

**SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF KINGS**

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MAURICE ANTHONY, COREY ALLEN,  
ANNA ADAMS, ANDY GNECO, ANDRE : Index No. \_\_\_\_\_  
GREENE, ERIC LEE, STEPHANIE PEÑA, : Date Index No. Purchased: May 7, 2024  
BOUBACARE TUNKARA, and ALTEREAK :  
WITHERSPOON, on behalf of themselves and :  
all others similarly situated, :

Plaintiffs, : **SUMMONS**

- against - :

NEW YORK STATE DEPARTMENT OF :  
CORRECTIONS AND COMMUNITY :  
SUPERVISION, DANIEL F. MARTUSCELLO :  
III, Acting Commissioner, New York State :  
Department of Corrections and Community :  
Supervision, NEW YORK STATE OFFICE OF :  
MENTAL HEALTH, and ANNE MARIE :  
SULLIVAN, Commissioner, New York State :  
Office of Mental Health, :

Defendants.

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**TO THE ABOVE-NAMED DEFENDANTS:**

**PLEASE TAKE NOTICE THAT YOU ARE HEREBY SUMMONED** to answer the Complaint of Plaintiffs Maurice Anthony, Corey Allen, Anna Adams, Andy Gneco, Andre Greene, Eric Lee, Stephanie Peña, Boubacare Tunkara, and Altereak Witherspoon, on behalf of themselves and all others similarly situated, and to serve a copy of your answer upon the undersigned attorneys for Plaintiffs within 20 days after service upon you of this Summons and Complaint, exclusive of the day of service, or within 30 days, if service is made upon you in any manner other than personal delivery. In the event of your failure to answer the Complaint within the time limits described above, judgment will be taken against you by default for the relief demanded in the Complaint.

The basis of venue is Plaintiffs’ residence. CPLR 503(a). All Plaintiffs are currently incarcerated. For purposes of establishing venue, Plaintiffs reside at their place of residence prior to their incarceration. *See, e.g., Iglesia v. Iglesia*, 292 A.D.2d 424 (2nd Dep’t 2002). Plaintiffs Maurice Anthony, Corey Allen, Anna Adams, and Stephanie Peña all resided in Brooklyn prior to their incarceration, and venue therefore properly lies in Kings County. Plaintiffs Anthony, Allen, Adams, and Peña’s current addresses are, respectively:

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Wende Correctional Facility  
3040 Wende Road  
Alden, NY 14004-1187

Corey Allen  
Great Meadow Correctional  
Facility  
11739 State Route 22  
P.O. Box 51  
Comstock, NY 12821-0051

Stephanie Peña  
Albion Correctional Facility  
3595 State School Road  
Albion, NY 14411-9399

Anna Adams  
Bedford Hills Correctional  
Facility  
247 Harris Road  
Bedford Hills, NY 10507-  
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Dated: May 7, 2024  
New York, NY

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**SUPREME COURT OF THE STATE OF NEW YORK  
COUNTY OF KINGS**

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MAURICE ANTHONY, COREY ALLEN,  
ANNA ADAMS, ANDY GNECO, ANDRE : Index No.  
GREENE, ERIC LEE, STEPHANIE PEÑA,  
BOUBACARE TUNKARA, and ALTEREAK :  
WITHERSPOON, on behalf of themselves and  
all others similarly situated, :

Plaintiffs, : **VERIFIED CLASS ACTION  
COMPLAINT**

- against - :

NEW YORK STATE DEPARTMENT OF :  
CORRECTIONS AND COMMUNITY :  
SUPERVISION; DANIEL F. MARTUSCELLO :  
III, Acting Commissioner, New York State :  
Department of Corrections and Community :  
Supervision; NEW YORK STATE OFFICE OF :  
MENTAL HEALTH, and ANNE MARIE :  
SULLIVAN, Commissioner, New York State :  
Office of Mental Health, :

Defendants.

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Plaintiffs Maurice Anthony, Corey Allen, Anna Adams, Andy Gneco, Andre Greene, Eric Lee, Stephanie Peña, Boubacare Tunkara, and Altereak Witherspoon, on behalf of themselves and all others similarly situated, by and through their undersigned attorneys, bring this Class Action Complaint against Daniel F. Martuscello III, Ann Marie Sullivan, the New York State Department of Corrections and Community Supervision (“DOCCS”), and the New York State Office of Mental Health (“OMH”), and in support thereof allege the following:

### **PRELIMINARY STATEMENT**

1. The Humane Alternatives to Long-Term Solitary Confinement Act (“HALT”) recognizes that solitary, or segregated, confinement<sup>1</sup> imperils the health and lives of everyone who lives and works in prison, and that it impairs—rather than furthers—the goal of rehabilitation into the wider community. This case addresses one of the most important requirements of HALT that, years after the law’s enactment, remains unrealized: ending the use of segregated confinement for people with disabilities.

2. HALT prohibits the use of segregated confinement in New York’s prisons for people with disabilities and creates rehabilitative alternatives to solitary that are proven to reduce violence. But, since HALT’s passage, Defendants have refused to implement this law.

3. HALT’s disability exclusion bars Defendants from placing *any* person with a disability in segregated confinement for *any* length of time. The exclusion is informed by penological and medical consensus concerning the disastrous—and frequently irreversible—effects of solitary confinement on people with disabilities. As one Plaintiff described it, solitary can feel like being locked in a casket that you cannot escape.

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<sup>1</sup> Throughout this Complaint, Plaintiffs use the terms “solitary confinement” and “segregated confinement” interchangeably. “Solitary confinement” means “segregated confinement” as defined in Correction Law § 2 (23).

4. Plaintiffs bring this case on behalf of two overlapping groups of incarcerated people with disabilities whom Defendants subject to solitary confinement in violation of HALT.

5. First, all Plaintiffs bring this case on behalf of a Practice Class, defined more specifically below, of people with disabilities whom Defendants subject to solitary confinement by holding them in cells for more than 17 hours per day. Plaintiffs, on behalf of the Practice Class, seek an injunction prohibiting Defendants from placing members of the Practice Class in solitary confinement, and a declaration that Defendants' current practice of doing so violates HALT.

6. Second, Plaintiffs Adams, Allen, Gneco, Greene, and Peña bring this case on behalf of a Policy Class, defined more specifically below, of people who have certain disabilities but whom Defendants, through their continuing policies, deny the disability-based protections of HALT, and put at constant risk of placement in segregated confinement. These policies—which Defendants promulgated after the codification of HALT and which they maintain today—permit the use of solitary confinement for people with many types of disabilities, including, for example, people with posttraumatic stress disorder, speech disabilities, and some mobility disabilities, as well as people who are hard of hearing or have low vision. Defendants have relied on these policies to impose segregated confinement on hundreds of people with disabilities, including numerous Plaintiffs, who should be excluded from solitary confinement under HALT. Plaintiffs, on behalf of the Policy Class, seek a declaration that these policies violate HALT, and an injunction prohibiting the maintenance of ongoing policies that narrow HALT's protections.

7. Plaintiffs ask this Court to hold Defendants to account for their unlawful conduct that violates HALT's disability-based exclusion. For centuries, people with disabilities have been harmed by the deprivations and indignities of solitary confinement. As one Plaintiff summarized: “[Solitary] is destroying me but I'm trying to stay strong.” HALT sought to end this harm once

and for all. Without Court intervention, however, Plaintiffs and the classes they represent will continue to have their legal rights under HALT violated.

### PARTIES

8. **Plaintiff Maurice Anthony** is a 42-year-old Black man from Brooklyn who has been incarcerated by DOCCS since May 15, 2014. He is blind. Following HALT's effective date, DOCCS has held Mr. Anthony in solitary confinement, including in the Step-Down Program at Mid-State Correctional Facility, the Residential Rehabilitation Unit ("RRU") at Upstate Correctional Facility, and the diversion unit at Wende Correctional Facility. DOCCS has held Mr. Anthony in the diversion unit at Wende Correctional Facility since January 2024.

9. **Plaintiff Corey Allen** is a 52-year-old Black man from Brooklyn who has been incarcerated by DOCCS since 2018. He has neuropathy and paralysis in his left hand, which DOCCS sometimes refers to as a deformity or contracture of his hand. Following HALT's effective date, DOCCS has held Mr. Allen in solitary confinement, including while he was housed in the Special Housing Unit ("SHU") and SHU Overflow Unit at Elmira Correctional Facility, the SHU at Collins Correctional Facility, the RRU at Gouverneur Correctional Facility, the SHU at Coxsackie Correctional Facility, general population and the A-1 SHU Unit at Five Points Correctional Facility, and the RRU at Upstate Correctional Facility. DOCCS is currently holding Mr. Allen at Great Meadow Correctional Facility, where he was held in the reception unit as of April 24, 2024.

10. **Plaintiff Anna Adams** is a 50-year-old Black woman from Brooklyn who has been incarcerated by DOCCS since May 2016. She has been diagnosed with lupus, asthma, posttraumatic stress disorder, and anxiety. Following HALT's effective date, DOCCS held

Ms. Adams in solitary confinement in the SHU at Bedford Hills Correctional Facility. Ms. Adams is currently held in DOCCS custody at Bedford Hills Correctional Facility.

11. **Plaintiff Andy Gneco** is a 39-year-old Black and Hispanic man from Manhattan who has been incarcerated by DOCCS since February 2019. He is hard of hearing. Mr. Gneco also has mental health disabilities; he is diagnosed with anxiety and depression. Following HALT's effective date, DOCCS has held Mr. Gneco in solitary confinement, including in general population (where he was held in his cell for 20 to 21 hours per day) and the SHU at Auburn Correctional Facility, the SHU at Clinton Correctional Facility, the RRU at Upstate Correctional Facility, and in general population at Attica Correctional Facility, where he is currently incarcerated.

12. **Plaintiff Andre Greene** is a 53-year-old Black man from New York City who has been incarcerated since August 2000. He is hard of hearing. Following HALT's effective date, DOCCS has held Mr. Greene in solitary confinement, including in the SHU at Sullivan Correctional Facility, an intake unit at Green Haven Correctional Facility, the RRU at Five Points Correctional Facility, and general population at Five Points Correctional Facility, where he is currently housed.

13. **Plaintiff Eric Lee** is a 32-year-old Black man from Mount Vernon who has been incarcerated by DOCCS since December 2018. He has mental health disabilities, for which he has been prescribed antidepressant and antipsychotic medications, and an intellectual disability. Following HALT's effective date, DOCCS has held Mr. Lee in solitary confinement, including in the SHU at Shawangunk Correctional Facility, the RRU at Collins Correctional Facility, the Correctional Alternative Rehabilitation Unit at Sullivan Correctional Facility, the RRU at Attica

Correctional Facility, and the Step-Down Program at Mid-State Correctional Facility. DOCCS has held Mr. Lee in the Step-Down Program at Mid-State Correctional Facility since April 2023.

14. **Plaintiff Stephanie Peña** is a 23-year-old Black and Hispanic woman from Brooklyn who has been incarcerated by DOCCS since August 2022. She has post-traumatic stress disorder and anti-social personality disorder. Following HALT's effective date, DOCCS has held Ms. Peña in solitary confinement, including during multiple periods in the SHU at Albion Correctional Facility, where she has been held since September 2022.

15. **Plaintiff Boubacare Tunkara** is a 27-year-old Black man from the Bronx who has been incarcerated by DOCCS since October 2017. In addition to having an intellectual disability, Mr. Tunkara has been diagnosed with bipolar disorder and anti-social personality disorder, among other mental health disabilities. Following HALT's effective date, DOCCS has held Mr. Tunkara in solitary confinement, including in the RRU at Upstate Correctional Facility, the Residential Mental Health Unit at Marcy Correctional Facility, the Diversion Unit at Elmira Correctional Facility, and the Residential Mental Health Unit at Five Points Correctional Facility, where Mr. Tunkara was housed until he was transferred in late April 2024. Mr. Tunkara is currently housed at Sing Sing Correctional Facility.

