

**IN THE UNITED STATES BANKRUPTCY COURT  
FOR THE SOUTHERN DISTRICT OF TEXAS  
HOUSTON DIVISION**

In re:	Chapter 11
Tehum Care Services, Inc.,	Case No. 23-90086 (CML)
Debtor.	<b>Re: Docket Nos. 7 &amp; 30</b>

**OBJECTION OF K.A. ET AL. TO DEBTOR’S EMERGENCY MOTION TO EXTEND  
AND ENFORCE THE AUTOMATIC STAY**

K.A. et al., (the “RMSC Plaintiffs”) by and through their undersigned counsel, submits this objection (the “Objection”) to the *Debtor’s Emergency Motion to Extend and Enforce the Automatic Stay* (the “Emergency Non-Debtor Stay Motion”) Docket No. 7. In support of this Objection, the respectfully states as follows:

**Background**

1. On June 24, 2016, the RMSC Plaintiffs filed their complaint in the United States District Court for the Southern District of New York, Case No. 16-04936. A copy of the Second Amended Complaint (the “Complaint”) is attached hereto as Exhibit A, and the allegations are incorporated herein as if stated in full.

2. As set forth in the Complaint, the RMSC Plaintiffs were female prisoners confined to the custody and care of the City of New York and its Rose M. Singer Center on Rikers Island (“RMSC”) who allege that they were repeatedly subjected to cruel, inhumane and dehumanizing brutality while at RMSC. The abuse was at the hands of Sidney Wilson, a Physician Assistant working at RMSC, who is named as a co-defendant to the Debtor.

3. The Debtor, by its Emergency Non-Debtor Stay Motion, seeks to extend the automatic stay to include Sidney Wilson. *See* Docket No. 30, at Ex. 1.

### **Objection**

4. The Debtor was created for the purpose of filing this bankruptcy. Whether this structure is appropriate is a decision for another day. For more immediate discussion and decision is whether to allow this Debtor to extend the important benefits of the automatic stay to non-debtor third party defendants, such as Mr. Wilson. Such an extension of the automatic stay provided by section 362 of the Bankruptcy Code will halt the prosecution of direct claims against Mr. Wilson.

5. Not only is the relief requested extreme, the Emergency Non-Debtor Stay Motion, was filed and scheduled to be heard on very limited notice to parties such as the RMSC Plaintiffs. The primary basis offered for such extreme relief is that the Debtor has apparently agreed to indemnify non-debtor parties such as Mr. Wilson.

6. Section 362(a)(1) of the Bankruptcy Code is not ordinarily a valid statutory basis to stay direct claims pending against non-bankrupt co-defendants or third parties. *See, e.g., Reliant Energy Servs. v. Enron Can. Corp.*, 349 F.3d 816, 825 (5th Cir. 2003) (“[b]y its terms the automatic stay applies only to the debtor, not to co-debtors under Chapter 7 or Chapter 11 of the Bankruptcy Code nor to co-tortfeasors.”). This is because the plan language of section 362(a) limits the applicability of the automatic stay to the debtor. *See Wedgeworth v. Fiberboard Corp.*, 706 F.2d 541, 544 (5th Cir. 1983).

7. Chapter 11 permits indemnification claims to be asserted by co-defendants. This is not an unusual concept. What is unusual, is the relief requested by this Debtor. The Debtor seeks a permanent extension of the automatic stay to all Non-Debtor Indemnified Parties. In effect, this would preempt prosecuting parties such as the RMSC Plaintiffs from asserting that Debtor is not necessary to litigation and proceeding only against non-debtor parties. Such relief is unnecessary and unwarranted.

8. The litigation has been pending for over 6 years, and discovery is ongoing. The U.S. District Court can appropriately determine whether to stay the action against the other defendants. The Emergency Non-Debtor Stay Motion seeks broad relief to extend the powerful relief requested under section 362 without regard to the specific facts and circumstances of the RMSC Plaintiff's Complaint. These Plaintiffs will be at a further disadvantage in that they would need to seek relief from this Court to seek relief from automatic stay against non-debtors, which is inconsistent with the goals of the Bankruptcy Code.

**Reservation of Rights**

9. The RMSC Plaintiffs reserve all rights to amend, supplement or further object to the Debtor's Motion, including raise any further and appropriate argument at the hearing. The RMSC Plaintiffs join the responses and objections of similarly aggrieved parties and their arguments to the extent those arguments are consistent with the positions raised herein.

**WHEREFORE**, The RMSC Plaintiffs respectfully requests that the Court enter an Order (i) denying the Debtor's Emergency Motion to Extend and Enforce the Automatic Stay, and (ii) granting other and further relief as may be just and appropriate.

DATED: March 3, 2023.

Respectfully submitted,

By: /s/ Johnie Patterson

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**CERTIFICATE OF SERVICE**

I, Johnie Patterson hereby certify that a true and correct copy was served on all parties receiving notice pursuant to the Court's CM/ECF service by electronic transmission on March 3, 2023.

By: /s/ Johnie Patterson  
Johnie Patterson

UNITED STATES DISTRICT COURT  
SOUTHERN DISTRICT OF NEW YORK

-----X  
K.A., S.A., L.R., L.J., and JANE DOES 1-25,

Plaintiffs,

-against-

CITY OF NEW YORK, CORIZON HEALTH, INC.,  
CORIZON, INC., and SIDNEY WILSON, individually  
and in his official capacity,

Defendants.

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16 Civ. 4936 (LTS)

**SECOND AMENDED  
VERIFIED COMPLAINT**

Jury Trial Demanded

Plaintiffs, by their attorneys, HELD & HINES, LLP, as and for their Second Amended  
Verified Complaint, hereinafter states and alleges as follows upon information and belief:

**PRELIMINARY STATEMENT**

1. Plaintiffs commence this action pursuant to 42 U.S.C. §1983 seeking compensatory damages against all defendants and punitive damages against Defendants Corizon and Sidney Wilson for violating their constitutional rights while acting under color of law, together with reasonable attorney's fees and costs pursuant to 42 U.S.C. §1988.

2. Plaintiffs also assert supplemental state law claims against Corizon Health, Inc. and Corizon, Inc. (collectively "Corizon"), their agents, servants and employees, as well as Defendant Sidney Wilson for violations of their statutory rights and those secured by the Constitution of the State of New York, as well as common law claims of sexual assault and rape, negligence, negligent hiring, training, supervision and retention, intentional and negligent infliction of emotional distress, failure to protect, and prima facie tort.

