medical treatment." Iseley v. Dragovich, 2003 WL 1793968 (E.D. Pa. 2003) (inmate had no right to keep inhaler on his person—so long as it is available as needed, no constitutional violation). All the HIV medications that plaintiffs have been prescribed are fully available to them at the med line.

B. Goals of Policy Change and the Goals Achieved.

Plaintiffs' assertion that the policy change was made in an effort to reduce inmate adherence to their HIV treatment regimens and that it was this reduced adherence that would result in a cost savings, is belied by all the evidence in this case. First, one of the express stated goals of the policy change was to increase inmate adherence to their HIV treatment regimens. [DOC Facts ¶¶ 51, 97, 420]. Given that inmates on KOP medications are not observed ingesting their medications, the only true objective means to measure adherence is to utilize pharmacy claims data, showing whether inmates request refills on time, and to look at inmates' viral load data. [DOC Facts ¶ 49]. Viral load data indicates whether the HIV medication regime is working or not, i.e., whether the viral load is detectable or undetectable. The overall main clinical goal for an HIV inmate is to have an undetectable viral load. [DOC Facts ¶ 50].

When the policy change was first being considered viral load data showed that only about 84% of the inmate population had an undetectable viral load. [DOC Facts ¶ 111]. Data also showed that, prior to the change in policy, there were a significant number of inmates on the KOP program requesting refills of their HIV medications either early or late, indicating they may not be in compliance with their medication regimes. [DOC Facts ¶ 60, 62]. Further, a review done of a cohort of inmates with detectable viral loads showed a correlation between the inmates with detectable viral loads and their adherence to their medication regimes; that review showed an overall adherence rate of only 81.2%. [DOC Facts ¶¶ 92-94]. Adherence rates of 95% or greater are the recommended goal for treatment of HIV patients. [DOC Facts ¶ 95].

While cost savings is always a consideration, only cost savings that would not negatively impact patient care and outcomes were considered. [DOC Facts ¶¶ 51, 84]. In 2008, UMCH was required, pursuant to M.G.L. c 29, § 9C, to review all its expenditures involving the De-

partment, including staffing modes, models for delivery of care and whether there was waste and/or redundancies, in order to determine if any efficiencies could be gained, all viewed with an eye to minimize or avoid impact on the inmate patients. [DOC Facts 51]. As such, there were discussions in 2008 regarding KOP compliance and waste of all medications, not just HIV medications. [DOC Facts ¶¶ 58-62]. Indeed, there were repeated and ongoing discussions of possibly removing Over-the-Counter medications from the KOP program. [DOC Facts ¶ 58]. SOPS conducted its own internal review of *all* wasted medications in the KOP program and found that the largest issue involving waste that implicated a cost savings among KOP medications was with the HIV medications. [DOC Facts ¶¶ 60-61].

The cost savings would come through SOPS' "Reclaim and Reuse" program for medications, which is where unused medications are returned to SOPS for determination as to whether they are waste or eligible for Reclaim and Reuse, in which case a credit it awarded back. [DOC Facts ¶ 54]. With the DOT program, HIV medications remain in the hands of licensed medical staff and, as such, are eligible for Reclaim and Reuse. [DOC Facts ¶¶ 53-56]. Medications provided to inmates through the KOP program, however, are not eligible for Reclaim and Reuse. [DOC Facts ¶ 56]. The SOPS data that was presented to UMCH and DOC illustrated that if HIV medications were removed from the KOP program, there was a potential to save up to $150,000 to $175,000 per year, due to reduced waste of medications and the ability to utilize the Reclaim and Reuse program, not reduced inmate adherence. [DOC Facts ¶ 63].

To the extent plaintiffs fault defendants for saving taxpayer money without negatively impacting patient care, their argument fails because the courts have long recognized that reducing unnecessary expenses is a valid penological interest. See e.g. Shakur v. Schriro, 514 F.3d 878, 885-86 (9th Cir. 2008) ("the reduction of administrative and budgetary concerns" is a le-

gitimate penological interest); Hall v. Ekpe, 408 Fed.Appx. 385, 388 (2d Cir. 2010) ("economy by minimizing unnecessary expenses" is a legitimate penological interest); Berryman v. Granholm, 343 Fed.Appx. 1, (6th Cir. 2009) ("controlling the cost" of a program is a legitimate penological interest); see also Turner, 482 U.S. at 89 (stating that "the allocation of prison resources" is to be taken into account).

In response to concerns voiced by some infectious disease doctors and nurses that a change to DOT may have a negative impact on the inmates, UMCH suspended the implementation of the policy change in order to gather more data and UMCH proposed an "Interim Plan." [DOC Facts ¶ 83]. Although the infectious disease doctors and nurses believed that inmates were compliant with their KOP HIV medications, this belief was largely based on self-reports of adherence, which are unreliable, and was not based on any aggregate data that they had compiled or reviewed. [DOC Facts ¶¶ 72- 73, 78-80].

UMCH considered and looked at all data, including viral loads and adherence rates, as well as information which showed that 93% of inmates on HIV medications already attended the daily med line for other medications. [DOC Facts ¶¶ 83-87]. Further, pharmacy claims data for June 2008 showed that 44% of all inmates obtaining their HIV medications KOP had requested refills late or failed to request refills at all; notably, this included four of the five plaintiffs from this case – *Carl Coe, John Doe, Peter Poe, and Richard Roe*.[4] [DOC Facts ¶ 88]. There was also a concern regarding early refills of one of the drugs, Atripla, because that drug has some "street value," so there was some question as to what the drug may be being used for. [DOC Facts ¶ 90]. UMCH was also aware that other states had successfully utilized DOT for administration of HIV meds and UMCH reached out to staff in Maryland about their program. [DOC

[4] Further, shortly before the policy change, Mr. Doe submitted grievances in which he complained that when he attended the KOP med line, his HIV medications were not available. This was due to the fact that Mr. Doe had been failing to turn in renewal stickers to request refills of his HIV KOP medications [DOC Facts ¶¶ 219-220].

Facts ¶ 91]. Ultimately, after consideration of all the data, input from clinical staff and consideration of medical literature and studies that indicated distributing medications DOT *increased* compliance rates, the decision was made to change the policy and implement DOT for HIV medications as of February 2, 2009. [DOC Facts ¶ 96].