16. **Plaintiff Alterek Witherspoon** is a 34-year-old Black man from Schenectady who has been incarcerated by DOCCS since December 2020. He has been diagnosed by Defendants with post-traumatic stress disorder and anti-social personality disorder. He was also previously diagnosed with schizoaffective disorder, and Defendants have prescribed him antipsychotic medication. Following HALT's effective date, DOCCS has held Mr. Witherspoon in solitary confinement, including in the Residential Mental Health Unit at Five Points

Correctional Facility and in the Transitional Intermediate Care Program at Attica Correctional Facility, where Mr. Witherspoon is currently housed.

17. **Defendant Daniel F. Martuscello III** is the acting Commissioner of DOCCS and is thus responsible for its administration and operation, including its compliance with New York state law (Correction Law §§ 5, 201).

18. **Defendant Ann Marie T. Sullivan** is the Commissioner of OMH and is thus responsible for its administration and operation, including its compliance with New York state law (Mental Hygiene Law § 41.44; Correction Law § 401).

19. **Defendant New York State Department of Corrections and Community Supervision** enforces the laws and regulations applicable to New York state prisons. Defendant DOCCS is statutorily responsible for the confinement and habitation of individuals placed in state correctional facilities and for their programming, their supervision, and the conditions of their confinement. DOCCS operates the prisons where Plaintiffs and members of the putative Practice Class and Policy Class are confined.

20. **Defendant New York State Office of Mental Health** enforces the laws and regulations that govern the provision of mental health treatment in the DOCCS system and is responsible for developing, implementing, and overseeing the provision of mental health treatment and mental health diagnoses in DOCCS custody. Defendant OMH is statutorily responsible for “seeing that mentally ill persons are provided with care and treatment, that such care, treatment and rehabilitation is of high quality and effectiveness, and that the personal and civil rights of persons receiving care, treatment and rehabilitation are adequately protected” (Mental Hygiene Law § 7.07 [c]).

**JURISDICTION AND VENUE**

21. This Court has jurisdiction over this action because it is brought pursuant to article 30 of the New York Civil Practice Law and Rules (“CPLR”).

22. Plaintiffs Maurice Anthony, Corey Allen, Anna Adams, and Stephanie Peña, although currently incarcerated, lived in Kings County at the onset of their incarceration and, upon their release from incarceration, intend to return to and remain in Kings County for the foreseeable future. Therefore, for the purposes of establishing venue, Plaintiffs Anthony, Allen, Adams, and Peña reside in Kings County.

23. Venue thus properly lies in Kings County pursuant to CPLR 503 (a) because multiple Plaintiffs reside there.

**STATEMENT OF FACTS**

24. In 2021, the New York State Legislature dramatically curtailed the permissible use of solitary confinement in the state’s prisons with the historic passage of HALT. In doing so, the Legislature responded to sustained calls from citizens and survivors and recognized the medical and scientific consensus concerning the devastating effects of solitary confinement, particularly on people with disabilities.

25. HALT took effect on March 31, 2022, and sets several limits on the use of solitary confinement, including limiting the permissible duration of stays in solitary and the types of offenses for which solitary sanctions can be ordered.

26. Critically, HALT also categorically excludes certain vulnerable groups—termed “special populations” under the Act—from solitary confinement altogether because they are particularly vulnerable to its harmful and potentially irreversible consequences (Correction Law

§ 137 [6] [h]). In addition to young and elderly individuals and pregnant and post-partum people, special populations include all people with disabilities, broadly defined.

27. As detailed further below, despite HALT's clear language exempting people with disabilities from solitary confinement, DOCCS and OMH continue to house people with disabilities in solitary. This case seeks to remedy these violations of HALT.

**I. Penologists, Medical Professionals, and Advocates Have Long Recognized That Solitary Confinement Causes Serious and Irreparable Harm**

28. Solitary, or segregated, confinement in conditions of social isolation and deprivation of occupational and anchoring perceptual stimulation is among the most extreme form of punishment which can be inflicted on human beings short of killing them. While the effects of solitary confinement are particularly destructive for individuals with disabilities, there is widespread recognition of the devastating effects of solitary confinement on all populations.

29. Solitary confinement was first developed as a penological strategy by Quaker reformers who believed that if convicted persons were confined alone and given time to reflect, they would realize their mistakes and repent.

30. Within a matter of years, reformers and the broader community recognized that solitary confinement not only failed to rehabilitate individuals but in fact caused severe deterioration. After visiting American penitentiaries in the nineteenth century, Alexis de Tocqueville concluded that solitary "devours the victim incessantly and unmercifully; it does not reform, it kills."<sup>2</sup>

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<sup>2</sup> Gustave Auguste De Beaumont & Alexis De Tocqueville, *On The Penitentiary System In The United States And Its Application To France* 41 (S Ill Univ Press 1979) (1833).

31. Over 125 years ago, the Supreme Court likewise acknowledged that even for detained people sentenced to death, solitary confinement carries with it “a further terror and peculiar mark of infamy” (*In re Medley*, 134 US 160, 170 [1890]). As the Court described:

“A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others, still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community” (*id.* at 168; *see also Davis v Ayala*, 576 US 257, 286–290 [2015, Kennedy, J., concurring] [discussing academic literature decrying solitary confinement]).

32. Considering its harmful effects and its ineffectiveness as a penological tool, the widespread use of solitary confinement was largely abandoned for a century, re-emerging only during the prison boom of the 1980s to 1990s. As the use of solitary confinement returned to American prison systems, states, including New York, built “supermax” prisons designed and outfitted to enforce extreme social isolation for periods stretching years or even decades.

33. Psychologists, physicians, and other experts documented the grave injury inflicted on people housed in solitary confinement, demonstrating with startling consistency that the central features of solitary confinement cause severe psychiatric, cognitive, psychosocial, and physical harm.

**A. Solitary Confinement Causes Severe Psychiatric and Cognitive Decompensation**

34. Solitary confinement is marked by reduced social, occupational, and anchoring perceptual stimulation, both of which result in severe psychological repercussions, the “massive effects” of which can emerge within days or hours.<sup>3</sup>

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<sup>3</sup> Peter S. Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 *Crime & Justice*, 441, 487 (2006), citing Reto Volkar, *Einzelhaft: Eine Literaturübersicht*, 42 *Schweizerische Zeit-*

35. There is medical consensus about the risk of harm inherent to solitary confinement. According to the American Psychiatric Association, solitary is associated with increased risk of self-mutilation and suicidal ideation, greater anxiety, depression, and paranoia.<sup>4</sup> The constellation of documented psychological symptoms that emerge in solitary paints a uniquely traumatic picture. Depression and anxiety have been reported at rates above 70 percent among people exposed to solitary confinement—appreciably more prevalent and intense as compared to the general prison population.<sup>5</sup> Even people without a prior mental health diagnosis experience debilitating symptoms, including lethargy, difficulty sleeping, nervous breakdowns, nightmares, and intrusive thoughts.

36. Studies have also demonstrated that restriction of social, perceptual, and occupational stimulation can cause more—extreme psychopathology, including delusions, hallucinations, and florid confusional psychosis. Not only does solitary have a disastrous impact on individuals' mental health, but its toxic effects may be irreversible.

37. Researchers and survivors alike have also drawn clear connections between solitary confinement and self-harm. Deprived of social and physical outlets for stress, the only relief for some is to turn the unrelenting tension and despondency against their own bodies. For others, physical pain offers an escape from otherwise punishing monotony. A large-scale 2014 study in

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schrift für Psychologie und ihre Anwendungen 1, 18–19 (1983); *see also e.g.* Bruce A. Arrigo & Jennifer L. Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change*, 52 *Intl J of Offender Therapy & Compar Criminology*, 622 (2008); Craig Haney, *Mental Health Issues in Long-term Solitary and “Supermax” Confinement*, 49 *Crime & Delinquency*, 124 (2003); Craig Haney, *The Wages of Prison Overcrowding: Harmful Psychological Consequences and Dysfunctional Correctional Reactions*, 22 *Wash U J L & Poly* 265 (2006); Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 *Wash U J L & Poly* 325 (2006); Stuart Grassian & Nancy Friedman, *Effects of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*, 8 *Intl J of L & Psych* 49 (1986).

<sup>4</sup> *See* Craig Haney, *Restricting the Use of Solitary Confinement*, 1 *Ann Rev Criminology* 285, 299 (2018).

<sup>5</sup> Smith, *supra* note 3, at 480–481; Haney (2003), *supra* note 3, at 133–137.

New York City jails revealed that people subjected to solitary confinement were a staggering 6.9 times more likely to self-harm than those who were not.<sup>6</sup> Prior research in various prison systems determined that most self-harm incidents occurred in solitary confinement.<sup>7</sup>

38. A vastly outsized proportion of prison suicides take place in solitary confinement. A 2005 survey determined that about 50 percent of New York's prison suicides occurred in solitary.<sup>8</sup> A five-year review in California found 60 percent of suicides occurred among the three to six percent of the population in solitary.<sup>9</sup>

39. These statistics do not account for an unknown number of people who leave prison but ultimately succumb to the suffering that solitary confinement brings. Kalief Browder was accused at age 16 of stealing a backpack in New York City, a charge which he denied and refused to plead guilty to. Browder spent three years in pre-trial detention on Rikers Island, much of it in solitary. His charges were ultimately dismissed, and he was released. Two years later, he died by suicide in his mother's apartment using strips of torn bed sheets—an approach that mirrored a prior suicide attempt he made while in solitary.

40. Compounding these devastating mental health impacts, people in solitary confinement also experience cognitive deterioration, consistently reporting difficulties with memory and concentration. Four-fifths of interviewees in one study suffered “confused thought

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<sup>6</sup> Fatos Kaba, et al., *Solitary Confinement and Risk of Self-harm Among Jail Inmates*, 104 Am J Pub Health, 442, 445 (2014).

<sup>7</sup> Craig Haney & Mona Lynch, *Regulating Prisons of the Future: A Psychological Analysis of Supermax and Solitary Confinement*, 23 NYU Rev L & Soc Change, 477, 525 (1997).

<sup>8</sup> Bruce B. Way, et al., *Factors Related to Suicide in New York State Prisons*, 28 Intl J L & Psychiatry, 207 (2005).

<sup>9</sup> Raymond F. Patterson & Kerry Hughes, *Review of Completed Suicides in the California Department of Corrections and Rehabilitation, 1999 to 2004*, 59 Psychiatric Services, 676, 678 (2008).

processes,” including problems maintaining attention and forming coherent ideas.<sup>10</sup> The intense monotony and absence of positive external stimuli lead many, even after a brief period, into a “mental torpor or fog,” in which alertness is so impaired that one is unable to maintain or shift focus.<sup>11</sup> Laboratory research confirms reductions in brain activity after just a few days of reduced sensory stimulation.<sup>12</sup> As people descend deeper into a mental fog, their ability to cope with external stimuli becomes impaired, making even ordinary stimuli intolerable.<sup>13</sup>

**B. Solitary Confinement Causes Severe Psychosocial Deterioration**

41. Solitary confinement is also known to cause lasting psychosocial transformations that cut to the very core of a person’s identity. After initially yearning for social contact, isolation ultimately leads many to withdraw further, disoriented or frightened by the prospect of human interaction.<sup>14</sup> Some cope by writing off social life altogether.<sup>15</sup> Aversion to social interaction can endure long after release and is deeply painful for survivors.<sup>16</sup>

42. Typically, the only physical touch people in solitary confinement experience are the gloved hands of officers shackling or searching them, or of physicians examining them.<sup>17</sup> The

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<sup>10</sup> Haney (2003), *supra* note 3, at 134.

<sup>11</sup> Grassian (2006), *supra* note 3, at 331; Smith (2006), *supra* note 3, at 470–471.

<sup>12</sup> Grassian (2006), *supra* note 3, at 331; Smith (2006), *supra* note 3, at 470–471; Paul Gendreau et al., *Changes in EEG Alpha Frequency and Evoked Response Latency During Solitary Confinement*, 79 J Abnormal Psych, 54–59 (1972), available at <https://www.semanticscholar.org/paper/Changes-in-EEG-alpha-frequency-and-evoked-response-Gendreau-Freedman/1fb9d976e193bb178912c034cbb1dd291222cf34>.

