IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF NEW YORK

UNITED STATES OF AMERICA, PLAINTIFF, v. ERIE COUNTY, NEW YORK; CHRIS COLLINS, COUNTY EXECUTIVE; ANTHONY BILLITTIER, IV, MD, COUNTY HEALTH COMMISSIONER; TIMOTHY B. HOWARD, ERIE COUNTY SHERIFF; RICHARD T. DONOVAN, ERIE COUNTY UNDERSHERIFF; ROBERT KOCH, SUPERINTENDENT, ADMINISTRATIVE SERVICES DIVISION, JAIL MANAGEMENT DIVISION; BARBARA LEARY, FIRST DEPUTY SUPERINTENDENT FOR ERIE COUNTY HOLDING CENTER; DONALD LIVINGSTON, FIRST DEPUTY SUPERINTENDENT FOR ERIE COUNTY CORRECTIONAL FACILITY, DEFENDANTS.	Civil No. 09-CV-0849

AMENDED COMPLAINT

PLAINTIFF, THE UNITED STATES OF AMERICA ("Plaintiff"), by its undersigned attorneys, hereby alleges upon information and belief:

1. The Attorney General files this Amended Complaint on behalf of the United States of America pursuant to the Civil Rights of Institutionalized Persons Act of 1980 ("CRIPA"), 42 U.S.C. § 1997, to enjoin the named Defendants from depriving persons incarcerated at the Erie County Holding Center ("ECHC") in Buffalo, New York, and the Erie County Correctional Facility ("ECCF") in Alden, New York, of rights, privileges, or immunities secured and protected by the Constitution of the United States.

JURISDICTION AND VENUE

2. This Court has jurisdiction over this action under 28 U.S.C. § 1345.

3. The United States is authorized to initiate this action pursuant to 42 U.S.C. § 1997a.

4. The Attorney General has certified that all pre-filing requirements specified in 42 U.S.C. § 1997b have been met.[1] The Certificate of the Attorney General is

---

[1] Under CRIPA, a certificate is required at the commencement of an action. *See* 42 U.S.C. § 1997b(a)

appended to this Amended Complaint as Attachment A and is incorporated herein.

5. Venue in the United States District Court for the Western District of New York is proper pursuant to 28 U.S.C. § 1391.

DEFENDANTS

6. Defendant ERIE COUNTY (the "County") is a governmental subdivision created under the laws of the State of New York. The Erie County Sheriff's Office is a division of the Erie County government. The County owns and operates ECHC and ECCF. This action concerns the administration of persons confined at ECHC and ECCF, which house pre- and post-trial detainees.

7. Defendant ERIE COUNTY is the entity charged by the laws of the State of New York with authority to maintain ECHC and ECCF and is responsible for the conditions of confinement and health and safety of persons incarcerated at ECHC and ECCF.

8. Defendant CHRIS COLLINS is the County Executive and serves as the chief administrator of the County

government. County Executive COLLINS is sued in his official capacity.

9. Defendant ANTHONY BILLITTIER, IV, MD, is the County Health Commissioner and is responsible for the daily oversight of health care employees at ECHC and ECCF. County Health Commissioner BILLITTIER is sued in his official capacity.

10. Defendant TIMOTHY B. HOWARD is the Sheriff of Erie County and is responsible for the day-to-day operations of ECHC and ECCF. In his official capacity as Sheriff, he has the custody, control, and charge of ECHC and ECCF and the inmates confined within. Sheriff HOWARD is sued in his official capacity.

11. Defendant RICHARD T. DONOVAN is the Undersheriff of Erie County and is responsible for the day-to-day operations of ECHC and ECCF. In his official capacity as Undersheriff, he has the custody, control, and charge of ECHC and ECCF and the inmates confined within. Undersheriff DONOVAN is sued in his official capacity.

12. Defendant ROBERT KOCH is the Superintendent of ECHC and ECCF and is responsible for the Administration,

Security, and Programs of both facilities. In his official capacity as Superintendent, he has the custody, control, and charge of ECHC and ECCF and the inmates confined within. Superintendent KOCH is sued in his official capacity.