3. At all times alleged herein, Plaintiffs were female prisoners confined to the custody and care of the City of New York at its Rose M. Singer Center on Rikers Island ("RMSC"), who were repeatedly subjected to cruel, inhumane and dehumanizing brutality by

Defendant Sidney Wilson, a Physician Assistant employed in the clinic at RMSC. As alleged herein, Plaintiffs were repeatedly raped, sexually assaulted and abused, forcibly touched, and forced to undergo unnecessary internal pelvic and breast examinations for the sexual gratification of Defendant Wilson.

4. New York State has recognized the coercive power correction officers and clinic staff wield over incarcerated individuals, and the related risk of rape and other sexual abuse, by criminalizing all sexual activity between incarcerated individuals and correctional staff in New York Penal Law §130.05(3)(f), New York Penal Law §130.25(1), and New York Penal Law §130.40(1). The City and Corizon are aware that New York State has identified a significant risk of sexual coercion of individuals in custody, but it nonetheless permits a culture of systemic rape and other sexual abuse of prisoners to exist on Rikers Island, in general, and RMSC in particular.

5. The pervasive culture of rape and other sexual abuse at RMSC is common knowledge within and without the facility. Correction officers<sup>1</sup> and staff, including clinical staff assigned thereto, know not only that prisoners are regularly abused, but also which individuals commit the abuses, which type of prisoners are most often abused, and when and where the abuse occurs.

6. Supervisory officials, officers, and clinic staff facilitated these rapes and other sexual abuses by making predictable rounds and otherwise failing to meaningfully oversee medical staff assigned to DOC facilities and the clinic within each facility.

7. The City of New York facilitated these rapes and other sexual abuses by failing to screen Corizon employees through background checks and other methods, by permitting its supervisory officials and staff to operate in the manner alleged herein, by failing to monitor

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<sup>1</sup> As used herein, the term “correction officer” is intended to refer to DOC staff in the general and not to any specific rank, title or position.

(through cameras or otherwise) known at-risk areas, by failing to require its officers to report rape and sexual abuse suspected or witnessed, by failing to encourage victims to report rape and sexual abuse, and by failing to post signs throughout Rikers Island and RMSC stating it is a felony for clinic staff to have sexual intercourse or contact with an inmate.

8. Corizon facilitated these rapes and other sexual abuses by failing to screen its employees through background checks and other methods, by permitting its supervisory officials and staff to operate in the manner alleged herein, by failing to monitor (through cameras or otherwise) known at-risk areas, by failing to require its clinic staff to report rape and sexual abuse suspected or witnessed, by failing to encourage victims to report rape and sexual abuse, and by failing to post signs throughout Rikers Island and RMSC stating it is a crime felony for clinic staff to have sexual intercourse or contact with an inmate.

9. It is known to the City of New York and Corizon that their sexually abusive clinic staff, including Defendant Wilson, keep prisoners, including Plaintiffs, from reporting their abuse by threat and/or exchanging contraband, money and promises for their silence. Here, Defendant Wilson told each of the plaintiffs that he loved them, that they were special to him, and that he considered himself to be in a serious personal relationship with each plaintiff, unbeknownst to the others. Defendant Wilson also provided some of the plaintiffs with contraband and/or special favors in the form of prescription medication, Popeyes chicken, cigarettes, candy, gum, and headphones, and would even make payments to some of the plaintiffs through his family members.

10. The City of New York, by its Department of Health and Mental Hygiene (“DOHMH”) and Department of Correction (“DOC”), has grossly failed to perform criminal background and fingerprint checks on Corizon employees prior to their employment and

thereafter, failed to supervise Corizon in its hiring practices, failed to perform phone checks and visitation history checks of prospective Corizon employees to prevent Corizon from hiring individuals who have familial or personal relationships with incarcerated persons, failed to review Corizon staff files to ensure Corizon was properly supervising its employees and regularly reviewing employee performance, failed to require Corizon to perform annual employee performance evaluations, failed to establish criteria for denying Corizon employees access to DOC facilities, failed to establish training requirements for Corizon employees working in DOC facilities, failed to initiate procedures to monitor, discipline and prevent contracted employees from bringing contraband into DOC facilities, and permitted Corizon employees to have unrestricted and lengthy prisoner contact with little to no supervision.

11. Corizon has grossly failed to perform and/or require DOC to perform criminal background and fingerprint checks on its prospective employees prior to their employment and thereafter, failed to ensure that hired employees were thoroughly interviewed, screened and vetted, failed to prevent the hiring of individuals who have familial or personal relationships with incarcerated persons, failed to supervise its employees and regularly review employee performance, failed to perform annual employee performance evaluations, failed to establish criteria for denying its employees access to DOC facilities, failed to establish training requirements for its employees working in DOC facilities, failed to initiate procedures to monitor, discipline and prevent its employees from bringing contraband into DOC facilities, and permitted its employees to have unrestricted and lengthy prisoner contact with little to no supervision.

12. Despite being on notice of allegations of bribery, contraband smuggling, and



inappropriate staff-prisoner<sup>2</sup> relationships by Corizon employees, the City of New York and Corizon continued to give clinical staff ample opportunity to engage in misconduct with prisoners, in deliberate indifference to the substantial risk of harm it posed to Plaintiffs and others in DOC custody. These customs, policies, practices, acts, and omissions of the City of New York and Corizon allowed Defendant Wilson to rape and sexually abuse the plaintiffs.

### **JURISDICTION AND VENUE**

13. Jurisdiction of this Court is invoked pursuant to 28 U.S.C. §§1331 and 1343(a)(3) and (4) and the aforesaid statutory and constitutional provisions.

14. Pursuant to 28 U.S.C. §1367, this Court has supplemental jurisdiction over claims which arise under the relevant provisions of New York state law.

15. Plaintiffs' claim for attorneys fees and costs is predicated upon 42 U.S.C. §1988, which authorizes the award of attorneys fees and costs to prevailing plaintiffs in actions brought pursuant to 42 U.S.C. §1983, as well as New York C.P.L.R. Art. 86 for pendent claims arising under New York state and local law.

16. Venue is appropriate in this Court pursuant to 28 U.S.C. §1391(b)(2), as a substantial part of the events or omissions giving rise to this claim occurred within Bronx County, New York, which is within this judicial district.