<sup>13</sup> See Craig Haney, *Restricting the Use of Solitary Confinement*, 1 Ann Rev Criminology, 285, 289 (2018); Grassian (2006), *supra* note 3, at 283; Haney & Lynch (1997), *supra* note 7, at 594–595; Smith (2006), *supra* note 3, at 491.

<sup>14</sup> Haney (2003), *supra* note 3, at 138–139; Grassian (2006), *supra* note 3, at 331.

<sup>15</sup> Haney (2018), *supra* note 13, at 297.

<sup>16</sup> Grassian (2006), *supra* note 3, at 333; Haney (2018), *supra* note 13, at 297.

<sup>17</sup> Haney (2018), *supra* note 13, at 297.

deprivation of caring physical contact is a significant contributor to the suffering inflicted in solitary. Caring touch calms stress and offers a sense of trust and belonging.<sup>18</sup> Most centrally, researchers note that compassion is “universally signaled through touch.”<sup>19</sup> Depriving a person of the opportunity to give and receive compassion through physical touch undercuts one of the most foundational affirmations of a person’s dignity and severs the essential bonds to family and community which bring meaning to life.<sup>20</sup>

**C. Solitary Confinement Is Known to Cause Pronounced Physical Decline**

43. Solitary confinement produces serious physiological maladies with measurable impacts on morbidity and mortality. Somatic symptoms include heart palpitations, headaches, sweating, insomnia, loss of appetite, weakness and fatigue, jaw disorders, and tremulousness.<sup>21</sup>

44. Other physiological effects appear related to deprivation of physical exertion and environmental stimuli, including aching joints, back pain, and deterioration of eyesight.<sup>22</sup> Gastrointestinal and gastro-urinary problems have also been documented.<sup>23</sup> Social isolation and deprivation of physical human touch leads to chronic elevations of the stress hormone cortisol, which accelerates disease and overall deterioration of mental and physical health.<sup>24</sup> Solitary has

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<sup>18</sup> Dr. Dacher Keltner, Expert Report in *Ashker v Brown*, No. 4:09-cv-05796-CW, at 10 (ND Cal 2015), available at <https://ccrjustice.org/sites/default/files/attach/2015/07/Keltner%20Expert%20Report.pdf>.

<sup>19</sup> Jennifer E. Stellar & Dacher Keltner, *Compassion*, Handbook of Positive Emotions, at 337 (2014).

<sup>20</sup> Keltner (2015), *supra* note 18, at 4, 14–15.

<sup>21</sup> Sharon Shalev, *A Sourcebook on Solitary Confinement*, at 15 (2008), available at [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2177495](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2177495); Haney (2003), *supra* note 3, at 133.

<sup>22</sup> Shalev (2008), *supra* note 21, at 15.

<sup>23</sup> *Id.*

<sup>24</sup> Keltner (2015), *supra* note 18, at 15.

also been found to be correlated with higher rates of hypertension, putting younger people at especially heightened risk of irreversible cardiovascular damage, heart attack, and stroke.<sup>25</sup>

**D. Solitary Confinement Poses Unique Risks to People with Disabilities**

45. Unsurprisingly, the psychological and social trauma attendant to solitary confinement is more extreme and enduring among people with disabilities, especially those with mental health conditions, brain injuries, and developmental disabilities.<sup>26</sup> The stress, deprivation of meaningful social contact, and absence of positive stimuli combine to exacerbate pre-existing psychiatric conditions and cause conditions to worsen, even if previously well-managed.

46. People with physical disabilities are also vulnerable to distinct physiological consequences from placement in solitary confinement. The cramped conditions in solitary—including the use of small pens within cells for so-called “recreation” (*see infra* at ¶ 143)—deprive people with physical disabilities the physical activity they require to maintain their health and prevent muscular atrophy.<sup>27</sup>

47. Certain physical disabilities such as paraplegia introduce self-care needs, for example, the use of colostomy or urostomy bags and other sterile supplies. Failure to provide supplies or other medically necessary self-care support, such as changing dressings on bed sores,

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<sup>25</sup> Louise C. Hawkley, Expert Report in *Ashker v Brown*, No. 4:09-cv-05796-CW, at 10 (ND Cal 2015), available at <https://ccrjustice.org/sites/default/files/attach/2015/07/Hawkley%20Expert%20Report.pdf>.

<sup>26</sup> Haney (2003), *supra* note 3, at 142–145; James Gilligan & Bandy Lee, *Report to the New York City Board of Correction*, at 5–10 (Sept. 5, 2013), available at <http://solitarywatch.com/wp-content/uploads/2013/11/Gilligan-Report.-Final.pdf> (last accessed Apr. 29, 2024); Haney & Lynch (1997), *supra* note 7, at 534; Grassian (2006), *supra* note 3, at 329; Sheilagh Hodgins & Gilles Cote, *The Mental Health of Penitentiary Inmates in Isolation*, 33 *Can J Criminology*, 175 (1991); *see also Madrid v Gomez*, 889 F Supp 1146, 1265 (ND Cal 1995).

<sup>27</sup> Jamelia N. Morgan, *Caged In: The Devastating Harms of Solitary Confinement on Prisoners with Physical Disabilities*, 24 *Buff Hum Rts L Rev* 81, 117, 126–127 (2018).

can lead to serious infection. People in solitary are entirely dependent on prison staff to provide these supplies because they are mostly confined to their cell.<sup>28</sup>

48. Likewise, sensorial disabilities can be both exacerbated by and amplify the harmful effects of solitary confinement. Deaf individuals are often unable to collect information about their surroundings through auditory stimulation, and the visible environment in solitary confinement is incredibly spartan. When prison staff are unable to communicate via sign language, deaf and hard of hearing people are cut off entirely from communicating with others while in solitary confinement.

49. In medicine, it is well-established that people with vision loss are especially vulnerable to developing hallucination, paranoia, and psychosis. In solitary, they are prevented from engaging in the few activities that are available in some units—reading, educational workbooks, and television—due to their disability.<sup>29</sup> Research has also shown that the lack of visual stimulation in solitary confinement causes or accelerates deterioration of eyesight, worsening extant vision disabilities.<sup>30</sup>

50. In addition to being more vulnerable to its harmful effects, people with disabilities—whether physical, sensorial, mental, or cognitive—are at increased risk for placement in solitary confinement.<sup>31</sup> People with mental health disabilities are more prone to struggle with the stressors

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<sup>28</sup> *Id.* at 122–123.

<sup>29</sup> *Id.* at 129–133.

<sup>30</sup> Stefan Enggist, et. al., *Prisons and Health*, World Health Organization, at 28 (2014), available at <https://www.who.int/europe/publications/i/item/9789289050593>.

<sup>31</sup> See David Lovell et al., *Recidivism of Supermax Prisoners in Washington State*, 53 *Crime & Delinquency* 633, 642 (2007); Matthew Lowen & Caroline Isaacs, *Lifetime Lockdown: How Isolation Conditions Impact Prisoner Reentry* 8 Am Friends Serv Comm (2012); *Solitary Confinement in New York's Prisons*, Correctional Association of New York (2019), available at [https://static1.squarespace.com/static/62f1552c1dd65741c53bbcf8/t/63f28f398f78b117187a4387/1676840762233/019\\_FactSheet-SolitaryConfinement.pdf](https://static1.squarespace.com/static/62f1552c1dd65741c53bbcf8/t/63f28f398f78b117187a4387/1676840762233/019_FactSheet-SolitaryConfinement.pdf).

of incarceration and therefore have trouble conforming their conduct to the highly regimented prison environment. Inadequately treated mental health conditions may lead people to display behavior perceived by others as bizarre or annoying, which can lead to conflicts with other incarcerated people and prison staff.

51. Analysis of data from the first year of HALT implementation demonstrates how this dynamic continues to play out in New York's prisons, leading to frequent and harsh discipline for people with mental health disabilities. For example, people in the Residential Mental Health Treatment Units—i.e., alternative disciplinary units specifically designated for people with mental health disabilities—have the highest rates of disciplinary segregation sanctions among all units across the DOCCS prisons system (Exhibit 1, Letter from New York Campaign for Alternatives to Isolated Confinement (CAIC) and Mental Health Alternatives to Solitary Confinement (MHASC) to OMH Commissioner Sullivan, at 5). During HALT's first year of implementation, people in these units had disciplinary hearings at a rate almost five times greater than the rate for all people in New York state prisons. Moreover, the average amount of time in solitary confinement that people in Residential Mental Health Treatment Units received as disciplinary sanctions was 8.45 times higher than the rate for the entire DOCCS population (*id.*). Likewise, during the first year after HALT came into effect, “[t]he hearing rate for RRU residents . . . was 3.7 times higher than the rate for all DOCCS prisons” (*id.* at 6).

52. The Campaign for Alternatives to Isolated Confinement and the Mental Health Alternatives to Solitary Confinement Campaign also found that a large number of people are disciplined with solitary confinement sanctions for conduct that may be manifestations of their mental illnesses. This includes conduct described as lewd or labeled aberrant or disruptive, but not violent. For example, the Campaigns found that, “[f]or hearings with charges of unhygienic

acts or lewd conduct,” people held in the disability-specific Residential Mental Health Treatment Units received SHU sanctions at a rate “59 times higher than for such hearings in the rest of DOCCS units” and that “the RRU rate was 10 times higher” (*id.*).

53. Prison officials generally respond to people exhibiting signs of mental health disabilities by issuing disciplinary infractions and placing them in solitary confinement. In turn, conditions in solitary confinement lead people with mental health disabilities to deteriorate further and have even less ability to comply with prison rules. The result is a deepening cycle of perceived misbehavior and repeated placements in isolation.<sup>32</sup>

54. People with hearing and vision disabilities are also particularly vulnerable to falling into a continuous cycle of solitary confinement.<sup>33</sup> When prison officials fail to communicate rules or demands in a format that people with such disabilities can understand, these individuals are likely to be issued disciplinary infractions when they violate the rules or disobey commands. A written rulebook is of little use to a blind individual and shouting commands at a deaf person is equally unhelpful.

55. People with mobility disabilities and other physical disabilities are likewise at heightened risk for repeated placements in solitary confinement. People with physical disabilities may be punished for actions or inactions caused by their disabilities. For example, people with lower extremity paralysis and incontinence may be punished for soiling their garments. And

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<sup>32</sup> Jeffrey L. Metzner & Jaime Fellner, *Solitary Confinement and Mental Illness: A Challenge for Medical Ethics*, 38 *J Am Acad Psychiatry L* 104, 104–106 (2010); Ashley Halvorsen, *Solitary Confinement of Mentally Ill Prisoners: A National Overview & How the ADA Can Be Leveraged to Encourage Best Practices*, 27 *S Cal Interdisc L J* 205, 206 (2017).

<sup>33</sup> Morgan (2018), *supra* note 27, at 147–152.

people with mobility disabilities may be unable to respond to commands from staff—to get down on the ground, for example—leading to discipline.<sup>34</sup>

56. In sum, there is broad consensus about the harms of solitary confinement and the particularly devastating effects for vulnerable populations. People with disabilities are both uniquely vulnerable to the harms of solitary confinement and face distinct risks for placement in such units due to the extra challenges they face under the rigors of prison life.

## II. HALT Restricts Defendants' Use of Solitary Confinement and Mitigates Its Significant Harm

57. Before HALT's enactment, DOCCS held thousands of people in solitary confinement, sometimes stretching for years and even decades. Many of these people were people with disabilities.

58. At that time, solitary confinement principally consisted of placement in the SHU or Long-Term Keeplock, in small cells approximately the size of a bathroom or parking spot, for between 22 and 23 hours each day. DOCCS required people confined in SHU and Long-Term Keeplock to eat alone in their cells and prohibited them from seeing other incarcerated individuals, working at prison jobs, attending programs (such as classes and group therapies), or engaging in other rehabilitative activities.

59. DOCCS maintained certain housing areas it labeled “alternatives” to SHU or Long-Term Keeplock for people with disabilities, but these nonetheless imposed conditions that amount to solitary confinement. For example, the Behavioral Health Unit, Group Therapy Program, Residential Mental Health Unit, Intensive Intermediate Care Program, Correctional Alternative Rehabilitation Unit, and Correctional Alternative Rehabilitation Unit Group Therapy Program—all units billed as disability-based “alternative to solitary” units—confined people with serious

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<sup>34</sup> *Id.*

mental illnesses and intellectual and developmental disabilities, respectively, in their cells for between 20 and 22 hours per day pursuant to DOCCS policy.