Since the February 2, 2009 change in policy, UMCH has continued to monitor the HIV medication program and collected, or was provided data, relating to adherence and viral loads, and has provided summaries of the data to the Department. [DOC Facts ¶102]. The purpose of this monitoring was for quality assurance purposes to ensure that the DOT initiative did not have a negative impact on the inmates. [DOC Facts ¶ 103]. The Adherence Analysis reports demonstrate that there has been an increase in inmate compliance with HIV medications since the conversion to DOT. [DOC Facts ¶ 108].

Moreover, the viral load data demonstrates a marked *increase* in the percentage of inmates with undetectable viral loads since the change in policy. [DOC Facts ¶¶ 111-112]. For the two reporting periods before the policy change, only 84% and 83% of inmates on a stable HIV medication regimen had undetectable viral loads. [DOC Facts ¶111]. The percentage of inmates on HIV medications with an undetectable viral load has been higher for every reporting period since the policy change, which occurred close to four years ago now. [DOC Facts ¶¶ 111-112]. For the two most recent reporting periods in 2012, **95%** of inmates on HIV medications had an **undetectable** viral load. [DOC Facts ¶ 112]. The viral load data also shows that for the two reporting periods prior to the change in policy, 30 and 36 HIV positive inmates for each respective period were not on stable HIV treatment; for the two most recent reporting periods in 2012, only 19 and 19 inmates for each respective period were not on stable HIV treatment. [DOC Facts ¶ 113]. Thus, there is no validity to plaintiffs' assertion that the policy change has resulted in

fewer inmates taking their HIV medications or that there is decreased adherence. Reclaim and Reuse data also shows that, since the change policy a cost savings has been effected through reclaimed costs for HIV medications. [DOC Facts ¶ 114].

In 2011, there was also an outside audit conducted by the Department of Public Health ("DPH"), which looked at the care of HIV-infected inmates in DOC. [DOC Facts ¶ 140]. The DPH Audit compared its results with results for HIV positive populations in the community, both within and without Massachusetts, and found that the "performance and outcome measures compared favorably with those observed in the care system in the general community and reported by a large health maintenance organization." [DOC Facts ¶ 147]. The audit concluded that the overall care compares well with generally recognized performance and outcome standards and concluded "The combination of case management and infectious disease specialty care, in addition to ongoing primary care, works well to deliver care to HIV-infected inmates, as evidence[d] by the high prevalence of viral load suppression which is similar to or exceeds reported rates in community settings." [DOC Facts ¶ 148].

Also in 2011, MGT of America, Inc. conducted an analysis of all health care issues in DOC. [DOC Facts ¶¶ 149-151]. In regard to the current policies involving pharmacy services, MGT concluded that the "[c]urrent policies are well crafted to minimize inventory, safeguard drugs from potential diversion of abuse, and minimize waste," and further stated that "[DOC], UMCH, MHM and SOPS should be credited with tight drug management policies and practices." [DOC Facts ¶ 151].

C. *Plaintiffs Have Not Produced Evidence to Support Their Assertions.*

What really emerges from the facts of this case in regard to Mr. Nunes is the portrait of an inmate who is simply refusing the medical care offered to him because it is not being dis-

pensed in the manner of his choosing.[5] What emerges from the facts in regard to the other plaintiffs is that they simply prefer to have their HIV meds KOP because it is more convenient for them. A mere disagreement as to the appropriate treatment or manner of treatment does not implicate a violation of an inmate's rights, since the "[r]ight to be free from cruel and unusual punishment does not include the right to treatment of one's choice." Layne, 657 F.2d at 473. See Jackson, 846 F.2d at 817; Ferranti, 618 F.2d at 890-891. The standard applied in the First Circuit is that inmates receive adequate medical care, not that correctional authorities cater to the individual preference of each inmate. United States v. DeCologero, 821 F.2d 39, 42 (1st Cir. 1987); Chase v. Quick, 596 F.Supp. 33, 35 (D.R.I. 1984).

The only "evidence" the plaintiffs have produced in an attempt to dispute the availability of their HIV medication at the med line consists mostly of anecdotal assertions or speculation that there could be difficulty in getting to the med line due to weather, scheduling conflicts, and/or illness, that their HIV medication was not available on some occasion, the med line was not called and/or fear of illness from waiting in the med line. Even if all these alleged assertions were true, which the evidence does not support, all it demonstrates is that no system is perfect and that there may have been sporadic issues that arose. It is hardly evidence that there is any systemic problem that denies the inmates access to their medication that would support a finding of a constitutional violation requiring restoration of HIV medications to the KOP program.

What the evidence does show is that in the instances where the plaintiffs, or other inmates, have complained about such issues, the matters were addressed and steps taken to resolve any legitimate issues. [DOC Facts ¶¶ 130-138]. For example, where scheduling conflicts have arisen, the timing of the med line has been changed and, where some inmates needed food with

[5] When Mr. Nunes has been in a Special Management Unit, he has taken his HIV medications. [DOC Facts ¶ 416]. Mr. Nunes also frequently refuses to have his blood drawn or attend medical appointments. [DOC Facts ¶¶ 373-375].

their medications, UMCH has written food orders. [DOC Facts ¶ 132]. If an inmate reports he is too ill to go to the med line, the inmate is supposed to tell a correction officer, who will notify medical staff to determine how to proceed. [DOC Facts ¶ 133]. Notably, although some of the plaintiffs claimed that, on rare occasion they felt too ill or injured to go to the med line, none of the plaintiffs[6] alleged they ever told DOC staff on such occasions or that they even filed sick slips; thus, neither DOC nor UMCH even had an opportunity to accommodate the plaintiffs because the purported need was not made known. [DOC Facts ¶¶ 297, 321-322, 360]. When any issue pertaining to HIV medications has been reported by an inmate, the inmate is individually counseled by an Infectious Disease Case Manager, who, in turn, works with UMCH and Department staff to implement accommodations as appropriate. [DOC Facts 134].

Moreover, many of these purported "issues" would exist with either the KOP med line/program or with DOT. When medications are received as KOP, in order to turn in refill stickers and then to pick up refills, the inmates have to walk to the same location, i.e, the HSU, as they do for DOT. [DOC Facts ¶ 30]. The inmates also have to wait in a line with other inmates to obtain the KOP medications, just as with DOT. [DOC Facts ¶¶ 30-31, 33]. Further, based on the testimony of the plaintiffs, the wait time for the KOP med lines is comparable with, and sometimes longer than, the wait times in the DOT med lines. [DOC Facts ¶¶ 33, 299, 312, 338, 348, 352, 358, 377, 380, 409].