### **PARTIES**

17. At all times mentioned herein, the plaintiffs were and remain residents of the State of New York.

18. At all times mentioned herein, the plaintiffs were prisoners classified and assigned by DOC to be housed at RMSC.

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<sup>2</sup> As used herein, the term "prisoner" or "inmate," or the plural thereof, shall refer to both pre-trial and sentenced inmates.

19. Plaintiffs Jane Does 1-25<sup>3</sup> are other anticipated victims of Defendant Wilson.

20. Upon information and belief, and at all times mentioned herein, the defendant, City of New York (hereinafter referred to as the “City”), was and remains a body corporate and politic, constituting a municipal corporation, duly organized and existing under and by virtue of the laws of the State of New York.

21. Upon information and belief, and at all times mentioned herein, the City maintains the New York City Department of Health and Mental Hygiene (hereinafter referred to as the “DOHMH”), pursuant to law.

22. Upon information and belief, and at all times mentioned herein, the City maintains the City of New York Department of Correction (hereinafter referred to as the “DOC”), pursuant to law.

23. Corizon Health, Inc. is a foreign corporation organized and existing by virtue of the laws of the State of Delaware, with its principal executive office in Tennessee. Corizon Health, Inc. is authorized to and does transact business in the State of New York.

24. Corizon, Inc. is a foreign corporation organized and existing by virtue of the laws of the State of Missouri, with its principal executive office in Tennessee. Corizon, Inc. is authorized to and does transact business in the State of New York.

25. At all times mentioned herein, Corizon Health, Inc. and Corizon, Inc. (collectively “Corizon”), its site medical directors, physicians, nurses, physician assistants, clinicians, therapists, and other medical staff, provided medical, mental health, dental and ancillary services to prisoners at Rikers Island pursuant to a contract with the City of New York and/or DOHMH. In carrying out its duties, Corizon was required to ensure that its policies, practices and

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<sup>3</sup> Plaintiffs’ counsel is presently aware of at least three (3) other victims of Defendant Wilson, but has not yet been retained by these individuals.

procedures, as well as the personnel it employed in the City's jails and hospital prison wards, complied with all City, DOC and DOHMH policies, the City's Minimum Standards for Health Care, and local, state and federal law.

26. At all times mentioned herein, DOHMH and DOC were responsible for supervising Corizon and overseeing Corizon's hiring and supervision of its clinic staff.

27. At all times mentioned herein, Corizon and its employees were acting color of law and performing governmental functions and/or quasi-governmental functions.

28. At all times mentioned herein, Plaintiffs were confined to DOC custody, control and care.

29. At all times mentioned herein, Defendant Sidney Wilson (hereinafter "Defendant Wilson"), was a physician assistant employed by Corizon.

30. At all times mentioned herein, Defendant Wilson was acting under color of law. Defendant Wilson is being sued in his individual and official capacities.

31. Upon information and belief, and at all times mentioned herein, the City and DOC owned, operated, maintained, managed, supervised, directed and controlled the jail facilities located within the City of New York, including but not limited to those located on Rikers Island.

32. Upon information and belief, and at all times mentioned herein, the City, DOC and/or DOHMH owned, operated, maintained, managed, supervised, directed and controlled the clinics located within DOC facilities.

33. Upon information and belief, and at all times mentioned herein, Corizon owned, operated, maintained, managed, supervised, directed and controlled the clinics located within the DOC facilities located on Rikers Island.

### **STATEMENT OF FACTS**

34. Plaintiffs are all adult women confined to the City's custody and care at the Rose M. Singer Center on Rikers Island ("RMSC") during the relevant period of time.

35. Corizon operates and maintains a clinic within RMSC where prisoners housed in said facility can seek medications and medical care and treatment.

36. During their time in DOC custody, Plaintiffs sought medical attention at the RMSC clinic.

37. At all times mentioned herein, Defendant Wilson was a physician assistant employed by Corizon and assigned to the clinic at RMSC.

38. At all times mentioned herein, the RMSC clinic was not monitored by security cameras.

39. It is a well-established practice of Corizon clinic staff (and DOC officers) to engage in unlawful, forceful and/or coercive acts with prisoners in facility clinics as said areas are outside the view of monitored security cameras.

40. Despite prior substantiated allegations of criminal conduct committed by clinic staff and correction officers in the clinic areas of DOC facilities against prisoners, including but not limited to sexual abuse and rape, bribery, beatings, passing contraband, threats, and coercing of statements and acts, as well as other unlawful conduct, the City of New York and Corizon failed to install monitored security cameras, increase the degree of supervision thereat, and/or take any other reasonable measures to provide greater security within the clinic areas.

41. The City and Corizon's inadequate supervision of the RMSC clinic made it easy for Defendant Wilson to forcibly touch, sexually harass, sexually assault, and rape the plaintiffs.

42. The City and Corizon's inadequate staffing of the RMSC clinic made it easy for

Defendant Wilson to forcibly touch, sexually harass, sexually assault, and rape the plaintiffs as no nurses or chaperones were present in the examination room at the time the abuses occurred.

43. DOC, DOHMH and Corizon staff and officers were aware that Defendant Wilson was abusing the plaintiffs at the time said abuses occurred as the examination areas are located in the middle of the clinic and only shielded from view by a portable privacy screen used during examinations. As the abuses were occurring, officers and clinic staff would be constantly walking up and down the aisle that separates examination areas and could hear what Defendant Wilson was saying to the plaintiffs, hear his moaning and heavy breathing, hear the unlawful things he was doing to plaintiffs and what he made them to do him, hear the bargaining for and passing of contraband, and smell the fast food Defendant Wilson brought into the examination areas for the plaintiffs even though no outside food was permitted in said area. On several occasions, while the abuses were going on, clinic staff would approach the outside of the examination area and tell Defendant Wilson he was taking too long with a plaintiff and that he needed to finish quickly as patients were waiting.

44. Plaintiffs contemporaneously reported Defendant Wilson's abuses to DOC, DOHMH and Corizon staff; however, these individuals failed to report the abuse as required. Plaintiffs were never removed from contact with Wilson, Wilson was never removed from duty pending an investigation, and an investigation was never conducted into Plaintiffs' claims of sexual assault and rape occurring in the RMSC clinic until months after their transfer out of DOC custody. Accordingly, the abuse was allowed to continue unabated.

45. Upon their transfer from DOC custody, Plaintiffs again reported Defendant Wilson's abuses, this time to staff at the New York State Department of Corrections and Community Supervision ("DOCCS"), who forwarded the allegations to DOCCS' Office of

Special Investigations, who referred the matter to the New York City Department of Investigation (“DOI”).