60. Directly impacted people, their families and communities, and advocates across New York initiated a years-long campaign to demand an end to the practice, culminating in the passage of HALT.

61. HALT was considered during eight legislative sessions from 2014 through 2021, during which time legislators amended it twice to address issues raised by corrections administrators. HALT was passed in early 2021 and signed into law on March 31, 2021.

62. HALT went into effect on March 31, 2022.

63. HALT amends and adds to portions of the New York Correction Law to curtail the use of solitary confinement in New York's prisons (*see* Correction Law § 137 [6] [h] [2]).

64. HALT applies to all DOCCS prisons (Correction Law § 137).

65. HALT defines "segregated confinement" as "the confinement of an incarcerated individual in any form of cell confinement for more than seventeen hours a day other than in a facility-wide emergency or for the purpose of providing medical or mental health treatment" (Correction Law § 2 [23]).

66. As discussed in more detail below (*see infra* at ¶¶ 69–71), HALT bars members of the special populations, including people with disabilities, from being placed in segregated confinement for any length of time.

67. HALT also requires the establishment of new units called RRUs, which are meant for incarcerated people who are serving disciplinary sanctions but cannot be held in solitary confinement, either because they are members of a special population or because they have spent too much time in solitary confinement already. The RRUs are modeled after units in New York

and California that have been proven to reduce violence (Correction Law § 2 [34]). The RRUs are intended to provide greater opportunities for out-of-cell time and congregate programming and recreation, such that the people living there are not in solitary confinement.<sup>35</sup>

68. HALT does not provide a specific or administrative means of recourse for incarcerated people to enforce its requirements within its statutory language, nor are there alternative administrative enforcement mechanisms prescribed by other sections of the Correction Law.

### **III. HALT Categorically Prohibits Defendants from Placing People With Disabilities in Solitary Confinement**

69. A key purpose of HALT was to protect particularly vulnerable populations from solitary confinement of any kind or duration. Indeed, the Legislature made plain that one of its objectives in passing HALT was to “end the segregated confinement of vulnerable people,” because “[s]egregated confinement can be particularly devastating for certain vulnerable people, such as young or elderly people, pregnant women, and people with disabilities or trauma histories.”

70. HALT therefore categorically prohibits the use of solitary confinement for certain groups (Correction Law § 137 [6] [i]). These groups, which the law calls “special populations,” are excluded from being placed in solitary for any length of time.

71. “Special populations” under HALT include “any person . . . with a disability as defined in paragraph (a) of subdivision twenty-one of section two hundred ninety-two of the executive law” (Correction Law § 2 [33] [c]). Executive Law § 292 (21) (“the New York State Human Rights Law”), in turn, defines “disability” as “a physical, mental, or medical impairment

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<sup>35</sup> RRUs are not intended to constitute solitary confinement. However, as discussed *infra* at ¶¶ 141, 145, 151, 158, 168, 174, 179, 181, 191, the conditions in many RRUs throughout the DOCCS prison system amount to solitary confinement.

resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques or (b) a record of such an impairment or (c) a condition regarded by others as such an impairment . . . .”

72. Courts have broadly interpreted Executive Law § 292 (21)’s definition of disability to “cover[ ] a range of conditions varying in degree from those involving the loss of a bodily function to those which are merely diagnosable medical anomalies which impair bodily integrity and thus may lead to more serious conditions in the future” (*Krause v Lancer & Loader Group, LLC*, 965 NYS2d 312, 399 n 5 [Sup Ct, New York County 2013], quoting *Davis v Bowes*, 159 F3d 1346 [2d Cir 1998] [explaining that the New York State Human Rights Law includes a more expansive definition of disability than the Americans with Disabilities Act because it does not require any showing that the disability substantially limits any major life activity]; see also *State Div. of Human Rights v Xerox Corp.*, 65 NY2d 213, 219 [1985]; Exhibit 1, Letter from CAIC and MHASC, at 2–3 [“[a]ccording to the NYS Division of Human Rights, ‘[t]here are no qualifiers as to the severity of the disability. Unlike federal law, there is no requirement under the NYSHRL that the impairment ‘substantially limit a major life activity,’” citing *Reasonable Accommodation and Disability Rights under the NYS Human Rights Law*, New York State Division of Human Rights, [May 2022], at 3 available at <https://dhr.ny.gov/system/files/documents/2022/05/nysdhr-disability-rights-handbook-073020.pdf> [last accessed May 2022]).

73. By incorporating this broad definition of “disability” from the New York State Human Rights Law, the Legislature made clear that HALT protects from solitary confinement *any* person with *any* disability.

74. Because HALT defines solitary confinement as any form of cell confinement for more than 17 hours a day, regardless of the name of the unit (Correction Law § 2 [23]), HALT bars Defendants from confining any person with any disability to their cell for more than 17 hours in a day—for any reason, in any unit, in any prison, unless the purpose is for mental health or medical treatment or there is a facility-wide emergency (Correction Law § 137 [6] [h]).

**IV. Defendants’ Policies Violate HALT’s Categorical Exclusion of People with Disabilities from Solitary Confinement**

75. Defendants maintain at least four written policies regarding who is a member of a “special population” and thus cannot be subjected to segregated confinement. These include: (1) DOCCS Directive 4933: Special Housing Units (Exhibit 2); (2) DOCCS Directive 4933D: Residential Rehabilitation Units (Exhibit 3); (3) a DOCCS “SHU Exclusions” Policy (Exhibit 4); and (4) OMH’s Policy No. 6.0: Special Housing Unit and Residential Rehabilitation Unit/Special Population Diversion Services (Exhibit 5). Together, this Complaint refers to these policies as “the DOCCS and OMH Solitary Policies.”

76. The DOCCS and OMH Solitary Policies make clear that the Special Housing Unit—or SHU—is the unit that Defendants admit is “segregated confinement” as defined by HALT (Exhibit 2, DOCCS Directive 4933: Special Housing Units).

77. The DOCCS and OMH Solitary Policies violate HALT’s prohibition on the placement of people with disabilities in solitary confinement by placing unlawful limitations on which disabilities qualify for protection from solitary confinement.

78. Despite HALT’s broad definition of disability, the DOCCS and OMH Solitary Policies define “disability” more narrowly than HALT and therefore permit people with certain disabilities to be placed in SHU. These policies permit solitary confinement in SHU for people with mental health disabilities like depression and post-traumatic stress disorder; speech

disabilities; hearing and visual disabilities that do not constitute deafness or blindness; mobility limitations that do not require the use of a wheelchair, and more.

79. Defendants violate HALT by maintaining ongoing policies that permit the placement of some people with disabilities in solitary confinement and in fact placing people with disabilities in solitary confinement.

80. The DOCCS and OMH Solitary Policies apply across every correctional facility in New York State, in which over 32,000 people are incarcerated.

**A. DOCCS Policies Unlawfully Narrow HALT's Categorical Protection**

81. After HALT was enacted, DOCCS issued Directives 4933 and 4933D regarding Special Housing Units and Residential Rehabilitation Units (*see* Exhibits 2, 3), and issued a SHU Exclusions Policy further explicating these Directives by listing the specific categories of people that DOCCS will not place in SHUs (*see* Exhibit 4). Together, these written documents set out DOCCS' ongoing policy of unlawfully narrowing the broad protections HALT requires for people with disabilities.

82. DOCCS Directives 4933 and 4933D state that incarcerated individuals who are members of "Special Populations" shall not be placed in SHU and should instead be diverted to RRU (Exhibit 2, DOCCS Directive 4933 § III [A] [1]; Exhibit 3, DOCCS Directive 4933D § II [A]). Although these Directives cross-reference the definition of "disability" in HALT, both the Directives and the SHU Exclusions Policy substantively contradict that definition by limiting which disabilities will trigger HALT's protections.

83. Directives 4933 and 4933D limit the mental health disabilities that trigger exclusion from SHU to those that Defendants recognize as "Serious Mental Illness (SMI)" (Exhibit 2, DOCCS Directive 4933 § III [A] [1] [e]; Exhibit 3, DOCCS Directive 4933D § II [B]). For purposes of DOCCS Directives 4933 and 4933D and its SHU Exclusions Policy, Defendants rely

on a definition of “serious mental illness” found in the outdated “SHU Exclusion Law,” (*see* Correction Law § 137 [6] [e]), which provided far less protection than HALT.<sup>36</sup> This narrow conception of “serious mental illness” includes only a small number of specific diagnoses, such as Schizophrenia and Bipolar Disorder I and II, and other specific criteria like active suicidality, rather than the full spectrum of mental health disabilities covered by HALT.

84. Many mental health disability diagnoses—such as post-traumatic stress disorder, generalized anxiety disorder, adjustment disorder, and more—do not meet Defendants’ very narrow definition of “Serious Mental Illness,” but are nonetheless protected disabilities under HALT.

85. The SHU Exclusions Policy further explicates Directives 4933 and 4933D by giving specific instructions to DOCCS staff regarding which people may not be placed in SHU due to their status as members of a “special population.” Indeed, DOCCS produced the SHU Exclusions Policy in response to a request for all documents “describing and discussing ‘special populations’ under New York Correction Law” (Exhibit 6, FOIL Response Log No. DOCCS-22-05-274; *see also* Exhibit 7, FOIL Appeal Log No. A-0209-24 [confirming that no updates have been made to policy]).

86. The SHU Exclusions Policy clarifies that DOCCS only considers people who meet a very small number of specific criteria to be “disabled” such that they are members of a special population, and therefore will not place them in SHU. Under this policy, “disabled” means: (1) people currently housed in a Regional Medical Unit, a Special Needs Unit, the Unit for Cognitively Impaired at Fishkill Correctional Facility, or the Correctional Alternative

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<sup>36</sup> The SHU Exclusion Law is an older piece of legislation that applied only to certain incarcerated people and was superseded by HALT. HALT’s special populations provision, which includes any person with a disability and not just people with certain mental illnesses, is more expansive than the SHU Exclusion Law. By relying on and incorporating the old law into their directives and policies, Defendants violate the statutory language of HALT.

Rehabilitation Unit at Sullivan Correctional Facility; (2) people with a “Beta IQ of 70 or below”; and/or (3) people who have “any of the following active medical Problems:

- 3440 Quadraplegia
- 3441 Paraplegia
- 3442 Hemiplegia
- B240 Legally Blind
- HL10 Deaf
- V801 Wheelchair Required Independent ADL
- V802 Wheelchair Required Not Independent ADL
- V803 Supplemental Oxygen
- SHU- SHU Medically Contraindicated” (*id.*).

87. Like Directives 4933 and 4933D, the SHU Exclusions Policy also limits HALT’s protections for people with mental illnesses to those who are “Seriously Mentally Ill (SMI Indicator = S)” (*see infra* at ¶¶ 99–101).

88. Together, these DOCCS policies fail to protect people with numerous disabilities—people who are hard of hearing but are not deaf, people who have low vision but are not legally blind, people who have a mental illness that Defendants do not define as a “Serious Mental Illness” in this context, certain people with cognitive disabilities, and people who have chronic physical illnesses that do not require the use of supplemental oxygen or a wheelchair, among others—from solitary confinement in SHU.

89. DOCCS has relied on these policies to unlawfully confine many people with disabilities to solitary confinement in SHU, including the Policy Class representatives (*see infra*, at ¶¶ 116–118, 121, 125, 129, 133–134).

90. State monitoring agencies and legislators have repeatedly confronted DOCCS about these unlawful policies. For example, in June 2022, a group of legislators, including the lead sponsor of HALT, wrote a letter to DOCCS to make clear the HALT definition of disability includes “any person in DOCCS custody who is on the mental health caseload,” and that all such

people are therefore “banned from segregated confinement” (Exhibit 8, Letter from New York State Senator Julia Salazar et al. to DOCCS Deputy Commissioner and Counsel, at 3).