Additionally, although plaintiffs[7] state they are concerned about privacy, they simply *assume* others know their HIV status; they have produced no evidence to demonstrate that anyone, whether inmate or staff, ascertained their HIV positive status as a result of the daily med line.

[6] Mr. Nunes has never intended or attempted to go to the daily med line for his HIV medications since the policy change. [DOC Facts ¶ 204].

[7] Plaintiff Nunes does not seek any relief directly related to allegations his privacy was breached. He is already open about his HIV status and has not attended the daily med line to get his HIV medications.

[DOC Facts ¶¶ 300-302, 319, 339-342, 354-357]. In fact, for the most part, it seemed that the plaintiffs were more concerned with privacy issues as a result of attending medical appointments. [DOC Facts ¶¶ 320, 343, 357]. Moreover, the KOP process potentially implicates privacy concerns to the same, if not greater extent, than the DOT process. Inmates in a KOP med line are given entire blister packs of their medications and the inmates then have to carry these whole packs back to their cells. [DOC Facts ¶ 34]. Pursuant to DOC policy, correctional staff also periodically conduct inspections and searches of inmates' cells and, when doing so, are required to utilize a report detailing which KOP medications an inmate is prescribed, verify that all KOP medications are properly secured, verify the KOP medications are properly labeled, are current, and belong to that inmate. [DOC Facts ¶ 36]. If anything, it is far easier for inmates and staff to possibly see what medications an inmate is receiving through the KOP program, than with DOT.

As for plaintiffs' purported fear of getting ill from the med line, there is no credible evidence to which plaintiffs can point to demonstrate that this supposed risk is any greater as a result of being in a DOT med line, as opposed to a KOP med line or anywhere else in the prison. As noted in the next paragraph, the plaintiffs are around other inmates every day, and in close proximity to them. Tellingly, not one of the plaintiffs claims to have actually gotten ill from the med line or produced evidence of anyone becoming ill from the med line, despite the DOT policy being in place for HIV medications for almost four years now.

Regarding assertions of the med line supposedly not being called, plaintiffs rely on only their unsupported general assertions that this occurred. Plaintiffs have produced no evidence this has actually occurred, or that, if it had happened on occasion, it is a systemic issue for all inmates. Indeed, only plaintiff Coe exhausted his administrative remedies regarding such general allegations through the grievance process; he filed a grievance where he alleged on "rare" occa-

sions the med line had not been called. [DOC Facts ¶¶207-277]. At his deposition, Coe estimated that this had happened a total of four times since the policy change and further testified it had not happened recently. [DOC Facts ¶¶ 296, 298]. While John Doe filed an initial grievance in July 2010 making broad allegations of med lines not being called, he provided no factual details and did not properly exhaust his remedies. [DOC Facts ¶¶ 237-239]. In any event, John Doe's own testimony at his deposition belies his assertions. He testified that between February 2009 and December 2011 he was "faithfully" at med line twice a day for his HIV medications. [DOC Facts ¶ 324]. Mr. Doe further testified he had missed the med line for other reasons, such as oversleeping or *not hearing* the correction officers call the line, which would mean that the med line was, in fact, called. [DOC Facts ¶ 323]. Peter Poe has provided no testimony or alleged in the Complaint that this has occurred in any instance when he needed to attend a med line. [DOC Facts ¶¶ 330-349; Complaint ¶¶ 169-176]. Similarly, Richard Roe neither alleged in the Complaint, nor in his testimony, that there have been instances where staff failed to call a med line.[8]

While it is possible that an emergency situation could arise impacting inmate movement, such as a med line, this is not something that regularly occurs and, in the event inmate movement is stopped for an extended period of time, accommodations are made to ensure that all inmates receive their medications. [DOC Facts ¶ 28]. Either UMCH staff bring medications to inmate housing units, or inmates may be allowed out of a particular unit to go to the med line as deemed appropriate. [DOC Facts ¶ 28]. None of the plaintiffs alleged in the Complaint that institutional emergencies hindered their access to HIV medications. See Complaint.

[8] As noted above, Mr. Nunes has never intended or attempted to go to the med line since the change and makes no allegations in the Complaint regarding this happening to him.

As for the plaintiffs' general assertion that it is a burden to get to the med line because they have to walk there on a daily basis and may have to go outside, defendants first note that since Mr. Nunes has never intended or attempted to even go to the daily med line to get his HIV medications since the change in policy [DOC Facts ¶ 204], he can rely on nothing other than speculation, which is insufficient. In any event, the plaintiffs have produced no credible evidence upon which a fact finder could rely to support this assertion. In fact, all of the plaintiffs, including Mr. Nunes[9], routinely move about their respectively facilities on a daily basis for various reasons, such as to get their meals three times a day, attend programs, exercise, work at jobs, and attend medical appointments. [DOC Facts ¶¶ 281-285, 308, 333, 353, 392-394, 401-404]. Additionally, other than Mr. Nunes, none of the other plaintiffs even claims to have any physical disability or limitation that would impact his ability to get to and stand in the med line.

Regarding Mr. Nunes' claim that he has physical limitations that impact his ability to walk to and stand in the med line, this matter has already been resolved. Whatever physical infirmities Mr. Nunes may have, which could theoretically impact his ability to attend and/or stand in the med line on some days, have already been addressed through reasonable accommodations offered to him by DOC and UMCH, which this Court has already found sufficient when it denied Mr. Nunes' Motion for Preliminary Injunction. [DOC Facts ¶¶ 157-176]. Further, there has been no material change since the Court made the finding that Mr. Nunes' concerns have been adequately addressed. The accommodations include: 1) Mr. Nunes is able to utilize a bench in the HSU to sit on during med line, should the need arise, without losing his place in line; 2) Mr. Nunes can use the bathroom in the HSU during med line, should the need arise; 3) Mr. Nunes was referred for use of a rolling walker; and 4) in instances where Mr. Nunes contends he is too

[9] This pertains to when inmates are in general population. When an inmate is not in general population, he/she has never had access to HIV medications as KOP even before the change in policy. [DOC Facts ¶ 38].

ill to go to med line, he is to report this a correction officer who, in turn, will report this to medical staff, who will assess him to determine how to proceed. [DOC Facts ¶¶157-176]. Nunes has refused to cooperate in the process to assess him for a walker. [DOC Facts ¶ 167]. Further, as noted above, by Mr. Nunes' own admission at his deposition, he has never intended or attempted to go to the daily med line to get his HIV medications. [DOC Facts ¶ 204]. Thus, there could not possibly have been any attempt on his part to invoke the accommodations offered to him.