46. DOI investigated the plaintiffs’ allegations against Defendant Wilson, interviewed the plaintiffs and others, and issued a report substantiating the plaintiffs’ allegations. Upon doing so, DOI referred the matter to the Bronx County District Attorney’s Office.

47. On or about March 30, 2017, a Bronx County grand jury returned a 42-count indictment against Wilson, including 2 counts of Rape in the Third Degree (P.L. 130.25(1)), 12 counts of Sexual Abuse in the Second Degree (P.L. 130.60(1)), 12 counts of Sexual Abuse in the Third Degree (P.L. 130.55), 13 counts of Official Misconduct (P.L. 195.00(1)), 1 count of Criminal Sexual Act in the Third Degree (P.L. 130.40(1)), 1 count of Promoting Prison Contraband (P.L. 205.20(1)), and 1 count of Forcible Touching (P.L. 130.52).

48. Defendant Wilson was never disciplined for his sexual abuses, assaults, and rapes of Plaintiffs.

49. Defendants City and/or Corizon did not terminate Defendant Wilson’s employment due to his sexual abuses, assaults and rapes of Plaintiffs. Upon information and belief, Defendant Wilson voluntarily resigned from Corizon in the midst of DOI’s investigation.

50. Upon information and belief, the defendants have never terminated the employment of a healthcare professional they determined to have committed sexual abuse on a prisoner. Upon information and belief, Defendants have allowed these offenders to resign.

51. Upon information and belief, Defendants City and Corizon have never reported a healthcare professional who they determined to have committed sexual abuse on a female prisoner to the State medical board, nor any licensing bureaus, nor any departments of professional responsibility.

*Plaintiff K.A.*

52. At all times relevant hereto, K.A. was confined to the City's custody and care at the Rose M. Singer Center on Rikers Island ("RMSC") from on or about October 4, 2013 through February 4, 2015.

53. Shortly after arriving at RMSC, K.A. went to the RMSC clinic seeking a prescription for a cream for her lips. Defendant Wilson asked K.A., "What are you willing to do for it?" This was the beginning of an improper and sexually abusive relationship between K.A. and Wilson that lasted approximately sixteen (16) months.

54. On several occasions thereafter, Wilson performed unnecessary and unsupervised internal pelvic examinations on K.A. for his own sexual gratification, during which K.A. could hear Wilson moaning and breathing heavily. Wilson did not have any medical basis to insist upon these internal pelvic examinations and did not use any medical equipment for these examinations. This was merely a pretext for Wilson to insert his fingers into K.A.'s vagina.

55. On approximately 8-10 occasions, when K.A. would report to the RMSC clinic for sick call, regardless of the reason she was there, Wilson made sure that he was the one to "examine" her. On these occasions, Wilson would instruct K.A. to remove her pants, expose her vagina to him, and he would then insert his fingers inside her vagina in a sexual manner. Wilson would also tell K.A. to rub his penis.

56. As a matter of law, K.A. did not and could not consent to engaging in any sexual acts with Wilson.

57. In consideration for K.A. not reporting these sexual abuses and rapes, Wilson routinely smuggled candy, cigarettes, Popeyes chicken, headphones and other contraband into RMSC and gave same to K.A. Wilson also issued prescriptions and/or medical orders that

directed DOC to provide K.A. with benefits such as an extra pillow and mattress. Wilson also coached K.A. in what to say to the neurologist in order for him/her to authorize unnecessary prescription medications, which he said she could then sell or trade to other prisoners for money.

58. As with the other Plaintiffs, Wilson informed K.A. that he considered her to be a very special person to him, that he loved her, and that they would continue to be together romantically upon her release from DOC custody. To that end, Wilson told K.A. personal information about himself, his children, his employment, and his graduate studies.

59. On separate occasions, K.A. reported to defendants' employees – Ms. Villanos and Social Worker Rodriguez – that a physician assistant working in the RMSC clinic was sexually abusing her; however, she did not reveal Wilson by name as he threatened her on numerous occasions what would happen if she “betrayed” him. On another occasion, K.A. informed a correction officer, believed to be Correction Officer West in Ride Support, about the foregoing and she responded that sex for candy, food and cigarettes seemed like “a fair exchange” to her. None of these individuals reported K.A.’s allegations to their supervisors, as they were required to do.

60. On several occasions, “Brian,” a member of the clinic staff, would walk through the clinic and tell Wilson he was taking way too much time with K.A. and to “hurry up” whatever he was doing with her.

***Plaintiff L.R.***

61. At all times relevant hereto, L.R. was confined to the City’s custody and care at the Rose M. Singer Center on Rikers Island (“RMSC”) from on or about July 21, 2014 through November 2014.

62. Shortly after arriving at RMSC, L.R. went to the RMSC clinic for a routine



checkup. There, L.R. met Defendant Wilson, who started complimenting her appearance, telling her she was beautiful, sexy, and had nice lips and white teeth. Wilson offered L.R. pills, but she declined, which surprised Wilson and caused him to take a greater interest in her. This was the beginning of an improper and sexually abusive relationship between L.R. and Wilson that lasted four (4) months.

63. On those occasions L.R. would report to the RMSC clinic, regardless of the reason she was there, Defendant Wilson made sure that he was the one to “examine” her. On these occasions, Wilson would instruct L.R. to remove her pants, expose her vagina to him, and he would then place his fingers inside her vagina in a sexual manner.

64. On numerous occasions, Wilson had vaginal, oral and anal sex with L.R., sometimes with and other times without condoms.

65. As a matter of law, L.R. did not and could not consent to engaging in any sexual acts or intercourse with Wilson.

66. In consideration for L.R. not reporting these sexual abuses and rapes, Wilson routinely smuggled candy, cigarettes, Popeyes chicken, and gum into RMSC and gave same to L.R. Wilson also smuggled in a personal sex device and gave same to L.R. Additionally, on at least two occasions, Wilson had his cousin deposit money into L.R.’s inmate account on his behalf.

67. As with the other Plaintiffs, Wilson informed L.R. that he considered her to be a very special person to him, that he loved her, and that they would continue to be together romantically upon her release from DOC custody. To that end, Wilson told L.R. personal information about himself, his children, his employment, and his graduate studies. Wilson even called L.R.’s grandmother’s house on occasion.