91. The Justice Center for the Protection of People with Special Needs (“Justice Center”), which is statutorily responsible for monitoring compliance with HALT as well as the quality of mental health care provided to people in DOCCS custody, has also brought these violations to Defendants’ attention (*see* Correction Law §§ 137; 138 [7]; 401).

92. In its 2022 Annual Monitoring Report, the Justice Center recommended that, consistent with HALT’s requirements, DOCCS and OMH “divert all individuals on the mental health caseload” to a program that “will provide better access to therapeutic programming than they will receive in segregated confinement.” In response, however, DOCCS doubled down on its improper and unlawful interpretation of HALT, claiming that “DOCCS and OMH are in agreement” that only those with a “serious mental illness” as DOCCS defines the term in its policies, are members of a special population, even though such a limitation is found nowhere in the text of HALT (Exhibit 9, Letter from DOCCS Associate Commissioner James Donahue to Justice Center, at 1).

93. On November 20, 2023, the Justice Center wrote to DOCCS regarding an individual they encountered during a site visit of Green Haven Correctional Facility, who had been subjected to solitary confinement despite having “bilateral hearing loss as well as a mental health diagnosis” (Exhibit 10, Green Haven Correctional Facility HALT Final Compliance and Quality of Care Review, at 4–5). The Justice Center explained that mental health staff had noted in the person’s records that their “lack of hearing is a very large obstacle to proper [mental health treatment]” and requested an explanation as to why Defendants did not consider this person to be part of a special population under HALT (*id.*). In response, DOCCS repeated the above position

regarding mental health disabilities and stated that the individual's diagnosis of "hearing loss/hard of hearing" does not prohibit them from being housed in solitary confinement (*id.*).

94. In March 2023, the Correctional Association of New York—an independent organization that is statutorily empowered to monitor and report to the Legislature on New York state prison conditions (*see* Correction Law § 146 [3]), issued a report documenting DOCCS' violations of HALT during the first eight months of the law's implementation, including DOCCS' placement of people with mental health diagnoses in solitary confinement. In response, DOCCS yet again confirmed its unlawful position that "[o]ther incarcerated individuals that are on the OMH caseload, but have not been identified as seriously mentally ill, do not meet the definition as provided for in Executive Law Section 21 or that of a 'special population'" (Exhibit 11, DOCCS Response to Correctional Association of New York Monitoring Report, at 46).

**B. OMH Policies Unlawfully Narrow HALT's Categorical Protection**

95. Defendant OMH's policy similarly violates HALT by defining the mental health disabilities the agency deems covered under the law too narrowly.

96. In May 2022, OMH published Central New York Psychiatric Center Corrections-Based Operations Policy No. 6.0, which defines "special populations" by limiting the disability-based category to people who are "sensorially disabled," are "physically disabled," and/or have a "serious mental illness" (Exhibit 5, OMH Policy 6.0).

97. As an initial matter, like the DOCCS policies, this policy does not include all people with mental health disabilities in its definition of "special population" but rather only those whom OMH has designated "seriously mentally ill (SMI)," a term of art from the outdated SHU Exclusion Law (*see* Correction Law § 137 [6] [e]) that is very narrow, and far narrower than the definition of disability included in HALT and Executive Law § 292 (21) (*see supra* at ¶ 83).

98. The OMH policy therefore permits DOCCS to place people with many mental health-related disabilities in solitary confinement in SHU, in violation of HALT.

99. OMH uses a numbered Mental Health Service Level system to track the mental health service needs of people incarcerated in state prisons. Any person designated Mental Health Service Level 1, 2, 3, or 4 is on the OMH mental health caseload. OMH adds an “S”-designation to a Level 1 or 2 designation (i.e., 1-S or 2-S) if OMH determines that the person meets the criteria for the term of art “Serious Mental Illness.”

100. HALT defines mental health disabilities more broadly and protects from solitary confinement any incarcerated person with a mental health disability, including any person on the OMH mental health caseload—meaning anyone whom OMH has assigned a Mental Health Service Level of 1-S, 1, 2-S, 2, 3, or 4—and any person who is not on the OMH caseload—meaning anyone who OMH has assigned a Mental Health Service Level of 6—so long as they maintain a mental health diagnosis.<sup>37</sup>

101. By contrast, OMH’s policy only excludes an individual from solitary confinement placement if OMH has assigned that person a Mental Health Service Level of 1-S or 2-S.

102. OMH’s policy does not exclude from solitary confinement any other individuals with diagnosed mental illnesses. Yet, these individuals have mental health disabilities as defined in HALT. OMH policy therefore violates HALT by failing to apply its protections to all people with mental health disabilities.

103. As they have with DOCCS, state monitoring agencies have confronted OMH about its policy’s non-compliance with HALT.

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<sup>37</sup> There is no Mental Health Service Level 5.

104. In October 2022, the Justice Center sent a request to OMH to ask why an individual on the mental health caseload at Ulster Correctional Facility was not considered to fall under the definition of a “special population” and had been placed in solitary confinement. OMH responded that it was their position that a person on the mental health caseload is not part of the “special population” unless they meet the criteria for “S-designation” (Exhibit 12, Letter from OMH Associate Commissioner Li-Wen Lee to Justice Center, at 1). In other words, because the individual had been designated as having a Mental Health Service Level of 3, OMH believed they could be subjected to solitary confinement, despite the statute’s clear requirement to the contrary.

105. On another occasion, the Justice Center wrote to Defendants about a person incarcerated at Clinton Correctional Facility who had been subjected to solitary confinement (Exhibit 13, Clinton Correctional Facility HALT Final Compliance and Quality of Care Review, at 5–6). Although the person had a Mental Health Service Level of 2 and therefore should have been protected from solitary confinement by HALT, DOCCS had placed the person in solitary confinement in a SHU cell. Only after the individual engaged in a suicide attempt two days later did OMH assign the person an “S-designation” such that the DOCCS and OMH Solitary Policies would exclude them from solitary confinement.

106. OMH repeated an unlawful interpretation of HALT in response to the Correctional Association of New York monitoring report discussed *supra* at ¶ 94 (see Exhibit 11, OMH’s Response to Correctional Association of New York Monitoring Report). The Correctional Association of New York report concluded that “HALT prohibits anyone with a mental health diagnosis, including anyone on the state Office of Mental Health (OMH) caseload” from being placed in solitary confinement (Exhibit 11, Correctional Association of New York Monitoring Report, at 24). OMH’s response was wrong: it referenced a definition of disability provided by an

irrelevant statute, the Mental Hygiene Law, to claim that “not all mental health diagnoses are synonymous with an individual experiencing substantial disability (Mental Hygiene Law 1.03)”; according to OMH, only individuals who are “experiencing substantial functional disability” due to their mental health and have thus been assigned an “S-designation” fall under the definition of special population in HALT (*id.* at 63).

107. The statute that OMH referenced to define disabilities, *see supra* at ¶ 106, the New York Mental Hygiene Law § 1.03, provides a more restrictive definition of mental illness than the scope of mental health disabilities that are subject to HALT—which defines “disability” more broadly by reference to the New York State Human Rights Law (Executive Law § 292 [21]), and not the New York Mental Hygiene Law.

108. The Mental Hygiene Law defines “Persons with serious mental illness” as:

“individuals who meet criteria established by the commissioner of mental health, which shall include *persons who are in psychiatric crisis*, or persons who have a designated diagnosis of mental illness under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders *and whose severity and duration of mental illness results in substantial functional disability.*” (Mental Hygiene Law § 1.03 [52] [emphases added]).

By contrast, by defining disability by reference to the New York State Human Rights Law, HALT protects people with a far broader array of mental health diagnoses. Employing the narrower scope of the Mental Hygiene Law definition, OMH denies HALT protections to incarcerated people with mental health conditions that qualify as disabilities under the New York State Human Rights Law, such as generalized anxiety disorder, panic disorder, and post-traumatic stress disorder (*see Hollandale Apts. & Health Club, LLC v Bonesteel*, 173 AD3d 55, 64 [3d Dept 2019]; *1 Toms Point Lane Corp. v New York State Div. of Human Rights*, 176 AD3d 930, 932 [2d Dept 2019]; *Reeves v Johnson Controls World Servs.*, 140 F3d 144, 154–156 [2d Cir 1998]; *Hughes v City of New York*, 2021 WL 7542440, \*7 (EDNY, Aug. 25, 2021, No. 20-CV-3341 (AMD) (RLM)]).

109. OMH policies therefore limit the scope of those protected by HALT due to a mental health disability to only “persons with serious mental illness,” as it improperly defines that term by reference to inapplicable statutes, rather than the full scope of people with mental health disabilities as codified by HALT.

110. People with mental health disabilities are routinely subjected to solitary confinement in SHU, in violation of HALT.

111. DOCCS’ own data show that, in any given month, it holds dozens of people with disabilities in SHU. As of the first of each month from May 2022 to April 2024, between 27 percent and 39 percent of the total population in SHU had a Mental Health Service Level of 1, 2, 3, or 4 and thus had a recognized mental illness, and people with mental illness represented at least one-third of the total SHU population in 20 of those 24 months. Likewise, DOCCS reports show that it places people with the highest-level medical needs in SHU. Because these data do not reflect people with Mental Health Service Levels of 6 or lower-level medical needs who nonetheless have a disability as defined under HALT, the true number of people with disabilities whom DOCCS holds in SHU is almost certainly higher.

112. Following site visits, the Justice Center similarly reported finding individuals on the mental health caseload in SHU at Attica Correctional Facility, Coxsackie Correctional Facility, Eastern Correctional Facility, Elmira Correctional Facility, Fishkill Correctional Facility, Franklin Correctional Facility, Green Haven Correctional Facility, Lakeview Correctional Facility, Mohawk Correctional Facility, Shawangunk Correctional Facility, Sing Sing Correctional Facility, Sullivan Correctional Facility, Ulster Correctional Facility, and Washington Correctional Facility. For example, at Sullivan Correctional Facility, an individual with a Mental Health Service Level of 2 had nonetheless been in SHU for 38 days.

113. The experiences of the Policy Class representatives demonstrate how the DOCCS and OMH Solitary Policies result in the unlawful placement of people with disabilities in solitary confinement.

114. **Corey Allen**, for example, has been diagnosed with neuropathy and paralysis, alternately referred to as a deformity or contracture, in his left hand (*see supra* at ¶ 9).

115. Mr. Allen's disability diagnoses are excluded from the DOCCS and OMH Solitary Policies.

116. Since HALT's enactment, DOCCS has placed Mr. Allen in SHU units at least four times at four different correctional facilities. Specifically, Mr. Allen was held in the SHU and SHU Overflow Unit at Elmira Correctional Facility from approximately early to late August 2022, in the Collins SHU from approximately late September through late October 2022, in the Cocksackie SHU from approximately late December 2022 through mid-March 2023, and in the A1 SHU Unit at Five Points Correctional Facility from approximately mid-January to early February 2024. Thus, Mr. Allen has spent months in SHU since HALT went into effect, despite his disabilities.

117. In these SHU units, Mr. Allen was generally permitted to leave his cell for no more than four hours per day, and often much less. Indeed, in the Collins S-Block where Mr. Allen spent several weeks, he generally remained in cell confinement for 24 hours per day, with his only "recreation" consisting of temporary access to a semi-outdoor portion of his cell which was surrounded by concrete on three sides and did not permit any interaction with other people.

118. Through their ongoing policies, DOCCS and OMH continuously fail to recognize Mr. Allen's disabilities as requiring exclusion from SHU under HALT, and put Mr. Allen at constant risk of placement in SHU (*see supra* at ¶¶ 50–56). Mr. Allen was most recently placed in SHU as a result of his objection to being housed with a cell mate since he feared that his

disabilities would render him unable to effectively defend himself should a cell mate choose to attack him. Mr. Allen's objections to DOCCS' attempts to assign him a cell mate led to the issuance of disciplinary tickets, and ultimately his placement in a SHU unit while he awaited a disciplinary hearing.

119. **Anna Adams** has been diagnosed with lupus, asthma, and anxiety, and previously was diagnosed with post-traumatic stress disorder (*see supra* at ¶ 10). As a result of having lupus, she has limited physical mobility and has been approved by DOCCS for a mobility aid as an accommodation for her disability.