Ultimately, the plaintiffs' "evidence" amounts to nothing more than a list of isolated instances or wholly speculative concerns, which neither individually nor in combination provide a basis for the broad relief sought by the plaintiffs, i.e., a declaration that the whole policy/practice is unconstitutional. There is no system based or wide constitutional or statutory defect remotely requiring such expansive relief.

Finally, plaintiffs have not produced any objective evidence whatsoever to support their assertions that inmate adherence has declined since the change in policy or that anyone "knew" adherence would be reduced. [DOC Facts ¶ 402]. As described above, the evidence is completely to the contrary. The facts clearly demonstrate that, at the time of the policy change, the goals of DOC and UMCH were to increase inmate adherence to HIV medication regimes and to also reduce waste of HIV medications, thereby effecting a cost savings. The evidence[10] clearly demonstrates that these goals have been achieved.

D. ***Crediting of Plaintiffs' Argument Would Result in the Department Being Unable to Operate Daily Med Lines to Administer Medications.***

If the plaintiffs' argument were to be credited, i.e., a DOT med line is unconstitutional for the reasons alleged, this would mean that every DOT med line in the Department is unconstitutional. Inmates receiving medications for any number of reasons attend the daily med lines in

[10] In fact, at the time of their depositions, other than Mr. Nunes who has refused to go to the med line for his HIV medications, all of the plaintiffs had undetectable viral loads. [DOC Facts ¶¶ 304, 327, 349, 366].

various DOC facilities to receive any and all medications that are administered DOT, not just HIV medications. Thus, the same arguments that plaintiffs assert regarding the supposed "unconstitutionality" of the DOT med line as pertains to HIV medications would apply to the same med line where all other medications are administered. Plaintiffs fail to make any allegations or provide any explanation as to how or why the DOT med line process would be unconstitutional solely as to HIV positive inmates, but not as to any other inmates who utilize the same DOT process.

The KOP program is not a right, but a privilege, and numerous other classes of medications are currently excluded from the KOP program, including all antituberculin drugs, psychotherapeutics, antidepressants, anticonvulsants, anti-gout agents, injectable medications and controlled substances. [DOC Facts ¶ 39, 41]. Many of these medications are for treatment of various illnesses/diseases/disabilities, such as tuberculosis and mental illness, which other inmates would similarly not want unnecessarily revealed. Even inmates with KOP privileges for approved KOP medications can have their privileges revoked for varied reasons such as failing to keep their medications secured, abuse of the program/medication or because the inmate is unable to comprehend the rules and regulations regarding administering the medications KOP. [DOC Facts 41]. Inmates excluded from the KOP program or who have their KOP privileges terminated also go to daily med lines at DOC facilities. [DOC Facts 42]. The plaintiffs offer no argument that it is unconstitutional for inmates excluded or suspended from the KOP program (which would include inmates taking HIV medications) to have to attend the daily med line, or allege it is unconstitutional for other inmates taking any of the other classes of KOP excluded medications to have to attend the daily med line. Indeed, in the Complaint, the plaintiffs appear

to concede a need for, and the utility of, the daily med lines at DOC facilities. See Complaint ¶¶ 31, 33.

In sum, for all the aforementioned reasons, the plaintiffs have no reasonable likelihood of prevailing on an Eighth Amendment claim. The evidence shows that the defendants acted in good faith relying on evidence that the policy change would benefit the inmate population and reduce waste when they made the policy change. The evidence shows that since the policy change there is *increased* inmate adherence to HIV medications and a marked increase in the percentage of inmates with undetectable viral loads. Indeed, this data suggests that if this Court were to order restoration of HIV medications to the KOP program, which is the relief the plaintiffs seek, this could actually be harmful to the inmate population. Plaintiffs have no possibility of proving to any reasonable fact finder that the defendants were deliberately indifferent to a serious medical need by implementing a policy that has resulted in better clinical outcomes for the inmate population as a whole.

IV. DEFENDANTS ARE ENTITLED TO SUMMARY JUDGMENT ON THE ADA AND REHAB ACT CLAIMS.

The liability standards under both Title II of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973 are the same. Quiles-Quiles v. Henderson, 439 F.3d 1, 4-5 (1st Cir. 2006). "Therefore, 'the caselaw construing the ADA generally pertains equally to claims under the Rehabilitation Act.'" Id. at 5, quoting Calero-Cerezo v. United States Dep't of Justice, 355 F.3d 6, 19 (1st Cir. 2004).

In order to state a claim under Title II of the ADA, a plaintiff must allege "(1) that he is a qualified individual with a disability; (2) that he was either excluded from participation in or denied the benefit of some public entity's services, programs or activities, or was otherwise discriminated against; and (3) that such an exclusion, denial of benefits, or discrimination was by

reason of his disability." Parker v. Universidad de Puerto Rico, 225 F.3d 1, 5 (1st Cir. 2000) (*citing* 42 U.S.C. §12132). To make out a *prima facie* case of discrimination, a plaintiff must establish that he (1) suffers from a "physical or mental impairment"; (2) that "substantially limits;" (3) "a major life activity."[11] School Board of Nassau County v. Arline, 480 U.S. 273, 279 (1987), *superceded by statute,* see Shiring v. Runyon, 90 F.3d 827 (3rd Cir. 1996); Olson v. General Elec. Astrospace, 101 F.3d 947, 951 (3d Cir. 1996). To state a claim under the Rehab Act, the plaintiff must establish the same requirements with the additional element that the program or activity at issue receive federal funding. See 29 U.S.C. § 794.

Although plaintiffs have positive diagnoses of HIV, they do not allege that they have any disabilities related to their HIV positive status that impacts their ability to attend the med line. Indeed, while HIV positive status may, in some instances, be considered a disability for purposes of the ADA and Rehab Act, see Bragdon v. Abbott, 524 U.S. 624 (1998), this diagnosis does not automatically qualify as a disability for a particular individual. See Carter v. Taylor, 540 F.Supp.2d 522, 528 (D.Del. 2008). To make a prima facie claim regarding their HIV positive status, the plaintiffs would have to set forth evidence that this particular impairment is substantially limiting a major life activity at issue in the instant case. See Bragdon, 524 U.S. at 637-638.