*Plaintiff S.A.*

68. At all times relevant hereto, S.A. was confined to the City's custody and care at the Rose M. Singer Center on Rikers Island ("RMSC") from March 2014 through November 2014.

69. Shortly after arriving at RMSC, S.A. went to the RMSC clinic seeking a follow-up examination of her toe, which underwent surgery shortly before her arrest. There, S.A. met Defendant Wilson for the first time. Despite presenting to the clinic for her toe, Wilson told S.A. to remove her clothes. Wilson then began rubbing S.A.'s breasts and inserted his fingers into her vagina. There was no medical basis for Wilson to touch S.A.'s breasts or vagina and it was done solely for his own sexual gratification. Upon S.A. asking Wilson why no nurse was present for this examination, Wilson responded that he likes S.A.'s appearance and that he can make things happen for her if she went along. This was the beginning of an improper and sexually abusive relationship between S.A. and Wilson that lasted approximately four (4) months.

70. Several weeks later, S.A. was taken to the clinic for a gynecological examination, even though she had recently had one during intake. Upon information and belief, Wilson orchestrated S.A. being brought to the clinic for this unnecessary examination. When S.A. presented to the clinic, Wilson made sure that he was the one to "examine" her. S.A. declined the examination; however, Wilson stated that it was "procedure" and he had to do it. No nurse was present for this examination. No medical instruments were used for this examination. Instead, Wilson used this as an opportunity to insert his fingers into S.A.'s vagina for his own sexual gratification.

71. On those occasions S.A. would report to the RMSC clinic thereafter, regardless of the reason she was there, Wilson made sure that he was the one to "examine" her. On these

occasions, Wilson would forcibly touch, kiss, masturbate and otherwise sexually abuse S.A. Wilson also tried to talk S.A. into touching his erect penis; however, she refused. On at least one occasion, it appeared to S.A. that Wilson had ejaculated in his pants.

72. As a matter of law, S.A. did not and could not consent to engaging in any touching or sexual acts with Wilson.

73. In consideration for S.A. not reporting these sexual abuses, Wilson routinely smuggled candy, cigarettes and food into RMSC for S.A. Wilson also caused unnecessary medications to be issued to S.A. for her to sell to other prisoners.

74. As with the other Plaintiffs, Wilson informed S.A. that he considered her to be a very special person to him, that he loved her, and that they would continue to be together romantically upon her release from DOC custody. To that end, Wilson told S.A. personal information about himself, his children, his employment, and his graduate studies.

***Plaintiff L.J.***

75. At all times relevant hereto, Plaintiff L.J. was confined to the City's custody and care at the Rose M. Singer Center on Rikers Island ("RMSC") from on or about December 3, 2013 through December 31, 2014.

76. Shortly after arriving at RMSC, Plaintiff L.J. presented to the RMSC clinic with cold symptoms. This is where she first met Defendant Wilson.

77. On approximately five occasions thereafter, beginning in early 2014, Defendant Wilson caressed and groped L.J.'s arms, legs and shoulders in a sexual manner, resulting in him becoming aroused. While doing so, Defendant Wilson would make harassing sexual comments to L.J. to the effect that she had large breasts.

78. On at least one occasion, Defendant Wilson performed an unnecessary and

unsupervised breast examination on L.J. for his own sexual gratification. Defendant Wilson did not have any medical basis to insist upon this breast examination. This was merely a pretext for Defendant Wilson to fondle L.J.'s breasts.

79. As a matter of law, Plaintiff L.J. did not and could not consent to engaging in any sexual touching with Defendant Wilson.

80. As with the other Plaintiffs, Defendant Wilson informed Plaintiff L.J. that he considered her to be a very special person to him. To that end, Defendant Wilson told L.J. personal information about himself.

### ***Defendant Sidney Wilson***

81. The sexual abuses experienced by Plaintiffs were a common occurrence at the RMSC clinic as, upon information and belief, PA Wilson also sexually abused, assaulted and raped other female prisoners prior to and contemporaneous with Plaintiffs.

82. Upon information and belief, Defendant Wilson was the subject of another DOI investigation prior to the plaintiffs' allegations.

83. Defendant Wilson used intimidation tactics to reinforce his authority and prevent Plaintiffs and his other victims from reporting the sexual abuse, including but not limited to threatening them that something bad would happen to them if they "betrayed" him.

### ***History of Sexual Abuse and Rape at the Rose M. Singer Center***

84. It is well-documented that correctional staff<sup>4</sup> and jail healthcare professionals<sup>5</sup> have subjected female prisoners to recurrent and ongoing acts of sexual misconduct at RMSC.

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<sup>4</sup> See, e.g., *Jane Doe 1, et al. v. City of New York and Benny Santiago*, Case No. 15 Civ. 3849 (AKH) (S.D.N.Y.) (putative class action accusing the City of New York of turning a blind eye as at least eight (8) officers repeatedly used anal rape to punish inmates); *Rape at Rosie's When the bad guys at Rikers are the guards*, New York Magazine (June 26, 2018); *Rikers guard admits to raping female inmate, avoids jail time*, New York Daily News (June 8, 2017); *Rikers rape accuser reveals she had sex with another guard*, New York Daily News (August 2, 2016).

<sup>5</sup> See, e.g., *People v. Franck Leveille* (2010 criminal action against RMSC clinic doctor charged with having oral sex with a female prisoner within the RMSC clinic during an unchaperoned examination taking place in a cubicle like

These include forcible rape, sexual intercourse, anal intercourse, oral sexual acts, sexual touching, voyeurism, invasion of personal privacy, demeaning sexual comments, and intimidation.

85. Pursuant to DOC procedure, all new inmates are required to go through the intake process. As part of that process, detailed medical, psychological, and social histories are taken from each inmate and medical examinations are performed. One of the questions asked of the plaintiffs and other female prisoners was whether they were the victim of prior sexual abuses since prior victims of sexual abuse are at heightened risk of further sexual abuse. Defendants City and Corizon were aware that Plaintiffs were at a heightened risk for sexual victimization while in DOC custody, yet they failed to create and implement reasonable policies and practices to protect female prisoners from sexual victimization by male healthcare professionals.<sup>6</sup>

86. Additionally, Defendants City and Corizon were aware of, or should have been aware of, internal reports, public guidance, prior allegations against staff, legal actions, investigative reports, and advocacy letters that detail the serious and disproportionate risk of sexual violence that female prisoners face in jail as well as specific instances of same<sup>7</sup>.