13. Defendant BARBARA LEARY is the First Deputy Superintendent of the Jail Management Division of Erie County and is responsible for the day-to-day operations of ECHC. In her official capacity as First Deputy Superintendent, she has the custody, control, and charge of ECHC and the ECHC overflow annex located at ECCF and the inmates confined within. First Deputy Superintendent LEARY is sued in her official capacity.

14. Defendant DONALD LIVINGSTON is the First Deputy Superintendent of the Jail Management Division of Erie County and is responsible for the day-to-day operations of ECCF. In his official capacity as First Deputy Superintendent, he has the custody, control, and charge of ECCF and the inmates confined within. First Deputy Superintendent LIVINGSTON is sued in his official capacity.

15. Defendants are legally responsible, in whole or in part, for the operation and conditions of ECHC and ECCF, and for the health and safety of persons incarcerated in ECHC and ECCF.

16. At all relevant times, the Defendants or their predecessors in office have acted or failed to act, as alleged herein, under color of state law.

FACTUAL ALLEGATIONS

17. ECHC and ECCF are institutions within the meaning of 42 U.S.C. § 1997(1).

18. Persons confined to ECHC are pre-trial detainees.

19. Persons confined to ECCF are sentenced inmates, with the exception of pre-trial detainees who are held in the ECHC overflow annex located at ECCF.

20. Defendants are obligated to operate ECHC and ECCF in a manner that does not infringe upon the federal rights of persons confined at ECHC and ECCF, as protected by the Eighth and Fourteenth Amendments to the Constitution of the United States.

21. Defendants have repeatedly and consistently disregarded known or serious risks of harm to inmates at

ECHC and ECCF, as detailed in the letter issued by Acting Assistant Attorney General Loretta King on July 15, 2009, detailing the investigative findings of conditions at ECHC and ECCF ("Findings Letter"), attached as Exhibit B.

22. Defendants have repeatedly failed to take reasonable measures to prevent staff from inflicting serious harm on inmates, even in the face of the obvious and substantial risk that staff will inflict such harm and the multiple occasions on which ECHC and ECCF staff have in fact inflicted such harm. These failures have manifested themselves in the following respects, among others:

a. multiple occasions on which staff have used excessive force on inmates, for example:

1. Erie County Sheriff's Office ("ECSO") deputies have made a practice of taking ECHC inmates on "elevator rides," during which deputies reportedly physically assault inmates, including slamming their heads against the elevator walls;

2. In January 2010, an ECHC inmate was punched in the face by deputies attempting to extract him from his cell for a court appearance. The inmate was diagnosed with a scratched cornea;

3. In April 2009, an inmate was pepper sprayed because he complained to guards about his treatment at the facility;

4. In August 2008, an ECHC inmate was handcuffed, stripped, and cavity searched by a deputy who then used the same rubber gloves to search other inmates. When the inmate requested that the deputy change his gloves, which were dirty with blood and fecal matter, the deputy struck the inmate on the head and forcibly performed the search, stating that he "did not have to do a damn thing";

5. In January 2008, ECSO deputies targeted inmates who were screaming to celebrate

the New Year. In the case of one of the inmates, the deputies punched, kicked, and tied a sheet around the inmate's neck, threatening to hang him. The inmate was then shackled and taken to an isolation cell, where the deputies continued to punch and kick him;

6. In August 2007, during the booking process, ECHC deputies struck a pregnant inmate in the face, threw her to the ground, and kneed her in the side of her stomach. When she informed deputies that she was pregnant, the deputies replied that they thought she was fat, not pregnant. The inmate lost her two front teeth as a result of the assault;

7. An ECCF inmate died of a stroke in March 2007, after suffering a brain injury when ECCF deputies smashed his

head against a wall. The inmate requested medical help following the incident, but was ignored despite noticeable signs of injury (such as dragging his foot when walking and continually dropping things);