120. Ms. Adams' disability diagnoses are excluded from the DOCCS and OMH Solitary Policies.

121. After HALT's enactment, DOCCS placed Ms. Adams in SHU, during which time she was confined to a cell for 23 hours each day. The SHU environment triggered Ms. Adams' anxiety and post-traumatic stress disorder symptoms. She also suffered asthma attacks and was repeatedly sent to the infirmary, only to then be sent back to SHU once treated despite the correlation between the environment and her symptoms.

122. Through their ongoing policies, DOCCS and OMH continuously fail to recognize Ms. Adams' disabilities as requiring exclusion from SHU under HALT and put Ms. Adams at constant risk of placement in SHU. *See supra* at ¶¶ 50–56.

123. **Andy Gneco** has multiple disabilities. DOCCS has designated Mr. Gneco as "HL-30" according to their system of hearing disability classification, acknowledged that he is hard of hearing in both ears, and has approved him to receive hearing aids as an accommodation for his disability. OMH has also diagnosed Mr. Gneco with anxiety and depression, placed him

on the OMH caseload to receive treatment for these disabilities, and, as of September 15, 2023, designated him as a Mental Health Service Level 3 according to the agency's classification system.

124. Mr. Gneco's hearing and mental health disability diagnoses are excluded from the DOCCS and OMH Solitary Policies.

125. Although both DOCCS and OMH acknowledge Mr. Gneco's diagnoses, which should have excluded him from being subjected to solitary confinement under HALT, DOCCS has twice placed him in SHU for a period of at least 45 days. During these periods, Mr. Gneco was confined to his cell for 22 to 23 hours per day and denied opportunities to access work, educational, or any other programming.

126. Through their continuing policies, DOCCS and OMH continuously fail to recognize Mr. Gneco's disabilities as requiring exclusion from SHU under HALT and put Mr. Gneco at constant risk of placement in SHU (*see supra* at ¶¶ 50–56).

127. **Andre Greene** is hard of hearing and DOCCS has designated him as HL-20. He has previously been housed in a special unit at Sullivan Correctional Facility for incarcerated people with hearing disabilities.

128. Mr. Greene's hearing disability diagnosis is excluded from the DOCCS and OMH Solitary Policies.

129. When HALT first went into effect, Mr. Greene was serving a disciplinary sanction in a SHU at Sullivan Correctional Facility; at the time, he was informed by DOCCS staff that he did not qualify for protection under HALT because he was hard of hearing, not deaf. He therefore remained in the SHU at Sullivan for approximately a few weeks.

130. Through their continuing policies, DOCCS continuously fails to recognize Mr. Greene's disabilities as requiring exclusion from SHU under HALT and put Mr. Greene at constant risk of placement in SHU (*see supra* at ¶¶ 50–56).

131. **Stephanie Peña** was diagnosed with multiple mental health disabilities shortly after being incarcerated by DOCCS in August 2022, including post-traumatic stress disorder and anti-social personality disorder.

132. Ms. Peña's mental health disability diagnoses are excluded from the DOCCS and OMH Solitary Policies.

133. Despite having diagnoses that should exclude her from solitary confinement under HALT, DOCCS has placed her in SHU six times. On many of these occasions, DOCCS sent her to SHU as a sanction for conduct related to her mental health conditions, such as allegedly resisting forceable extraction from her cell during a suicide attempt.

134. In total, Ms. Peña has spent over 70 days in SHU at Albion Correctional Facility. During these periods, DOCCS confined Ms. Peña to her cell for approximately 23 hours per day, with just one hour of "recreation" in a single-person metal cage. DOCCS thereby denied her opportunities to access work, recreation, or any programming during those periods. Despite the known mental harms associated with solitary confinement, Defendants provided minimal mental health care to her and others in SHU.

135. Through their continuing policies, DOCCS and OMH continuously fail to recognize Ms. Peña's disabilities as requiring exclusion from SHU under HALT and put her at constant risk of placement in SHU (*see supra* at ¶¶ 50–56).

136. The DOCCS and OMH Solitary Policies constitute continuing policies of the Defendants to unlawfully deny people with disabilities the full protection of HALT.

V. **Defendants' Practices Routinely Violate HALT By Placing People with Disabilities in Solitary Confinement**

137. In addition to violating HALT through their unlawful written policies, Defendants' common practices routinely violate HALT by subjecting people with disabilities—including even people with disabilities incorporated in and covered by the DOCCS and OMH Solitary Policies—to solitary confinement.

138. HALT defines solitary confinement as *any form* of cell confinement, regardless of the name of the unit, for more than 17 hours a day other than in a facility-wide emergency or for the purpose of providing medical or mental health treatment (Correction Law § 2 [23]).

139. As discussed above, Defendants violate HALT by placing people with disabilities, including people who are members of both the Policy Class and the Practice Class, in SHU—by definition a form of prohibited solitary confinement that violates HALT (*see supra* at ¶¶ 89, 110–112, 116–118, 121, 125, 129, 133–134).

140. In addition, Defendants hold people with disabilities in their cells for more than 17 hours a day in many different units and for many purposes.

141. Defendants hold people with disabilities in their cells for more than 17 hours per day in Administrative Segregation, Residential Rehabilitation or Residential Mental Health Units, Step-Down Units, and others. Even some people who are held in general population units are locked in their cells for more than 17 hours a day. Regardless of the name of the unit, HALT bans all these forms of solitary confinement for people with disabilities.

142. Defendants maintain solitary confinement in these units by denying people sufficient access to programming, congregate meals, recreation, and other activities and out-of-cell time.

143. In many of these units, DOCCS provides recreation only in small, single person “recreation pens,” which are accessed through a door in an individual’s cell and are typically surrounded by concrete walls or fencing on three or four sides. These pens do not allow for any meaningful interaction between incarcerated individuals and are thus nothing more than semi-outdoor portions of each individual’s cell. These “recreation pens” are a form of cell confinement, and thus do not constitute out-of-cell time as required by the HALT.

144. On April 4, 2024, the Campaign for Alternatives to Isolated Confinement and the Mental Health Alternatives to Solitary Confinement Campaign wrote to OMH to express their “deep[ ] concern[ ] about the systematic violations of the HALT Law taking place across New York state prisons that continue to mean in practice that the prisons are still subjecting thousands of people to solitary by another name, and about the resulting negative impacts on people’s mental health and even loss of life” (Exhibit 1, Letter from Campaign for Alternatives to Isolated Confinement and Mental Health Alternatives to Solitary Confinement to OMH Commissioner Sullivan at 1). For example, the Campaigns noted the “numerous complaints” received from people held in Residential Mental Health Treatment Units and reports from “OMH and DOCCS staff that out-of-cell time and programming at multiple facilities has not substantially changed after HALT was enacted, that people are provided similar amounts of programming as was provided prior to HALT, and that people are not being provided access to the required seven hours of daily group out-of-cell programs and activities” (*id.* at 3).

145. The Campaigns also described, in their April 4, 2024, letter, the “innumerable reports” that people held in RRUs do not receive the required out-of-cell time, noting that “[m]any people report that they do not receive any out-of-cell time, while others receive up to at most three hours to—rarely—six hours of group out-of-cell time, often only during weekdays” (*id.* at 4). At

Upstate Correctional Facility, the largest RRU in the state, “the official policy at the facility has been that people at most get access to one module of three hours per day of out-of-cell time (and many people do not receive any out-of-cell time)” (*id.*).

146. Even when Defendants allow people with disabilities more than seven hours out of their cell, this period can be short lived. DOCCS correctional officers, facility rules, or even unwritten practices can change quickly, and people can find themselves cycling back into unlawful and harmful periods of solitary confinement.

147. Defendants’ practice of subjecting people with disabilities to solitary confinement is widespread across DOCCS facilities.

148. The experiences of the Practice Class representatives exemplify DOCCS’ practice of placing people with disabilities in solitary confinement, regardless of how DOCCS labels their cells.

149. **Maurice Anthony** is legally blind and has been approved by DOCCS to receive accommodations for his disability. DOCCS also previously held him in a unit specifically for people with sensorial disabilities.

150. Despite having a recognized disability, DOCCS held Mr. Anthony in solitary confinement during periods from October 2021 to May 2023 while he was in Step-Down Program at Mid-State Correctional Facility. The time DOCCS confined Mr. Anthony to his cell while in the Step-Down Program varied between approximately 19 to 23 hours per day depending on the stage of the Step-Down program. The only recreation he was permitted was by himself in a small semi-outdoor portion of his cell.

151. From May 2023 through January 2024, DOCCS confined Mr. Anthony in solitary in the RRU at Upstate Correctional Facility. While in the RRU, DOCCS confined him to his cell

for approximately 21 hours per day. While DOCCS technically permitted Mr. Anthony to leave his cell to attend programming during the remaining few hours of the day, he was functionally unable to participate in any educational or therapeutic programming because DOCCS failed to provide him with accommodations for his disability that were necessary to access program materials.

152. Even if he wanted to attend programs, he and others in his unit were required to stand at the door of their cells between 5:30 a.m. and 7:30 a.m. to possibly be added to the list for program attendance for the day. At Upstate, the only recreation allowed was to stand alone in a small, semi-outdoor portion of his cell.

153. DOCCS has housed Mr. Anthony in a diversion unit at Wende Correctional Facility since January 2024. He is held alone in a cell, to which he is confined for approximately 20 hours per day. He is only allowed one hour of “recreation” each day, but it just consists of being allowed to go alone into a small 10 foot by 10 foot cage. Recreation in this space does not permit interactions with any other incarcerated individuals.

154. As a result of the extreme isolation of being held in solitary confinement conditions, Mr. Anthony has experienced claustrophobia, blackouts, hopelessness, and extreme frustration. He finds the routine torturous and it makes him feel like he just needs to sleep all the time. Mr. Anthony has compared solitary confinement to being caught “in a trunk” or a “casket” where “you can’t get out.” He has blacked out several times while being held in solitary confinement.

155. Mr. Anthony feels that, even if he is eventually allowed out of these unlawful conditions, it is only a matter of time until he is again placed in these unlawful conditions.

156. **Corey Allen** has a physical disability, namely neuropathy and paralysis in his left hand (*see supra* at ¶ 9).

157. As noted *supra* at ¶¶ 116–118, he has been repeatedly placed in solitary confinement—in SHU—while incarcerated.

158. In addition, he has also been held in solitary confinement in other units, including the RRU at Gouverneur Correctional Facility, where he was required to spend approximately 21 hours per day in cell confinement; the RRU at Upstate Correctional Facility, where he was again forced to spend approximately 21 hours per day in cell confinement; and even the general population unit at Five Points Correctional Facility, where he was forced to spend approximately 22 hours per day in cell confinement.

159. As of April 24, 2024, Mr. Allen was in solitary confinement in the reception unit at Great Meadow Correctional Facility, where he was generally forced to spend approximately 21 hours per day in his cell, typically permitted to leave only for one or two hours of recreation per day and for meal times.

160. Spending so much time in solitary confinement has caused Mr. Allen to feel stress and lethargy. He feels as though he has been treated like an animal.

161. **Anna Adams** has been diagnosed with physical and mental health disabilities, including lupus, asthma, and anxiety, and she was previously diagnosed with post-traumatic stress disorder (*see supra* at ¶ 10).

162. As noted *supra* at ¶ 121, she has been subjected to solitary confinement in SHU by Defendants, during which time she was confined to a cell for 23 hours each day.

163. While in SHU and immediately thereafter, Ms. Adams required repeated medical treatment for asthma attacks and a lupus flare up. The restrictive SHU setting also triggered Ms. Adams' anxiety and brought up past traumatic experiences.

164. Ms. Adams worries that she will again be subjected to unlawful solitary confinement and continues to experience heightened anxiety and fear that she will have a medical crisis while locked away in SHU.

165. **Andy Gneco** has hearing and mental health disabilities, which are recognized by DOCCS and OMH, as detailed above (*see supra* at ¶ 123–124).

166. As noted *supra* at ¶ 125, however, DOCCS has repeatedly held Mr. Gneco in solitary confinement in SHU while incarcerated.