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[11] Major life activities have been defined as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning and working. 29 C.F.R. §1620.2; Rother v. Lutheran General Hospital, 57 F.3d 1446, 1454 (1995) (seeing and learning); Hamm v. Runyon, 51 F.3d 721, 724 (7th Cir. 1995) (walking); Kotlowski v. Eastman Kodak Co., 922 F.Supp. 790, 797 (W.D.N.Y. 1996) (working). "Substantially limits" is defined as "'[u]nable to perform a major life activity that the average person in the general population can perform;' or '[s]ignificantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity as compared to the condition, manner, or duration under which the average person in the general population can perform that same major life activity.'" Sutton v. United Air Lines, Inc., 527 U.S. 471, 480 (1999).

Not all impairments which affect a major life activity will result in a finding of disability under the ADA. See Nedder v. Rivier College, 908 F. Supp. 66, 75 (1st Cir. 1995) (teacher's inability to walk in commencement line not a substantial impairment). The courts consider the following factors: "(1) the nature and severity of the impairment, (2) the duration or expected duration of the impairment, and (3) the permanent or long term impact, or the expected permanent or long term impact of, or resulting from the impairment." Hamm , 51 F.3d 725, *citing* 29 C.F.R. pt. 1630 app. §1630.2(j). The ADA does not recognize "certain intermittent, episodic impairments" as disabilities. Id. Likewise, impairments resulting in minor limitations do not constitute a disability. Sarko v. Penn-Del Directory Co., 968 F.Supp. 1026, 1034 (W.D.Pa. 1997).

As already noted herein, plaintiffs Coe, Doe, Poe and Roe do not allege that they have any disability, whether related to HIV or not, that impacts their ability to attend the med lines.

Even if plaintiffs were found to have a disability under the ADA and Rehab Act that impacted their ability, either occasionally or on a daily basis, to go to the med line, defendants would still be entitled to summary judgment. In such circumstances, "reasonable accommodations" would need to be made to allow plaintiffs to receive their HIV medications. See Bibbo v. Massachusetts Department of Correction, 2010 WL 2991668, * 1 (D.Mass. 2010); Fulton v. Goord, 591 F.3d 37, 43-44 (2nd Cir. 2009). A "reasonable accommodation" does not mean that prison officials must accede to every demand of an inmate; rather, an accommodation is reasonable so long as it gives "meaningful access" to the services sought. Bibbo, 2010 WL 2991668, *1, citing Alexander v. Choate, 469 U.S. 287, 301 (1985).

As argued in Section I, supra, plaintiffs Coe, Doe, Poe and Roe did not submit any reasonable accommodation requests to receive their medications KOP. In fact, of these plaintiffs, only plaintiff Doe submitted *any* proper requests for reasonable accommodation related to attending the med line after the change in policy. [DOC Facts ¶¶ 188-195]. Doe's request was to attend an early evening med line, which, was allowed for a period of time based on medical recommendations. [Id.]. The accommodation is no longer in effect because it is now unnecessary as Mr. Doe now takes all his HIV medications in the morning and testified that he now consistently gets his medications between 8:20 and 8:30 AM every day. [DOC Facts ¶ 326]. He has also had, and presently has, an order in place for an evening snack should it be necessary. [DOC Facts ¶ 195].

In regard to Mr. Nunes, as argued at length in Section III above, the issue of reasonable accommodations related to his alleged disabilities under the ADA has already been fully ad-

dressed by this Court. Mr. Nunes has been afforded various accommodations to assist him in attending the med line, which this Court has already found adequate. Mr. Nunes has presented no evidence of a change in circumstance to require this matter to be considered again. As evidenced by his own deposition testimony that he has never intended or attempted to go to the daily med line to obtain his HIV medications since the change in policy, Mr. Nunes has made no attempt to even invoke any of these accommodations. Nor has Mr. Nunes produced evidence to show that anything about his physical condition has materially changed.

Finally, for all the reasons noted in Section III above, there is no evidence that the plaintiffs have been selectively discriminated against by virtue of their HIV status or any other purported disability. The program change for KOP medications was done for the primary purpose of increasing inmates' adherence to their treatment regimens. Prior to the change, UMCH had found adherence rates among the HIV positive inmate population to be lower than national guidelines. Since the policy change, UMCH data indicates adherence rates have improved. UMCH data also demonstrates that viral loads have decreased to undetectable levels in a higher percentage of inmates since converting to DOT. This is hardly evidence of discrimination based on a disability. The goal of improving the health and safety of inmates is a legitimate penological objective and hardly discriminatory. See Iseley, 2003 WL 1793968, *8.[12] As noted by the First Circuit, in the context of a physician referring an HIV positive patient to another doctor for more specialized treatment, that "[i]t would be nonsensical, and downright contrary to the pur-

[12] If one were to accept the plaintiff's claim that the mere act of excluding a medication as KOP, if such medication is used to treat someone with a disability, regardless of the reason for the exclusion, automatically equates to a violation of the ADA and Rehab Act, defendants would essentially be prohibited from excluding many of the medications currently excluded as KOPs. For example, antituberculin and antipsychotic drugs are excluded from the KOP program. Inmates with tuberculosis and mental illness would also qualify as having disabilities. Additionally, plaintiff's assertion that the only way to accommodate inmates who legitimately have some disability that impacts their ability to receive medications in a med line is to provide the medications as KOP, would open the floodgates to similar claims by other inmates for medications excluded from the KOP program. The varied legitimate reasons for excluding various medications from the KOP program would be compromised. As noted herein, KOP is not the only accommodation possible.

poses of the [ADA] statute, to read the statute's 'solely because of' language to prohibit medical treatment that is appropriate 'solely because of' a patient's disability." Lesley v. Hee Man Chie, M.D., 250 F.3d 47, 53 (1st Cir. 2001). Indeed, to ignore evidence that a change in policy might *benefit* HIV-positive inmates, and then to ignore the results demonstrating that the benefit to these inmates has been achieved, is what would be concerning. See id., at 54 & n.6.