8. In April 2006, an ECHC inmate (held in the facility for urinating in public) was knocked unconscious and sustained a collapsed lung, fractures to six ribs, and a spleen injury (resulting in removal) as a result of a beating by County deputies; and

9. In 2005, a female inmate was severely beaten by booking deputies in an isolation room with no security camera. She suffered two fractured ribs and a punctured lung.

b. inadequate protection from harm and serious risk of harm caused by sexually abusive

behavior between staff and inmates at ECHC and ECCF, for example:

1. On September 16, 2008, a male ECCF deputy resigned after engaging in inappropriate sexual conduct with a female inmate;

2. On September 9, 2007, a female inmate accused a male deputy of rape. The inmate was sent to the hospital and subsequently moved to a different unit within ECHC;

These failures continue.

23. Staff abuse of inmates, exemplified by the incidents in paragraph 22, has resulted from Defendants' failure to adopt policies necessary to prevent constitutional violations, including, but not limited to, policies providing operational guidance on staff use of force and policies governing investigations of uses of force, when such policies were necessary to prevent violations of constitutional rights.

24. Staff abuse of inmates, exemplified by the incidents in paragraph 22, has resulted from Defendants' failure to adequately train their employees and agents on use-of-force and reporting of such force, among other related areas, when training was and continues to be necessary to prevent violations of constitutional rights.

25. Staff abuse of inmates, exemplified by the incidents in paragraph 22, has resulted from Defendants' failure to adequately supervise and/or discipline their employees and agents when supervision and/or discipline was and continues to be necessary to prevent violations of constitutional rights.

26. Defendants have repeatedly failed to take reasonable measures to protect inmates against the serious harm inflicted on them by other inmates, even in the face of the obvious and substantial risk that inmates will inflict such harm and the multiple occasions on which ECHC and ECCF inmates have in fact inflicted such harm. These failures have manifested themselves in the following respects, among others:

a. inadequate protection from inmate-on-inmate abuse, including failing to protect vulnerable inmates from harm, such as those who are at risk of harm from other inmates, for example:

1. In April 2010, an ECHC inmate suffered a broken eye socket, jaw, and other facial fractures after being beaten by another inmate. As the inmate stood bleeding, ECHC staff refused to call an ambulance;

2. In late 2009, an ECHC inmate suffered a fractured jaw after being physically assaulted by another inmate;

3. In a period of just over one year, between January 1, 2007 and February 9, 2008, there were over 70 reported incidents of inmate-on-inmate assaults, including sexual assaults. In many of the incidents of inmate-on-inmate violence, ECSO deputies on duty were

not present or were otherwise distracted, giving inmates ample opportunity to fight;

4. On December 11, 2007, an ECHC inmate punched a fellow inmate in the face for refusing to stop spitting in the public sink. Both inmates were under the care of the Forensic Mental Health Staff;

5. On June 22, 2007, an ECHC inmate attacked a fellow inmate, striking him with his fists and forcing him to the floor, immediately after learning his last name, calling him a "rapist" who "kills women." Both inmates were housed on constant observation at the time of the incident;

6. On April 12, 2007, an inmate was grabbed by the throat and punched in the face by three other inmates, suffering a swollen right eye and left cheek as a result of the attack.

According to the County's records, the deputy on duty was taking a "bathroom break" when the assault occurred;

7. On March 28, 2007, deputies discovered an inmate, who had been in a fight with another inmate, lying on the floor, bleeding from a head wound;

8. On February 2, 2007, an inmate was stabbed with a broken broom handle. The deputy on duty reported that he did not see the assault because he was moving a box into the elevator at the time; and

9. On January 10, 2007, an ECHC inmate attacked a fellow inmate without provocation. According to the incident report, the inmate aggressor was "under care of Forensic Mental Health, and has a history of unprovoked violent behavior."

b. ECSO deputies affirmatively place inmates in harm's way by relying on inmates to discipline each other, for example:

1. Deputies have made a practice of openly announcing the charges of alleged sexual offenders, including describing inmates as "Rape-Os," and then leaving the room, allowing the other inmates an opportunity to physically assault the alleged sexual offenders;