167. In addition, despite his disabilities, Mr. Gneco has also repeatedly been held in solitary confinement conditions in units other than SHU. At Auburn Correctional Facility, DOCCS held Mr. Gneco in his general population cell for 20 to 21 hours a day.

168. DOCCS has also held Mr. Gneco in solitary confinement during two separate periods in the RRU at Upstate Correctional Facility. The most recent placement in the RRU began on approximately September 15, 2023, and lasted until he was transferred to Attica Correctional Facility in late April 2024. DOCCS offered Mr. Gneco approximately three hours of out of cell programming each day in the Upstate RRU. DOCCS otherwise confined him to his cell, which included a small semi-outdoor “recreation pen” with large concrete walls on three sides and metal fencing at the rear. The pen did not allow for meaningful interaction with anyone aside from his cellmate.

169. Access to out-of-cell time was further restricted by practices among DOCCS staff requiring that incarcerated individuals stand at their doors between 5:30 a.m. and 6:30 a.m. to be placed on the list to be let out of a cell for programming. For people who are hard-of-hearing like Mr. Gneco, it was easy to miss the announcement and be denied out-of-cell time altogether.

170. DOCCS currently holds Mr. Gneco in a general population unit at Attica Correctional Facility. There, Mr. Gneco is only able to participate in one of the two recreation windows offered due to a loss-of-recreation disciplinary sanction he received. The morning recreation window in which he is permitted to participate only happens three days per week, and lasts for about an hour to an hour and a half. Aside from this, Mr. Gneco is permitted to leave his cell for about 15 minutes to use the phone/kiosk every other day, and for approximately 15 minutes for each of his meals. As a result, even though he is in general population, Mr. Gneco is generally forced to spend between 21 and 23 hours in his cell each day.

171. The isolation and sensory deprivation of solitary confinement has exacerbated Mr. Gneco's depression and anxiety, leading to feelings of hopelessness, frustration, and hypervigilance. The enforced isolation from his family, including his young daughter, have caused Mr. Gneco particular distress.

172. **Andre Greene** has hearing disabilities, as noted *supra* at ¶ 127.

173. Despite this, DOCCS held Mr. Greene in solitary confinement in SHU at Sullivan Correctional Facility after the enactment of HALT (*see supra* at ¶ 129).

174. After his placement in SHU at Sullivan, DOCCS transferred Mr. Greene to an intake unit at Green Haven Correctional Facility. The conditions at Green Haven were even worse than in SHU—DOCCS locked Mr. Greene in his cell for 24 hours each day and denied him access to showers, phones, his property, and recreation. DOCCS transferred Mr. Greene to the RRU at Five Points Correctional Facility in April 2022, where he remained until October 2022. While in the RRU, DOCCS permitted Mr. Greene to leave his cell for only one to two hours in the morning to attend program, and one hour in the afternoon for “gallery recreation” which constituted being alone in a room chained to a table.

175. In October 2022, DOCCS released Mr. Greene from the RRU and placed him in general population at Five Points Correctional Facility. Upon his arrival, Mr. Greene was upset to learn that he still received very little out-of-cell time in general population; he was generally only permitted to leave his cell for between one and four hours daily, and was denied access to yard recreation.

176. Mr. Greene's mental health suffered during his time in solitary confinement. He had trouble sleeping and was not eating right.

177. Mr. Greene worries that he will continue to be subject to unlawful solitary confinement, as he repeatedly has in several different DOCCS facilities, and that if he receives another disciplinary ticket in the future, that he will again be placed in SHU.

178. **Eric Lee** has mental health disabilities which are recognized by DOCCS and OMH, and has been prescribed antidepressant and antipsychotic medications. He also has an intellectual disability and has been housed by DOCCS in a special unit for people with intellectual disabilities.

179. DOCCS has repeatedly held Mr. Lee in solitary confinement. After HALT went into effect, Mr. Lee was held in solitary confinement in SHU at Shawangunk Correctional Facility for approximately two weeks, and then was transferred to the RRU at Collins Correctional Facility. While DOCCS held Mr. Lee at the Collins RRU, DOCCS permitted him to leave his cell for only two to three hours of programming for four days per week. The remainder of his time was spent alone in cell confinement, in either the indoor portion or semi-outdoor "recreation pen" portion of his cell. The "recreation pen" was a small area within Mr. Lee's cell that he could access only intermittently, which had concrete walls on both sides separating him from other incarcerated people, and a grate that allowed him to look outside at grass, but not to interact with others.

180. In approximately May 2022, DOCCS transferred Mr. Lee to the Sullivan Correctional Alternative Rehabilitation Unit, where he was held for approximately three months. There, he was held in his cell for more than 17 hours per day. DOCCS held Mr. Lee in a cell with no mattress and no lights, causing him to experience claustrophobia, paranoia, and panic symptoms such as hyperventilation, and to become suicidal. He feared he would die alone in his cell at the Sullivan Correctional Alternative Rehabilitation Unit.

181. Mr. Lee also was subjected to solitary confinement while in the RRU at Attica Correctional Facility from December 2022 to April 2023. While he was at the Attica RRU, DOCCS did not consistently provide Mr. Lee seven hours of out-of-cell per time day. Recreation varied between one and four hours per day and took place in one-man outdoor cages. Mr. Lee also had access to two hours per day of programming. For the remainder of his time, DOCCS locked him in his cell. While in solitary confinement conditions at Attica, Mr. Lee experienced a mental health crisis during which he engaged in self-harm.

182. Since approximately April 2023, DOCCS has held Mr. Lee in the Mid-State Step-Down Program. The amount of time Mr. Lee remains in his cell has varied as he has worked through the different stages of the program, but DOCCS has never consistently provided Mr. Lee with seven hours per day outside of his cell. Currently, DOCCS permits Mr. Lee to leave cell confinement for only approximately two to three hours per day of programming a few days each week, and even this out-of-cell time is often cancelled. He is intermittently permitted to use a small semi-outdoor portion of his cell, which has tall concrete walls and does not permit a view of the outdoors or any interaction with other people.

183. The prolonged isolation and sensory deprivation associated with solitary confinement has made Mr. Lee feel desperate, paranoid, and scared that he will hurt himself. He

reports that “[s]taring at a blank white wall all day everyday just makes me want to give up” and that he does not feel that Defendants treat him like a human.

184. Mr. Lee fears that, even if he is released from solitary confinement, it is only a matter of time before he will again be held in these dangerous conditions.

185. **Stephanie Peña** has mental health disabilities including post-traumatic stress disorder and anti-social personality disorder (*see supra* at ¶ 131).

186. As discussed *supra* at ¶¶ 133–134, DOCCS has repeatedly placed Ms. Peña in solitary confinement in SHU while incarcerated at Albion Correctional Facility.

187. Ms. Peña reports that solitary confinement is “destroying [her]” and has caused her to experience drastic mood swings such as crying at night and then suddenly starting to laugh. The experience has exacerbated symptoms associated with her post-traumatic stress disorder, including having nightmares and flashbacks. She frequently cries at night and has attempted suicide while incarcerated. She has even been denied the opportunity to speak with her family using the tablet system.

188. While she is trying to stay strong, she lives in constant fear that any misstep or perceived disobedience of DOCCS rules will result in being sent again to SHU, as she has repeatedly experienced while at Albion.

189. **Boubacare Tunkara** has mental health disabilities including bipolar disorder and anti-social personality disorder. He also has an intellectual disability (*see supra* at ¶ 15).

190. Since April 2022, DOCCS has repeatedly subjected Mr. Tunkara to solitary confinement, despite his disabilities.

191. From about March to April 2023, when DOCCS held Mr. Tunkara in the RRU at Upstate Correctional Facility, DOCCS generally permitted him to leave his cell for approximately

one to three hours per day. His recreation time took place in a semi-outdoor portion of his cell called a recreation pen. He could access programming only if he was by his cell door early in the morning when officers silently walked by. On days Mr. Tunkara did attend programming, it would last for about two hours during which he was shackled to a chair the entire time.

192. The conditions in the Upstate RRU, exacerbated by OMH's failure to consistently provide Mr. Tunkara with his medication, caused Mr. Tunkara's mental health to deteriorate such that he overdosed on ibuprofen, which resulted in DOCCS transferring him out of the RRU and eventually to the Central New York Psychiatric Center for about two months.

193. After Mr. Tunkara was discharged from the Central New York Psychiatric Center, DOCCS transferred him to the Residential Mental Health Unit at Marcy Correctional Facility, where they again housed him in solitary confinement from approximately June 2023 until January 2024. On most days, DOCCS offered Mr. Tunkara two hours of out-of-cell programming in the morning and otherwise kept him locked in his cell. About once a week, DOCCS provided Mr. Tunkara with four hours of out-of-cell programming. Mr. Tunkara's only recreation again occurred alone in a semi-outdoor portion of his cell with concrete walls on three sides that prevented him from seeing or talking with anyone else.

194. In January 2024, DOCCS held Mr. Tunkara in solitary confinement for about 10 days in the Diversion Unit at Elmira Correctional Facility. There, DOCCS permitted Mr. Tunkara to leave his cell solely for one hour of recreation alone in a metal pen.

195. DOCCS then transferred Mr. Tunkara from the Diversion Unit at Elmira Correctional Facility to the Residential Mental Health Unit at Five Points Correctional Facility, where DOCCS subjected him to solitary confinement, offering him only about six hours of out-

of-cell time each day; during four of those hours, his legs were shackled to a chair and he could not move. Mr. Tunkara was transferred to Sing Sing Correctional Facility in late April 2024.

196. These long periods in solitary confinement have exacerbated Mr. Tunkara's mental health symptoms. He experiences paranoia and hypervigilance which leaves him on edge around other people. He wakes up angry and suffers from ongoing depression.

197. **Alterek Witherspoon** has multiple mental health disabilities, including post-traumatic stress disorder and antisocial personality disorder. Mr. Witherspoon has also been diagnosed with schizoaffective disorder, but OMH does not currently recognize that diagnosis despite prescribing him Haldol, an antipsychotic medication that is used to treat schizophrenia and schizoaffective disorders.

198. OMH has designated Mr. Witherspoon with a Mental Health Service Level of 1S and DOCCS housed him in the Residential Mental Health Unit at Five Points Correctional Facility from the time HALT went into effect until April 2024, when he was transferred to Attica Correctional Facility. At Attica Correctional Facility, Mr. Witherspoon is housed in the Transitional Intermediate Care Program, which is a program intended for people with serious mental illnesses.

199. DOCCS subjected Mr. Witherspoon to solitary confinement conditions in the Five Points Residential Mental Health Unit. On weekdays in the Residential Mental Health Unit, DOCCS permitted Mr. Witherspoon to leave his cell for approximately four hours per day for programming, which at times took place shackled to a chair, and two hours per day for recreation in a fenced-in pen with between two and five other people. On weekends, Mr. Witherspoon did not have access to programming, but received additional recreation time. In general, Mr. Witherspoon was required to remain in his cell for approximately 18 hours per day.

200. At one point during his time in the Residential Mental Health Unit, Mr. Witherspoon was hired as a porter, which meant he was let out of his cell to pass out supplies or clean the unit, but even with this additional flexibility he did not consistently receive the out-of-cell time mandated by HALT.

201. On approximately April 15, 2024, DOCCS transferred Mr. Witherspoon to the Transitional Intermediate Care Program at Attica, where DOCCS continued to hold him in cell confinement for more than 17 hours per day as of April 22, 2024. In the Transitional Intermediate Care Program, Mr. Witherspoon is generally permitted one period of recreation outside of his cell on weekdays and two on Saturdays, with each period lasting approximately one and a half to two hours. He is also permitted to eat meals outside of his cell, for about 30 minutes per meal, and to use the phone for about 15 minutes every other day. As of April 22, 2024, Mr. Witherspoon was not provided with any programming in Transitional Intermediate Care Program.

202. As a result of the prolonged isolation and sensory deprivation associated with solitary confinement, Mr. Witherspoon's mental health symptoms have worsened, and he has begun experiencing physical manifestations of the stressful environment such as hair loss.

203. By holding members of the Practice Class in cell confinement for more than 17 hours per day, whether in SHU, RRU, general population, or any other units, Defendants violate HALT and cause great harm to those most at risk from this barbaric practice.