IV. DEFENDANTS ARE ENTITLED TO SUMMARY JUDGMENT ON THE EQUAL PROTECTION CLAIM.

"The Equal Protection Clause of the Fourteenth Amendment...commands that no State shall 'deny to any person within its jurisdiction the equal protection of the laws.' The Equal Protection Clause does not forbid classifications. It simply keeps governmental decisionmakers from treating differently persons who are in all relevant respects alike." Nordlinger v. Hahn, 505 U.S. 1, 10 (1992), quotin F.S. Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920). To state an equal protection claim, a plaintiff has to demonstrate that the defendants treated him differently from other persons situated similarly in all relevant aspects and "that such selective treatment was based on impermissible considerations such as race, religion, intent to inhibit or punish the exercise of constitutional rights, or malicious or bad faith intent to injure a person." Rubinovitz v. Rogato, 60 F.3d 906, 910 (1st Cir. 1995), quoting Yerardi's Moody St. Restaurant & Lounge, Inc. v. Board of Selectmen, 878 F.2d 16, 21 (1st Cir. 1989). See Ortega Cabrera v. Bayamon, 562 F.2d 91, 103 (1st Cir. 1977); Dupont v. Commissioner of Correction, 448 Mass. 389, 399 (2007). HIV-infected inmates do not constitute a suspect class, see Doe v. Wigginton, 21 F.3d 733, 739 (6th Cir. 1994); Mofield v. Bell, 3 Fed. Appx. 441, 443 2001 WL 128383 (6th Cir. 2001) (unpublished), and, as argued in Section III(A) above, there is no constitutional right to receive medications KOP. Plaintiffs have no reasonable possibility of prevailing on this claim.

As an initial matter, plaintiffs have not identified individuals similarly situated in all relevant aspects from whom they were treated differently. Indeed, the plaintiffs' main complaint seems to be that all the HIV positive inmates are being treated similarly and that they have to go to the med line along with other inmates who do not have their medications KOP.

In any event, this claim fails. HIV medications are not the only medications excluded from the KOP program. As noted elsewhere in this memo, in addition to HIV medications, other medications excluded from the KOP program include, among others, all antidepressants, all injectable medications, all psychotherapeutics and all antituberculin drugs. [DOC Facts ¶ 39]. This wide array of medications excluded from the KOP program demonstrate the lack of selective treatment from others similarly situated. As noted elsewhere in this memo, inmates can also be excluded from the KOP program for a variety of reasons including, , failure to comply with the rules and regulations of the program, if they are determined to be at-risk for abuse of the program, being unable to comprehend the rules and regulations, or if they do not have an individual, lockable storage area available to them. Since the KOP program is not available to all inmates, regardless of their HIV status, and numerous classes of drugs meant to treat a wide array of other ailments and diseases are also excluded from the program, there is simply no competent evidence of intentional selection and treatment of plaintiffs.

Further, HIV medications were not the only medications that were initially considered for removal when the possible change was being discussed; rather all KOP drugs were considered. [DOC Facts ¶ 58-60]. Ultimately, SOPS data demonstrated that there was a significant amount of waste with HIV medications and SOPS did not find any opportunities in terms of reducing waste with other KOP medications, as the other medications had no significant dollar amount associated with them. [DOC Facts ¶ 61]. Moreover, the change to DOT for HIV medications

was just one of many potential cost savings measures taken at that time. [DOC Facts ¶¶ 98-99]. In addition, over the years, other medications that had once been approved for inclusion in the KOP program were removed from the KOP approval list. [DOC Facts ¶ 40].

As already discussed in Section III above, in light of all the information available, the decision was made to change the policy because there was potential to actually improve medication compliance, reduce detectable viral loads among the inmate population and to potentially do all this is a more cost efficient manner. [DOC Facts ¶ 97]. All these goals have been achieved.

This is hardly "evidence that defendants harbored any ill will towards plaintiffs, either as individuals or as members of any class of persons, much less that defendants acted with the specific intent of harming them." Ortega Cabrera v. Municipality of Bayamon, 562 F.2d 91, 103 (1st Cir. 1977). Quite the contrary, the evidence demonstrates that there was intent to benefit the HIV positive inmate population, and this intention was achieved. As the First Circuit noted, in the context of an ADA/Rehab Act claim, it would be nonsensical to prohibit people from considering factors/actions that would *benefit* someone with HIV because this very prohibition would arguably put the person with HIV in a different, and arguably worse, position than someone without HIV. Hee Man Chie, 250 F.3d at 53-54 & n. 6.

V. THE DEFENDANTS ARE ENTITLED TO SUMMARY JUDGMENT ON THE RIGHT TO PRIVACY CLAIM.

Plaintiffs allege that defendants have violated their constitutional right to privacy.[13] Complaint at ¶¶ 210-217. The gravamen of the privacy claim is that requiring HIV positive in-

[13] While certainly there are various statutes in Massachusetts and throughout the country that pertain to medical information/privacy, the Complaint only alleges a Federal constitutional violation.

mates to receive their medication in med line with other inmates risks inadvertently disclosing their HIV status to security staff and other inmates.[14] Id. This claim fails for several reasons.

First and foremost, although it has been recognized that individuals have a general constitutionally derived right of privacy which protects an "interest in avoiding disclosure of personal matters," see Whalen v. Roe, 429 U.S. 589, 599 (1977),[15] neither the Supreme Court nor the First Circuit has yet to address whether individuals outside of prison, let alone inmates, have specific privacy rights in connection with the disclosure of medical information. See Borucki v. Ryan, 827 F.2d 836, 840-49 (1st Cir. 1987) (declining to decide whether a constitutional right to privacy regarding medical records exists). "Whether the Fourteenth Amendment includes a right against the disclosure of private information is an unsettled and hotly contested question of law." Coughlin v. Town of Arlington, No. 10-10203-MLW, 2011 WL 6370932, * 13 (D. Mass. 2011). As recently as 2011, the Supreme Court explicitly declined to answer "whether there is a constitutional right to informational privacy." Nat'l Aeronautics & Space Admin. v. Nelson, 131 S.Ct. 746, 756-57 n. 10 (2011). Moreover, the First Circuit has stated that if a constitutional right against disclosure of private information exists at all, it is not clearly established. Borucki, F.2d at 844-45; see Demers ex rel. Demers v. Leominster School Dept., 263 F.Supp.2d 195, 204 n. 4 (D. Mass. 2003) ("The First Circuit has not directly decided whether [the Constitution] protects individuals against dissemination of their confidential medical information."); Coughlin, 2011 WL 6370932, * 13 (noting that "the question remains unsettled in the First Circuit."). The Court in Borucki stated that while Whalen "provides little guidance regarding the nature of the confidentiality branch of the right of privacy, "it does indicate[] that not every government action

[14] As noted in Section III(D) above, this purported "risk' is no different than for all inmates. All inmates getting DOT medications go the same med lines and the same UMCH/DOC privacy policies and protocols are maintained for all inmates. [DOC Facts ¶ 137].