2. In 2008, ECSO deputies ordered other inmates to go into the cell of an inmate who refused to shower, pull the inmate out of the cell, strip him and wash him on the floor of the pod common area with rags and a bucket of water; and

3. Inmates who file substantial grievances have been placed in the area housing gang members as retaliation.

c. inadequate protection from harm and serious risk of harm caused by a failure to protect inmates vulnerable to sexual abuse by other inmates at ECHC and ECCF, for example:

1. In April 2009, an ECHC inmate was charged with sexually assaulting another ECHC inmate;

2. In August 2008, a 16 year-old boy was placed in the "bullpen" at ECHC with adults. Placed among an adult population, this vulnerable youth was attacked and sexually assaulted in the middle of the night; and

3. On January 24, 2008, an inmate was sexually harassed and assaulted by three inmates who pulled his pants down, slapped him on the buttocks, called him "honey," grabbed towards his genitalia in a teasing manner, and grabbed his nipples.

These failures continue.

27. Inmate-on-inmate abuse, exemplified by the incidents in paragraph 26, has resulted from Defendants' failure to adopt policies necessary to prevent constitutional violations, including, but not limited to, policies governing inmate classification and inmate supervision, when such policies were necessary to prevent violations of constitutional rights.

28. Inmate-on-inmate abuse, exemplified by the incidents in paragraph 26, has resulted from Defendants' failure to adequately train their employees and agents on supervision of inmates and proper conflict intervention practices, among other related areas, when training was and continues to be necessary to prevent violations of constitutional rights.

29. Inmate-on-inmate abuse, exemplified by the incidents in paragraph 26, has resulted from Defendants' failure to adequately supervise and/or discipline their employees and agents when supervision and/or discipline was

and continues to be necessary to prevent violations of constitutional rights.

30. Defendants have repeatedly failed to provide adequate mental health and medical treatment and services to inmates with serious mental health and medical needs that are known or obvious in the following specific respects, among others:

a. inadequate suicide prevention (including the placement of suicidal inmates in cells that contain multiple means for committing suicide)[2].

b. inadequate mental health care and treatment, including but not limited to failures to take necessary steps to prevent self-injurious behavior, arrange for critically needed care, and respond to clear signs of mental illness, such as:

---

[2] The suicide prevention aspect of this case, as set forth in paragraph 23.a. of the original complaint (Docket No. 1), was resolved through a stipulated settlement between the parties (Docket No. 89-2), which was approved by the Court on June 22, 2010 (Docket No. 91).

1. Failing to establish treatment plans for inmates with histories of mental illness, including inmates suffering from self injurious behavior and suicidal ideation;
2. Failing to timely and accurately assess serious mental health disorders such as schizophrenia and bipolar disorder;
3. Failing to treat inmates who have either reported a history and use of psychotropic medications and/or affirmatively sought mental health consultation; and
4. Failing to automatically schedule follow-up treatment and counseling for inmates suffering from mental illness, instead requiring that the inmate submit a sick call request slip for a follow-up session.

c. inadequate mental health care and treatment has resulted in potential serious physical harms, for example:

1. In February 2010, an ECHC inmate mutilated his body with a razor.

2. In January 2010, an ECHC inmate mutilated his body with razor, cutting arms, stomach, and neck.

3. In September 2009, an ECHC inmate starved himself.

4. In September 2009, an ECHC inmate swallowed a spoon while on the forensic unit and later that month swallowed a toothbrush while on constant observation.

5. In July 2009, an ECHC inmate banged his head against the wall.

6. In October 2007, ECHC deputies found an inmate, who had attempted suicide on a prior occasion, holding a broken light bulb to his neck.

7. In September 2007, deputies witnessed an inmate smash his cell window and cut his arm with a broken piece of glass.

8. In June 2007, an ECHC inmate verbally threatened self-harm after he flooded his cell and smeared feces on himself and the cell wall.