87. Despite being aware of the foregoing, Defendants City and Corizon failed to take reasonable measures to ensure the safety and security of female prisoners undergoing medical

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the ones Plaintiffs were sexually abused in; Leveille fled the country while released on bail and absconded from justice). In 2009, a different prisoner had reported being groped by Dr. Leveille, but no administrative action was taken against him by City or Corizon, allowing his abuse to continue. In that victim's civil suit filed the following year against *inter alia* Dr. Leveille and the City, she testified that she was repeatedly groped by Dr. Leveille and that he fondled her breasts and rubbed his finger over her nipple during an unchaperoned medical examination in RMSC.  
<sup>6</sup> In the New York City Criminal Justice report of February 2018, defendant City acknowledges that 72% of the female jail population is designated as having a mental health need and that "the majority of women in jail have histories of trauma..."

<sup>7</sup> In his April 27, 2011, testimony to the Department of Justice and the Review Panel on Prison Rape, Jack Beck, Director of the Correctional Association of New York's Prison Visiting Project, stated that "Studies show that women with abuse histories are highly likely to be targeted for harassment and abuse, are statistically more likely to be re-victimized, and, when targeted, are especially prone to suffer symptoms of Post-Traumatic Stress Disorder. Because of the extraordinary rates of abuse histories among women in prison, women as a whole category are at particular risk of experiencing abuse in prison."

examinations by male healthcare professionals. Defendants acted with reckless disregard for and deliberate indifference to the safety of Plaintiffs and maintained unconstitutional policies, customs and practices that led to sexual abuse.

88. Despite these known risks, Defendants City and Corizon failed to remediate that risk. These defendants did not address vulnerable inmates' safety, nor properly assess the danger they were in. These defendants knew that the clinic was understaffed, unmonitored, and isolated at night because they conducted rounds of the area, read the area logbooks, and made visual inspections. It is reasonable to believe or infer that these defendants knew about Wilson's ongoing sexual abuse and harassment of Plaintiffs and turned a blind eye to same. These defendants also created policies, customs and practices that allowed the unconstitutional acts to occur, including but not limited to the routine lack of adequate supervision in the areas where Plaintiffs were sexually harassed and abused, the handling of day-to-day security that allowed Wilson to be alone with Plaintiff for extended periods of time, and in making routine rounds that allowed Wilson to know when it was safe to harass and abuse Plaintiffs.

89. According to a survey conducted by the U.S. Department of Justice's Bureau of Justice Statistics entitled *Sexual Victimization in Prisons and Jails Reported by Inmates, 2011-12*, the Rose M. Singer Center had the highest rate nationally<sup>8</sup> (5.6%) of jail inmates reporting being coerced by facility staff in the previous 12 months (without any use or threat of force), including being pressured or made to feel that they had to have sex or sexual contact with facility staff.

90. Moreover, the DOJ survey found that 8.6% of RMSC inmates reported being sexually victimized<sup>9</sup> in the previous 12 months (compared to 3.2% nationally), with 5.9%

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<sup>8</sup> The Bureau of Statistics surveyed, *inter alia*, 52,296 jail inmates age 18 and older in 358 jails across the U.S.

<sup>9</sup> The DOJ survey defines "sexual victimization" as "all types of sexual activity, e.g., oral, anal or vaginal

reporting staff sexual misconduct<sup>10</sup> (compared to 1.8% nationally) and 5% reporting inmate-on-inmate victimization (compared to 1.6% nationally). Furthermore, 2.3% of RMSC inmates reported being physically forced by staff, 5.6% reported being pressured by staff, and 2.9% reported being sexually victimized by staff without force or pressure.

91. Despite this report being published in May 2013, five months prior to K.A.’s first interaction with Defendant Wilson in October 2013, Defendants City and Corizon took no action to protect their highly susceptible inmate population at RMSC, nor to modify their policies and practices, nor to train/retrain their employees on fraternizing with inmates, recognizing the signs of abuse and the requirement to report all allegations of sexual abuse made to them, nor to ensure that they were in compliance with the Prison Rape Elimination Act of 2003.

92. Additionally, an August 4, 2014 report by the United States Attorney’s Office for the Southern District of New York to the Mayor of the City of New York, Commissioner of the Department and Correction, and Corporation Counsel of the City of New York detailed the results of the Justice Department’s investigation of the New York City Department of Correction jails on Rikers Island, conducted pursuant to the Civil Rights of Institutionalized Persons Act, and expressed “concern that DOC may be under-reporting sexual assault allegations.”

93. This underreporting of staff-on-inmate sexual assault is consistent with DOC and DOHMH’s culture of failing to report other abuses by staff. In its August 2014 report, the U.S. Attorney stated,

Additionally, in some cases, officers and supervisors pressure inmates not to report, using a phrase that is widely used and universally known at Rikers: “hold it down.” This expression is code for, “don’t report what

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penetration; hand jobs; touching of the inmate’s buttocks, thighs, penis, breasts, or vagina in a sexual way; abusive sexual contacts; and both willing and unwilling sexual activity with staff.”

<sup>10</sup> The DOJ survey defines “staff sexual misconduct” as including “all incidents of willing and unwilling sexual contact with facility staff and all incidents of sexual activity that involved oral, anal, vaginal penetration, hand jobs, blow jobs, and other sexual acts with facility staff.”

happened.” Inmates who refuse to “hold it down” risk retaliation from officers in the form of additional physical violence and disciplinary sanctions. A DOC Associate Commissioner acknowledged the underreporting of use of force by officers, noting that it would be “disingenuous” to claim that it doesn’t exist. The head of the Investigation Division also acknowledged the problem.

A senior DOHMH official told us that he also was very familiar with the phrase, “hold it down,” and conveyed his belief that adolescents were often instructed not to report incidents. He indicated that one of the reasons inmates might agree to “hold it down” was that if inmates do not report a use of force, they themselves were then less likely to be infracted and disciplined. (emphasis added)

This suggests that the numerous instances of inmate sexual victimization by staff that have been reported represent only a small fraction of the actual sexual abuse that occurs on Rikers Island.

94. Upon information and belief, Defendant Wilson’s illegal and abusive behavior was common knowledge amongst supervisors, co-workers, and correction officers because, in part, his misconduct was open and notorious. Further, facility staff often comment that “nothing is a secret” in jail.