[15] In Whalen, it was held that a statute which required collection by the state of medical data relating to prescription medications, did not violate any constitutional right.

which affects the confidentiality of medical records will impose a constitutionally cognizable burden on the right of privacy." Borucki, 827 F.2d at 841.[16]

The circuit courts that have recognized this specific right for individuals in the community are not uniform as to whether the right exists in the prison setting. Compare Doe v. Wigginton, 21 F.3d 733, 740 (6th Cir. 1994) (disclosure of an inmate's HIV positive status to prison guards did not violate right of privacy under Fourteenth Amendment) with Doe v. Delfie, 257 F.3d 309 (3rd Cir. 1991) (right of privacy encompassed HIV status). See also Moore v. Prevo, 379 F. App'x 425, 428 (6th Cir. 2000) (distinguishing *Wigginton* and holding that an inmate has a constitutionally protected interest in avoiding disclosure of HIV positive status of other inmates, subject to legitimate interests); Holden v. Michigan Department of Corrections, 2012 WL 2317538 (W.D. Mich. 2012) (rejecting claim that correction officer's disclosure of HIV status of inmate violated constitutional rights, finding that *Moore* decision not controlling as *Moore* was unpublished and does not employ the proper analysis); Franklin v. McCaughtery, 110 Fed. App'x. 715 (7th Cir. 2004) (noting Seventh Circuit has never held that inmates enjoy constitutional right of privacy to medical information); Rollins v. Miller, 2012 WL 4974966 *2 (W.D.N.C. 2012 (noting in HIV privacy claim that neither Fourth Circuit nor Supreme Court has recognized constitutional rights of privacy of inmates' medical information); Sherman v. Jones, 258 F. Supp. 2d 440, 444 (E.D. Va. 2003) (no fundamental constitutional right in personal medical information as to inmate claim of HIV disclosure).

[16] Some Massachusetts federal district court decisions have recognized, in certain circumstances, the existence of a right to privacy in one's medical information. *See* Doe v. Town of Plymouth, 825 F. Supp. 1102, 1107 (D. Mass. 1997) (non-disclosure of one's HIV status); Marchand v. Town of Hamilton, 2009 Dist. LEXIS 92934 at *22-23 (D. Mass. 2009) right of privacy to nondisclosure of confidential mental health information for no legitimate purpose); Klein v. MHM Corr. Serv. Ins.,, 2010 WL 324529) (D. Mass. 2010) (assuming without deciding an inmate's right of privacy as to medical information); Doe v. Magnuson, 2005 WL 758454 *4 (D. Me. 2005).

Even assuming that a constitutional privacy right in medical information exists, the precise contours of what that right would be in the prison context are unclear. As the Supreme Court has held, "imprisonment carries with it the circumscription of loss of many significant rights." Hudson v. Palmer, 468 U.S. 517, 524 (1984). "[L]awful incarceration brings about the necessary withdrawal or limitation of many privileges and rights, a retraction justified by the considerations underlying our penal system." Pell v. Procunier, 417 U.S. 817, 822(1974) citing Price v. Johnson, 334 U.S. 266, 285 (1948). Just because a right is enjoyed by free citizens does not mean that it is likewise enjoyed by prisoners to the same extent as in the community. Indeed, it cannot exist to same extent inside of prison because such a right would be fundamentally incompatible with the continued surveillance of inmates. See Hudson, 468 U.S. at 524 (holding no Fourth Amendment proscription on unreasonable searches in prison). In Turner v. Safely, 482 U.S. 78 (1987), the Supreme Court held that a prisoner only "retains those constitutional rights that are not inconsistent with his status as a prisoner." Id. at 95 (alterations omitted).

Moreover, as the Supreme Court has held, prison regulations may still impinge on a constitutional right so long as they are "reasonably related to legitimate penological interests." Turner, 482 U.S. at 89.[17] In light of this, the various courts that have recognized the constitutional right to privacy in a prison context have noted the limited nature of the right, because it is subject to legitimate restrictions related to the prison setting. See Wigginton, 21 F.3d at 740 (no constitutional privacy right barring disclosure of inmate's HIV positive status to correction offi-

[17] In Turner, the Court articulated four factors to be considered in evaluating the reasonableness of a prison regulation: (1) whether there is a "valid, rational connection between the prison regulation and the legitimate governmental interest put forward to justify it;" (2) "whether there are alternative means of exercising the rights that remain open to prison inmates;" (3) "the impact of 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 of ready alternatives." Id. at 89-90. The last factor is not a least restrictive alternative test; prison officials do not have to set up and then shoot down every conceivable alternative method of accommodating the claimant's constitutional complaint. Id. at 90-91. Moreover, "[w]hen accommodation of an asserted right will have a significant 'ripple effect' on fellow inmates or prison staff, courts should be particularly deferential to the informed discretion of correctional officials." Id. at 90.

cers); Doe v. Delie, 257 F.3d 309, 317 (3rd Cir. 2001) (right exists to extent not fundamentally inconsistent with incarceration – the right is subject to "substantial restrictions and limitations in order for correctional officers to achieve legitimate correctional goals and maintain institutional security"); Smith v. Hayman, 2012 WL 3024429 *4 (3rd Cir. 2012) (inmates right to privacy counter-balanced by penological interests and practicality of accommodation); Moore, 379 Fed.Appx. at 428 ("We join our sister courts in finding that, as a matter of law, inmates have a Fourteenth Amendment privacy interest in guarding against disclosure of sensitive medical information from other inmates *subject to legitimate penological interests*."); Powell v. Schriver, 175 F.3d 107 (2d Cir. 1999) ("prison officials can impinge on [the constitutional right to maintain the confidentiality of previously undisclosed medical information] only to the extent that their actions are '*reasonably related to legitimate penological interests*.'"). See also Franklin, 110 Fed. App'x at 719 (inmates do not enjoy greater privacy protections than ordinary citizens and that "some amount of sharing of medical information in areas it might be overheard … is commonplace"); Allah v. Hayman, 442 Fed. Appx. 632 (3rd Cir. 2011) ("we seriously doubt that merely conducting a TB skin test in view of other prisoners results in disclosure of confidential medical information sufficient to rise to level of constitutional violation"); Wilson v. Dovey, 369 Fed. App'x 844 (9th Cir. 2010) (no privacy claim under Fourteenth Amendment due to presence of nurses and correctional officers during inmates medical appointments); Simpson v. Joseph, 248 Fed. App'x 746 (7th Cir. 2007) (prison regulation requiring posting of guards during medical examinations not a violation of any privacy right in nondisclosure of medical condition as any such right is subject to the reasonable concerns related to incarceration). The Ninth Circuit has also acknowledged that the Turner standard applied to a case involving the disclosure of an inmate's mental health records to psychologists who examined the inmate for civil commitment as

a sexually violent predator. Seaton v. Mayberg, 610 F.3d 530, 532 (9th Cir. 2010). The court wrote:

> Loss of privacy is an inherent incident of confinement. A right of privacy in traditional Fourth Amendment terms is fundamentally incompatible with the close and continual surveillance of inmates and their cells required to ensure institutional security and internal order. We are satisfied that society would insist that the prisoner's expectation of privacy always yield to what must be considered the paramount interest in institutional security. We join our sister circuits in holding that prisoners do not have a constitutionally protected expectation of privacy in prison treatment records when the state has a legitimate penological interest in access to them.

Id. at 534. Thus, the Second, Third, Sixth and Ninth Circuits have all held that while inmates do retain a limited constitutional right to medical privacy, a prison regulation that impinges on this right "is valid if it is reasonably related to legitimate penological interests." Turner, 482 U.S. at 89.

Here, the DOT policy for HIV medications clearly passes the Turner reasonableness test as it is related to the legitimate goals of medication adherence, medical care and medication waste prevention. See Eskridge v. Fugua, 2001 WL 391324 *5 (requiring inmate to takes his medication on "watch take" did not constitute violation of any privacy right as related to reasonable penological/medical purpose); Moore v. Mabus, 976 F.2d 268, 271 (5th Cir. 1992) (rejecting constitutional challenge to practice of segregating HIV positive prisoners from rest of prison population); Harris v. Thignen, 941 F.2d 1494, 1521 (11th Cir. 1991) (same). As discussed more fully in Section III (B) above, DOT furthers the legitimate interests of increasing inmate adherence to their HIV medications, decreasing overall viral loads across the inmate population, and minimizing unnecessary costs. Indeed, as the viral load data demonstrates, DOT has led to a marked *increase* in the percentage of inmates with undetectable viral loads. Inmates have full

access to their HIV medications simply by attending the med line and the evidence of greater adherence and the higher percentage of inmates with undetectable viral loads is proof of this.

Further, as discussed in Section III(C), the plaintiffs have produced no evidence to demonstrate that anyone, inmate or staff, has actually ascertained their HIV status as a result of DOT. Nor have the plaintiffs provided any other facts to explain how the DOT med line medication distribution practice somehow constitutes an unconstitutional invasion of privacy. Plaintiffs have provided only speculation to support their proposition that by having to attend a daily med line to obtain their medications any constitutional privacy right is violated. Going to the med line does not constitute a disclosure of HIV status or personal medical information. The HIV medications are not the only medications under the DOT program; inmates go to the DOT med line to obtain medications for any number of reasons.[18]

Plaintiffs' claim that DOT violates their right to privacy fails. There is no reasonable possibility of plaintiffs prevailing. As such, defendants are entitled to summary judgment on the privacy claim.

VI. PLAINTIFFS CANNOT SHOW IRREPARABLE INJURY.

Not only have the plaintiffs failed to produce evidence upon which a reasonable fact finder could rely in support of their claims, but they have similarly failed to produce evidence to demonstrate irreparable injury which would result absent the injunctive relief requested. Plaintiffs have full access to their HIV medications. The only difference between KOP and DOT is the manner of distribution of the medications. Plaintiffs are fully able to attend the med lines and

[18] Even if DOT were discontinued, inmates would still have to go to a KOP med lines to receive entire blister packs of their medications and then carry them back to their cells—a situation that arguably makes it more likely that others will discern their HIV status. Further, under the KOP policy, correctional staff has to have access to lists of KOP medications inmates are prescribed in order to conduct inspections and searches of inmates' cells. Therefore, the alternative policy that plaintiffs seek—KOP for all inmates with HIV—arguably makes it far easier for others to discover an inmate's HIV status.

the defendants have done nothing to hinder their access. When legitimate issues have arisen with the plaintiffs, or any other inmates, reasonable accommodations have been afforded. Further, there is also a grievance procedure in place where any issues can be addressed should they arise in the future. The plaintiffs also have regular access to both their infectious disease physician and case managers to address any such issues. Plaintiffs have produced no evidence of a trial-worthy nature to demonstrate irreparable injury. No order is necessary to ensure plaintiffs' access to adequate medical care; the evidence show they already receive such and will continue to do so in the future.

VI. NEITHER THE BALANCING OF HARMS NOR THE PUBLIC INTEREST MANDATE THAT PLAINTIFFS BE ACCORDED THE INJUNCTIVE RELIEF REQUESTED.

Similarly, neither any balancing of harms nor weighing of the public interest require the issuance of the injunctive relief requested. The plaintiffs have access to their medications simply by attending the med line and plaintiffs have produced no evidence of any meaningful impediment to attending the med line. As argued in Section III(D) above, if this Court were to accept plaintiffs' argument, this would mean that DOT could not be used as to any medications in any DOC prison.

Further, objective data demonstrates that since the policy change there is increased inmate adherence to HIV medication regimes, a greater percentage of HIV inmates on treatment have undetectable loads and there have also been reductions in waste and overall cost. The inconvenience of going to a med line, which is what plaintiffs' claims ultimately boil down to, hardly outweighs the public interest in having efficient, cost effective medication administration that has been shown to increase overall statistical compliance through-out the DOC system.

CONCLUSION

For the aforementioned reasons, the defendants respectfully request this Court allow their motion for summary judgment.

Respectfully submitted,

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Dated: December 14, 2012

/s/ Sheryl F. Grant

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CERTIFICATE OF SERVICE

I hereby certify that this document 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 the NEF this date.

Date: December 14, 2012

/s/ Sheryl F. Grant

Sheryl F. Grant, Counsel