9. On May 19, 2007, an inmate died of pneumonia brought on by starvation and dehydration after spending four months in ECHC. ECHC staff had ignored the inmate's clear signs of mental illness, such as splashing urine, throwing food, and spreading feces on his face.

d. administration of mental health services lacks substantive quality improvement programs or monitoring procedures that internally assess the quality of health care at the facilities;

e. inmates not initially referred to mental health during intake must rely on the sick

call system to obtain mental health treatment and services, including counseling and medication, resulting in untimely treatment, for example:

1. In February 2010, an ECHC inmate with post traumatic stress disorder was not seen for more than a month, despite multiple sick call request slips to mental health.
2. In January 2010, an inmate was admitted to ECMC for hypertension and cardiac arrhythmia and later admitted to the psychiatric service because of a history of depression and suicidal ideation. Despite her mental health condition, the inmate did not receive a mental health or psychiatric assessment upon her return to ECHC, nor was a treatment plan developed to address her mental health and substance abuse concerns.

3. As of March 2010, ECHC had not developed a treatment plan for an ECHC inmate who has been hospitalized at ECMC six or seven times since incarceration in November 2008 for bipolar, schizophrenia.

f. inadequate management of medical services and treatment, including, but not limited to failures to take necessary steps to ensure appropriate management of medical care, to arrange for critically needed care, and respond to clear signs of medical injury, illness, or harm, for example:

1. There are no on-site health care administrators to manage healthcare services;

2. There are no quality improvement programs or monitoring procedures in place to internally assess the quality of health care at the facilities; and

3. The facilities employ Licensed Practical Nurses ("LPN") without the direction or supervision of a registered nurse. In one case, an LPN provided negligent and inadequate medical care, leading to the death of an inmate who suffered from congestive heart failure.

4. In April 2010, ECHC employees resisted calling an ambulance for an injured inmate. The inmate sustained a broken eye socket, a broken jaw and other facial fractures.

5. In March 2010 an ECCF inmate required additional surgery on his left foot after medical staff ignored repeated requests for treatment. The inmate's foot was swollen and infected. Reportedly, the nurse on staff informed the inmate that he could withstand the pain until his release in July 2010.

6. In late 2009, ECHC refused to administer medication for an inmate with a broken neck and back.

7. In July 2008, an ECHC inmate died of hypertension after medical staff failed to administer the inmate's blood pressure medication and monitor her blood pressure. Prior to incarceration, the inmate was taking medication that could result in serious side effects when abruptly discontinued. Despite knowledge of this fact, medical staff abruptly discontinued the inmate's medication and failed to appropriately monitor her withdrawal from medication.

8. In April 2008, an inmate was told by a nurse for 60 days that he had a spider bite, which was later diagnosed as MRSA.

9. In March 2008, an inmate suffering from a ruptured achilles tendon during recreation was misdiagnosed with a sprain.

10. In November 2007, an ECCF inmate was denied treatment to for a swollen knee that was later diagnosed at another correctional facility as arthritis.

11. In April 2005, an ECHC inmate went two days without insulin despite repeated requests for assistance, resulting in a diabetic coma.

g. inadequate administration of medication, including controlled dangerous substances, resulting from nursing staff being untrained in critical areas of security, accountability, and common side effects of medications, for example:

1. ECHC has an inadequate system for the management of pharmaceuticals, and

controlled substances are not counted at each shift;

2. In 2007, an inmate hoarded his medication for several weeks before deputies located it on his shelf, and another inmate admittedly faked a seizure in order to obtain his prescription medication;

3. In February 2007, inmate was found to have 38 unidentified pills in a cup in his cell.

h. inadequate infection control, including failing to test timely for Tuberculosis and failing to adequately treat, contain, and manage infectious diseases such as Methicillin-resistant Staphylococcus aureus.

These failures continue.

31. Inadequate medical and mental health care, exemplified by the conditions in paragraph 30, has resulted from Defendants' failure to adopt policies necessary to prevent constitutional violations, including, but not

limited to, policies governing assessment and treatment, referrals, medication practices, recordkeeping, staffing levels, and quality improvement, when such policies were necessary to prevent violations of constitutional rights.