### **CLASS ALLEGATIONS**

204. Plaintiffs bring this action pursuant to section 901 of the New York Civil Practice Law and Rules ("CPLR") on behalf of all persons in DOCCS custody with a disability—as defined by Executive Law § 292 (21) (a)—who, since March 31, 2022, have been, are, or will be subjected to segregated confinement as defined by Correction Law § 2 (23) ("the Practice Class").

205. Plaintiffs also bring this action on behalf of all persons in DOCCS custody with any disability—as defined by Executive Law § 292 (21) (a)—that is omitted from the DOCCS and OMH Solitary Policies (“the Policy Class”).

206. The Practice Class and Policy Class satisfy the numerosity, commonality, typicality, adequacy, and superiority requirements of CPLR 901.

207. The Practice Class and Policy Class are sufficiently numerous that joinder of all individual class members is impracticable. Defendants have subjected hundreds of people with disabilities as defined by HALT to solitary confinement each year since the HALT took effect on March 31, 2022, and they will continue to do so with respect to additional members of the Practice Class and Policy Class while their current policies and practices regarding solitary confinement remain in place.

208. Joinder is also impracticable because Practice Class members are, by definition, held in solitary confinement in prisons across the state, meaning their ability to efficiently communicate with each other, their counsel, and the courts is severely curtailed. Members of the Policy Class are similarly incarcerated and held in isolating conditions across the state, and a lack of accommodations for their disability may prevent effective communication with each other, their counsel, and the courts.

209. Members of the Practice Class are affected by common questions of law and fact that predominate over questions affecting only individual members. Without limitation, these common questions include:

- a. Whether Defendants maintain a policy or practice of subjecting class members to cell confinement, regardless of the name of the unit, for more than 17 hours per day;
- b. Whether any such policy violates HALT, Correction Law § 137 [6] [h]; and

- c. Whether, as a result of their segregation, class members have been denied the rights and benefits provided to them as members of a “special population” under HALT.

210. Similarly, many questions of law and fact are common to the Policy Class members, all of whom make the same claim, including, without limitation:

- a. Whether Defendants’ policies exclude disabilities as defined by the NYSHRL, N.Y. Exec. Law § 292 [21];
- b. Whether Defendants violate HALT by omitting class members’ disabilities from their policies; and
- c. Whether members of the Policy Class have been denied the rights and benefits provided to them as members of a special population under HALT as a result.

211. The claims of the individual class representatives—Plaintiffs Anthony, Allen, Adams, Gneco, Greene, Lee, Peña, Tunkara and Witherspoon—are typical of those of the Practice Class as a whole. All putative Practice Class representatives have a disability as defined by HALT and have been or are held in cell confinement for longer than 17 hours per day.

212. The claims of the individual putative Policy Class representatives—Plaintiffs Allen, Adams, Gneco, Greene, and Peña—are typical of the Policy Class as a whole. All putative Policy Class representatives are members of at least one disability-based special population under HALT and, because their disability is omitted from the DOCCS and OMH Solitary Policies, their rights under HALT are violated as Defendants maintain a continuing policy that permits their placement in solitary confinement in SHU and puts them at constant risk of such placement.

213. Declaratory and injunctive relief are appropriate for each of the putative Practice Class and Policy Class as a whole. A declaration that the DOCCS and OMH Solitary Policies and that Defendants’ practices violate HALT and an injunction requiring Defendants to comply, in their

policies and practices, with the relevant provisions of HALT would resolve the claims of each of the putative classes.

214. Each of the Named Plaintiffs will fairly and adequately protect the interests of the proposed classes. Their interests in opposing Defendants' policy and practice of placing people with disabilities in solitary confinement align with those of other members of the Practice Class and Policy Class.

215. Further, the Practice Class and Policy Class will be represented by the Prisoners' Rights Project at The Legal Aid Society, Disability Rights Advocates, and Winston & Strawn LLP, each of which has extensive experience litigating class actions, including regarding the rights of incarcerated people in New York and other states and the rights of people with disabilities, and will therefore adequately represent the Classes. Counsel for the proposed classes anticipates no difficulty in managing this matter as a class action.

216. A class action is the superior method for the fair and efficient resolution of the Practice Class and Policy Class members' claims. The filing of numerous individual actions by class members would be duplicative, impracticable, and inefficient, thus wasting the court's and the parties' financial, administrative, and procedural resources, and placing undue burdens on individual members of the proposed classes, all of whom are incarcerated. Numerous individual actions would also risk the possibility of legal confusion caused by conflicting decisions.

217. It is desirable to concentrate litigation challenging DOCCS and OMH's policies and practices regarding the unlawful placement of people with disabilities in solitary confinement in Kings County because it is one of the counties with the highest number of DOCCS commitments in the state (*see* DOCCS Incarcerated Profile Report – March 2024,<sup>38</sup> [reflecting that 10.1 percent

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<sup>38</sup> DOCCS Incarcerated Profile Report, Mar. 1, 2024, available at [https://doccs.ny.gov/system/files/documents/2024/03/2024\\_03\\_01-uc-profile.pdf](https://doccs.ny.gov/system/files/documents/2024/03/2024_03_01-uc-profile.pdf) (last accessed Apr. 29, 2024).

of total DOCCS commitments originated in Kings County and 30.6 percent of the population incarcerated in DOCCS facilities from all counties within the Second Department, with Kings County having the highest number]). Further, Kings County is where Plaintiffs Anthony, Allen, Adams, and Peña resided before their incarceration commenced. Lastly, Plaintiffs and their counsel are not aware of any other action that raises these claims on behalf of the putative classes.

### **FIRST CAUSE OF ACTION**

#### **(Violation of Correction Law § 137 [6] [h]) (Permanent Injunction and Declaratory Judgment by All Plaintiffs on Behalf of the Practice Class Against All Defendants)**

218. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 217 as if fully set forth herein.

219. HALT specifies that “[p]ersons in a special population . . . shall not be placed in segregated confinement for any length of time, except in keeplock for a period prior to a disciplinary hearing” (Correction Law § 137 [6] [h]).

220. The law defines special populations as including “any person . . . (c) with a disability as defined in paragraph (a) of subdivision twenty-one of section two hundred ninety-two of the executive law” (Correction Law §§ 2 [33]).

221. Executive Law § 292 (21)—commonly referred to as the New York State Human Rights Law—defines disability as “(a) a physical, mental, or medical impairment resulting from anatomical, physiological, genetic, or neurological conditions which prevents the exercise of a normal bodily function or is demonstrable by medically accepted clinical or laboratory diagnostic techniques or (b) a record of such an impairment or (c) a condition regarded by others as such an impairment . . . .”

222. This definition of “disability” in Executive Law § 292 (21) covers conditions that are “merely diagnosable medical anomalies which impair bodily integrity and thus may lead to more serious conditions in the future” (*Xerox Corp.*, 65 NY2d at 219).

223. Plaintiffs are individuals with disabilities as defined by Executive Law § 292 (21).

224. Because Plaintiffs and members of the Practice Class are individuals with disabilities as defined by Executive Law § 292 (21), HALT bars Defendants from holding them in solitary confinement for any period of time.

225. Defendants have nonetheless placed Plaintiffs and members of the Class in solitary confinement, or “segregated confinement,” as that term is defined by Correction Law § 2 (23).

226. Defendants’ actions violate Correction Law § 137 (6) (h).

227. If Defendants are not enjoined and restrained from violating Correction Law § 137 (6) (h), Plaintiffs and members of the Class will continue to suffer irreparable harm.

228. Plaintiffs and members of the Class have no adequate remedy at law.

229. The Court should therefore declare that Defendants are violating Correction Law § 137 (6) (h) by subjecting people with disabilities to conditions of confinement that constitute solitary confinement, and permanently enjoin Defendants from violating § 137 (6) (h) in this manner.

## **SECOND CAUSE OF ACTION**

### **(Violation of Correction Law § 137 [6] [h]) (Permanent Injunction and Declaratory Judgment by Plaintiffs Allen, Adams, Gneco, Greene, and Peña on Behalf of the Policy Class against All Defendants)**

230. Plaintiffs repeat and reallege the allegations contained in paragraphs 1 through 229 as if fully set forth herein.

231. DOCCS and OMH have continuing policies that define which disabilities the agency considers to fall within the scope of HALT.

232. Those continuing policies define “disability” more narrowly than Executive Law § 292 (21) and thus subject people with disabilities that are not delineated in those policies to solitary confinement in violation of HALT.

233. Defendant DOCCS’ continuing policies exclude from solitary confinement on the basis of disability only the following groups of people: people with a “serious mental illness,” as that term is narrowly defined by DOCCS; people who are currently housed in certain units serving people with cognitive disabilities or chronic illnesses; people who have a BETA IQ score of 70 or below; people who require a wheelchair; people who require supplemental oxygen; are HL10 (deaf); are B240 (blind); and/or people who have been diagnosed with quadriplegia, paraplegia, hemiplegia. HALT’s protections against solitary confinement extend to not only these groups, but all people with any disability, broadly defined. Thus, Defendant DOCCS’ policies permit Defendants to place people with other disabilities, as defined in Executive Law § 292 (21), in solitary confinement in violation of Correction Law § 137 (6) (h).

234. Defendant OMH’s continuing policy renders an incarcerated person eligible for a mental health disability-based exclusion from segregated confinement only if the person is diagnosed with “serious mental illness,” as that term has been defined by outdated legislation (*see* Correction Law § 137 [6] [e]). This definition is narrower than the definition provided in Executive Law § 292 (21). As a result, Defendant OMH’s policy authorize Defendants to place people with all other qualifying mental health disabilities, as defined in Executive Law § 292 (21), in solitary confinement in violation of Correction Law § 137 (6) (h).

235. The DOCCS and OMH Solitary Policies authorize Defendants to place people with disabilities in solitary confinement despite New York state law barring Defendants from doing so.

As a result of these unlawful and continuing policies, Defendants authorize themselves to and have in fact unlawfully placed members of the Policy Class in solitary confinement.

236. If Defendants are not enjoined and restrained from violating Correction Law § 137 (6) (h), Plaintiffs and members of the Policy Class will continue to suffer irreparable harm.

237. Plaintiffs and members of the Policy Class have no adequate remedy at law. Plaintiffs therefore seek judicial review and explanation of HALT as it pertains to the disabilities of the members of the Policy Class who are denied the protections of HALT by virtue of Defendants' continuing policies, and to permanently enjoin Defendants from maintaining continuing policies that violate Correction Law § 137 (6) (h).

### **PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs respectfully request that this Court enter judgment:

- a) Certifying, pursuant to CPLR 901:
  - a. A Practice Class defined as: all persons in DOCCS custody with a disability—as defined by Executive Law § 292 (21)—who, since March 31, 2022, have been, are, or will be subjected to segregated confinement as defined by Correction Law § 2 (23); and
  - b. A Policy Class defined as: all persons in DOCCS custody with any disability—as defined by Executive Law § 292 (21)—that is omitted from the DOCCS and OMH Solitary Policies.
- b) Appointing the undersigned as class counsel pursuant to CPLR 901;
- c) Declaring, pursuant to CPLR 3001, that Defendants have violated Correction Law § 137 (6) (h) by holding in segregated confinement, as defined by § 2 (23), Plaintiffs, and members of the Classes, despite their disabilities;
- d) Declaring, pursuant to CPLR 3001, that Defendants' DOCCS and OMH Solitary Policies (i.e., DOCCS Directives 4933 and 4933D, DOCCS SHU Exclusions Policy, and OMH Policy. 6.0) violate Correction Law § 137 (6) (h);
- e) Permanently enjoining Defendants from holding Plaintiffs and members of the Practice Class and Policy Class in Segregated Confinement, as defined by Correction Law § 2 (23);

- f) Permanently enjoining Defendants from maintaining continuing policies that violate Correction Law § 137 (6) (h);
- g) Order reasonable and appropriate attorneys' fees and costs;
- h) Ordering such other and further relief as the Court deems appropriate.

Dated: May 7, 2024  
New York, NY

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<sup>39</sup> The Prisoners' Rights Project of the Legal Aid Society also wishes to acknowledge the contributions of former legal intern Molly Crane.

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