***Defendant Wilson was Enabled to Abuse and Continue Abusing Plaintiffs Due to Defendants City and Corizon’s Long-Standing Failure to Follow Their Own Chaperone Policy***

95. Pursuant to DOHMH Correctional Health Services (“CHS”) Policy #MED 2C issued October 13, 2010, by CHS Medical Director Homer Venters, M.D.,

**POLICY:**

Any healthcare professional undertaking an intimate examination (defined as any examination, investigation or treatment that involves the rectum, genitalia or breasts) will do so with the presence of a chaperone.

**PURPOSE:**

*Due to the nature of intimate examinations, there are occasions where there is the potential for abuse of a person in a vulnerable position, and, conversely, for false allegations to be made. The purpose of this policy is to promote a comfortable setting for patients and to protect both patients and staff from abuse or allegations of abuse.*



**PROCEDURES:**

1. The clinician responsible for the clinical encounter is responsible for securing a chaperone. A chaperone is a member of the clinic staff who is present for a clinical encounter that involves an intimate examination. When possible, the chaperone should be the same gender as the patient; however, the lack of a same gender chaperone should not preclude the use of a chaperone.
2. The chaperone may be part of the clinical encounter. Chaperones may assist with the clinical encounter if appropriate to their level of training and job title.
3. In the case of a medical emergency, if no chaperone is available to conduct the examination, the provider may proceed absent a chaperone provided that the clinician fully documents the circumstances in the medical record.
4. The name of the chaperone attending a clinical encounter must be entered as part of the medical documentation of the encounter by the M.D. or P.A. or nurse who is responsible for documenting the encounter.

(emphasis added)

96. On or about November 14, 2014, CHS Medical Director Ross MacDonald, M.D. revised DOHMH/NYCHHC Policy #MED 2C as follows:

**POLICY:**

*To safeguard patients from potential abuse and to safeguard providers from false allegations of abuse, any healthcare professional undertaking an intimate examination (defined as any examination, investigation or treatment that involves the rectum, genitalia or breasts) will do so with the presence of a chaperone.*

(emphasis added)

The “Purpose” section of the policy was removed in the revision. The “Procedures” section was left unchanged.

97. Although the abuses alleged herein occurred between October 2013 and February 2015, while both versions of the policy were in effect, Defendant Wilson routinely performed

intimate examinations on Plaintiffs without a chaperone present. Had chaperones been present during these examinations, as required by Defendants' policy, Defendant Wilson would not have been able to sexually abuse Plaintiffs.

98. Clinic staff and officers knew that Wilson was performing intimate examinations on Plaintiffs without a chaperone; however, none of them ever insisted that a chaperone be present nor was Wilson verbally reprimanded or subject to discipline for performing intimate examinations on Plaintiffs without a chaperone present.

99. Given their policy, Defendants City and Corizon clearly know that female prisoners are at risk of sexual assault, abuse and harassment by healthcare professionals, yet they failed to take necessary and appropriate action to protect the plaintiffs from these risks.

100. In addition, the American Medical Association has issued numerous Code of Medical Ethics Opinions stating that medical providers should adopt policies that make chaperones available (irrespective of the appointment requiring an intimate examination) upon patient request, that the provider always honor the patient's request to have a chaperone, and that the provider have an authorized member of the healthcare team serve as a chaperone.

101. Defendants City and Corizon knew or should have known that allowing and assigning male healthcare professionals to perform unchaperoned intimate examinations on female prisoners places them at substantial risk of being sexually victimized; that sexual misconduct by staff is ongoing and recurrent; that victims of sexual abuse or harassment in a correctional setting are unlikely to come forward with complaints of such misconduct; and that defendants' policies and practices were grossly inadequate to prevent and remedy sexual misconduct. Despite the obvious nature of these risks and despite the recurrent incidence of sexual abuse and harassment by male healthcare professionals against female prisoners,

Defendants City and Corizon failed to take reasonable, necessary, and appropriate steps to prevent and remedy such misconduct.

102. Defendants know that allowing and assigning male healthcare professionals to perform unchaperoned intimate examinations on female prisoners created obvious risks of sexual abuse and that the absolute disparity in power between male staff and female prisoners renders any sexual activity between male staff and female prisoners inherently coercive.

103. Defendants are aware of the substantial risk of sexual misconduct by male healthcare professionals upon female prisoners given their actual experience. Over the years, numerous female prisoners have credibly alleged that they were the victim of sexual abuse by male healthcare professionals at RMSC; male healthcare professionals at RMSC have been the subject of internal investigations for engaging in sexual misconduct with female prisoners; several instances of sexual misconduct have been substantiated; and other substantiated matters have been referred to the district attorney's office for prosecution.

104. Despite these known risks and incidence of sexual misconduct by male healthcare professionals, the defendants, through their policies and practices, recklessly disregarded these risks and failed to protect the plaintiffs from harm by requiring and enforcing chaperones be present for all examinations by male professionals.

105. Defendants City and Corizon failed to appropriately supervise and discipline their staff so as to prevent and remedy staff sexual misconduct. For example, male healthcare professionals, such as Defendant Wilson, regularly performed unchaperoned intimate examinations on female prisoners against official policy and were not disciplined or reprimanded for such misconduct. In fact, Defendants' staff, rather than request a chaperone on behalf of the

prisoner-patient or allow that prisoner-patient to wait for a female chaperone to become available, would routinely pressure prisoner-patients to proceed with an unchaperoned intimate examination in order to make the staff member's own life easier (e.g., quicker clinic runs, do not have to bring the prisoner back another time, less paperwork, etc.). In doing so, Defendants' staff regularly placed the Plaintiffs in substantial risk of harm.

106. Furthermore, defendants' supervisory officials' repeated failures to take corrective action against the violators of this policy, including but not limited to Wilson, expressly or tacitly endorsed their conduct that violated formal policy by failing to enforce a policy intended to protect the plaintiffs and other women.

107. In addition, Defendants City and Corizon failed to adjust their staffing practices to ensure that the clinic was adequately staffed with chaperones, security staff, nurses, and supervisors at all hours of the day. Defendants City and Corizon also failed to install monitored security cameras and/or take any other reasonable measures to provide greater security to female prisoners in the RMSC clinic.

***Failures of the City and Corizon in Their Hiring, Screening and Supervision of Clinic Staff  
and the Failures of the City to Prevent Officers and Corizon Staff from Smuggling  
Contraband Into Its Facilities***

108. Upon information and belief, Defendants City and Corizon failed to adequately screen Defendant Wilson prior to offering him employment, failed to conduct a background check, failed to conduct a fingerprint check, ignored and/or missed numerous red flags prior to offering him employment and once employed, failed to adequately supervise him after employment, failed to conduct regular performance evaluations, and failed to follow strict

professional and character standards, resulting in Defendant Wilson being hired despite being unqualified and unfit for this type of employment.