32. Inadequate medical and mental health care, exemplified by the conditions in paragraph 30, has resulted from Defendants' failure to adequately train their employees and agents on proper quality of care, medication practices, and recordkeeping, among other related areas, when training was and continues to be necessary to prevent violations of constitutional rights.

33. Inadequate medical and mental health care, exemplified by the conditions in paragraph 30, has resulted from Defendants' failure to adequately supervise and/or discipline their employees and agents when supervision and/or discipline was and continues to be necessary to prevent violations of constitutional rights.

34. Defendants have maintained a pervasive physical environment at ECHC that poses an unreasonable risk of serious harm to inmates' health and safety by failing to correct facility maintenance problems that pose a risk of

harm to the safety of inmates and staff within the facility and its exterior. Defendants have continued to maintain such an environment notwithstanding these known or obvious risks, including the following examples:

a. One inmate was forced to wear dirty clothes for twelve days, because ECHC lacked sufficient laundry staff.

b. Inmates have been forced to sleep on metal beds, because no mattresses were available.

c. Shower areas are covered in mold, and cells are infected with insects.

d. Inmates have been denied hygiene products, including razors, soap, toothpaste, feminine products, and toilet paper. Deputies have suggested that inmates requesting additional hygiene products use their shirts instead.

e. Electrical hazards exist that neither correctional officers nor maintenance staff seem to be concerned about, despite the potential for harm being readily apparent.

f. Jail staff fail to properly secure sanitation equipment and supplies when not in use, allowing inmates ample opportunity to employ these cleaning supplies as weapons. For example, inmates have used sanitation equipment, like a broom, as weapons. In one case, a broom handle was broken and used to stab another inmate.

g. Due to the dilapidated condition of scores of cells, shower areas, and various dayroom features, inmates have ample material for fabricating weapons, including floor tiles, metal from light fixtures, metal from the ventilation system, glass from cell light bulbs, electrical wiring, and plumbing fixtures. For example:

1. Inmates have been found with shanks of varying size that are made of broken glass and metal rods.

2. Inmates have also been found with handcuff keys and a syringe, and in

> March 2007 an inmate handed deputies a 40-caliber hollow point bullet he found under his cellmate's bed. At the time, both inmates were assigned to a cell designated for constant observation.

These failures continue.

35. Unsafe and unsanitary conditions, as exemplified in paragraph 34, have resulted from Defendants' failure to adopt policies necessary to prevent constitutional violations, including, but not limited to, policies governing health and safety, when such policies were necessary to prevent violations of constitutional rights.

36. Unsafe and unsanitary conditions, as exemplified in paragraph 34, have resulted from Defendants' failure to adequately train their employees and agents on proper health and safety practices, among other related areas, when training was and continues to be necessary to prevent violations of constitutional rights.

37. Unsafe and unsanitary conditions, as exemplified in paragraph 34, have resulted from Defendants' failure to adequately supervise and/or discipline their employees and

agents when supervision and/or discipline was and continues to be necessary to prevent violations of constitutional rights.

38. The factual allegations set forth in paragraphs 17 through 37 have been obvious and known to Defendants for a substantial period of time, yet Defendants have failed to adequately address the conditions described.

39. Based upon the factual allegations set forth in paragraphs 17 through 37, Defendants knew or should have known that their policies and/or practices were, and continue to be, deficient enough to result in constitutional violations.

40. Based upon the findings made by entities tasked with reviewing ECHC and ECCF, including the New York State Commission of Correction, the National Commission on Correctional Health Care, and the United States Department of Justice in its Findings Letter in this matter, each of which put Defendants on notice of the deficiencies alleged above, Defendants knew or should have known that their policies and/or practices were, and continue to be, deficient enough to result in constitutional violations.

VIOLATIONS ALLEGED

41. The United States incorporates by reference the allegations set forth in paragraphs 1 through 40 as fully set forth herein.

42. Defendants are, have been, or should have been, aware of the deficiencies alleged in paragraphs 17 through 37, but have failed to take effective measures to remedy such deficiencies. Such failures amount to deliberate indifference to the health and safety of ECHC and ECCF inmates, in violation of the rights, privileges, or immunities of those inmates as secured or protected by the Constitution of the United States. U.S. Const. amend. VIII, XIV. Such deliberate indifference was the cause of the violations of constitutional rights alleged herein.

43. Defendants exhibit deliberate indifference by failing to adopt policies necessary to prevent constitutional violations, when such policies were and continue to be necessary to prevent the violations of constitutional rights alleged in paragraphs 17 through 37.

44. Defendants fail to adequately train their employees and agents, when training was and continues to be

necessary to prevent the violations of constitutional rights alleged in paragraphs 17 through 37.

45. Defendants fail to adequately supervise and/or discipline their employees and agents, when supervision and/or discipline was and continues to be necessary to prevent the violations of constitutional rights alleged in paragraphs 17 through 37.

46. Unless restrained by this Court, Defendants will continue to engage in the acts and omissions set forth in paragraphs 17 through 37, among others, that deprive persons confined in ECHC and ECCF of the privileges or immunities secured or protected by the Constitution of the United States.

PRAYER FOR RELIEF

47. The Attorney General is authorized under 42 U.S.C. § 1997 to seek equitable and declaratory relief.

WHEREFORE, the United States prays that this Court enter an order:

a. declaring that the acts, omissions, and practices of Defendants set forth in paragraphs 17 through 37 above and outlined in the Findings Letter constitute a

pattern or practice of conduct that deprives inmates confined at ECHC and ECCF of rights, privileges, or immunities secured or protected by the Constitution of the United States and that those acts, omissions, and practices violate the Constitution of the United States;

b. permanently enjoining Defendants, their officers, agents, employees, subordinates, successors in office, and all those acting in concert or participation with them from continuing the acts, omissions, and practices set forth in paragraphs 17 through 37 above and outlined in the Findings Letter and requiring Defendants to take such actions as will ensure lawful conditions of confinement are afforded to inmates at ECHC and ECCF; and

c. granting such other and further equitable relief as it may deem just and proper.

Respectfully submitted,

ERIC H. HOLDER, JR.
Attorney General of the
United States

WILLIAM J. HOCHUL, JR.
United States Attorney
Western District of New York
138 Delaware Avenue
Buffalo, New York 14202

THOMAS E. PEREZ
Assistant Attorney General
Civil Rights Division

SAMUEL R. BAGENSTOS
Principal Deputy Assistant
Attorney General
Civil Rights Division

JUDY C. PRESTON
Acting Chief
Special Litigation Section

LUIS E. SAUCEDO
Acting Deputy Chief
Special Litigation Section

ZAZY I. LÓPEZ
AARON S. FLEISHER
ALYSSA C. LAREAU
CHARLES W. HART
Attorneys
Civil Rights Division
Special Litigation Section
U.S. Department of Justice
950 Pennsylvania Avenue, NW
SPL, 601 D Street, Rm. 5426
Washington, DC 20530
(202)305-8702

CERTIFICATE OF SERVICE

I hereby certify that on July 23, 2010, I electronically filed the foregoing with the Clerk of the District Court, Western District of New York, using its CM/ECF system, which would then electronically notify the following CM/ECF participants on this case:

Kristin Klein Wheaton Kristin.KleinWheaton@erie.gov

Cheryl A. Green cheryl.green@erie.gov

And, I hereby certify that I caused the foregoing to be mailed, by the United States Postal Service, first class mail, to the following non-CM/ECF participants:

NONE

ZAZY I. LOPEZ
AARON S. FLEISHER
ALYSSA C. LAREAU
CHARLES W. HART
Attorneys
Civil Rights Division
Special Litigation Section
U.S. Department of Justice
950 Pennsylvania Avenue, NW
SPL, 601 D Street, Rm. 5426
Washington, DC 20530
(202) 305-8702