109. The sexual victimization experienced by Plaintiffs by Defendant Wilson were a foreseeable result of the City and Corizon's deliberate indifference in their hiring and screening processes and supervision of clinic staff.

110. On June 10, 2015, the New York City Department of Investigation released a critical review of Corizon, DOC and DOHMH's failures to engage in proper screening and supervision of staff, entitled *Investigation Finds Significant Breakdowns by Corizon Health Inc., the City-Contracted Health Care Provider in the City's Jails, and a Lack of Oversight by the City Correction and Health Departments*. Therein, the Department of Investigation detailed numerous instances of Corizon employees smuggling contraband into Rikers Island facilities and being hired despite prior felony convictions. Said report found the following:

- Corizon failed to do adequate background checks on employees, resulting in employment of eight mental health staff with prior criminal convictions including Second Degree Murder and drug possession. Even where Corizon did have evidence of criminal activity – including possession of a controlled substance, burglary, and forgery – Corizon nonetheless hired these individuals.
- In 89 of the total 185 files reviewed, there was no evidence that Corizon conducted a candidate background investigation of any kind.
- In 58 of the 137 [mental health clinician] files reviewed, there was no evidence that Corizon verified the candidates' professional licenses prior to employment. Further, Corizon failed to monitor the licensing of employees after they began work.
- Corizon's failures continued even after employment. Only 8 of 134 employees who have worked at Corizon for over one year had performance reviews in their files covering each year of their service at Corizon.
- The Department of Health and Mental Hygiene (DOHMH), along with DOC, have responsibility for supervising Corizon, to ensure, among other

things, that hired employees have been properly vetted. They failed to do so.

- In perhaps the most concerning example of this failed supervision, at the outset of this investigation, certain DOC staff informed DOI that DOC had no ability to conduct background checks of the staff that Corizon sent to Rikers Island. In fact, however, DOC did have both the authority and the obligation to conduct fingerprint checks of such employees. As a result, Corizon sent fingerprint cards to DOC on a regular basis; but, rather than forwarding the cards to the State to run checks, a DOC Deputy Commissioner allowed the cards to pile up on a shelf outside his office. The cards were discovered, unprocessed, by DOI in the course of its investigation.
- Indeed, DOC only began processing fingerprints for Corizon employees in May 2015, six months after DOI informed DOC – including Commissioner Ponte – of this basic failure.
- DOHMH similarly failed to adequately supervise Corizon. For example, DOHMH did not review staff files to see if Corizon was properly supervising and reviewing employee performance. As noted above, such evaluations rarely took place. Additionally, DOHMH never followed up to make sure the fingerprints submitted to DOC by Corizon were actually processed.

Said report also found that “[t]he failure to require or even verify basic candidate information such as references, prior employment, and professional licensure is, at best, emblematic of Corizon’s sloppiness in screening its candidates. At worst, it demonstrates Corizon’s indifference toward the quality of the employees it hires to work within DOC’s jails, and, as discussed below, the quality of care these employees deliver to DOC inmates.” (emphasis added)

111. Upon information and belief, DOC, DOHMH and Corizon did not perform adequate background checks on Defendant Wilson and his supervisors/co-workers that allowed the abuses to occur, did not adequately screen and interview them prior to offering employment, did not review their professional licenses and criminal histories, did not conduct performance reviews, and did not supervise them. Had the City and Corizon not been deliberately indifferent to these basic responsibilities, Wilson and his enablers would have been screened out prior to

being offered employment and/or caught before the abuses became so rampant. Discovery is expected to reveal facts that will further elucidate the defendants' failures in this regard.

112. Additionally, seven months prior to the aforesaid report, on November 6, 2014, the New York City Department of Investigation released a critical review of DOC's failure to prevent smuggling of contraband into its facilities, entitled *New York City Department of Investigation Report on Security Failures at City Department of Correction Facilities*. "The Report documents the recent arrests of six Correctional staff and a [Corizon] nurse regarding the smuggling of contraband ... [which is] then distributed to inmates. The failure to prevent smuggling to date – especially smuggling by Correction Officers and staff – has two causes: First, the previous protocols for screening staff upon entrance to the facility were not sufficient to actually detect and prevent illegal conduct. Second, even these ineffective protocols were not consistently followed in practice."

113. Due to City and Corizon supervisors and staff's long-standing failure to take reasonable action to prevent smuggling and catch and punish offenders, Wilson was emboldened to bring contraband into the facility and pass it openly to Plaintiffs. Had his fellow employees and DOC staff reported smelling Popeye's chicken and it being shared by Wilson with Plaintiffs in the clinic examination cubicle, Wilson's abuse of Plaintiffs would have been discovered. Rather, they turned a blind eye and allowed his criminal exchange of contraband with prisoners to continue unabated.

114. As a result of the City and Corizon's deliberate indifference to the constitutional rights of prisoners confined to their custody and care by virtue of their grossly negligent hiring and screening processes and supervision of clinic staff, including but not limited to Defendant Wilson, Plaintiffs suffered the constitutional violations aforesaid.

115. As a result of the City and Corizon's deliberate indifference to the constitutional rights of prisoners confined to their custody and care by virtue of their grossly negligent efforts to prevent contraband smuggling by officers and staff, including but not limited to Defendant Wilson, Plaintiffs suffered the constitutional violations aforesaid.

***Defendants City and Corizon's Long-Standing Failure to Comply with the Standards Set by the Prison Rape Elimination Act Led to the Pervasive Abuses by Defendant Wilson***

116. With the enactment of the Prison Rape Elimination Act of 2003, the National Prison Rape Elimination Commission was created and charged with drafting standards for eliminating prison rape. Those standards were published in June 2009 and given to the U.S. Department of Justice for review and passage as a final rule. The Department of Justice published the final PREA Standards in the Federal Register on June 20, 2012, and they became effective August 20, 2012 – more than a year prior to any of the plaintiffs' first contact with Wilson.

117. In what Defendant City touted as a "major milestone," RMSC became DOC's first PREA-compliant facility in September 2019 – more than seven years after the PREA standards became effective and more than 2 ½ years after Defendant Wilson was indicted.<sup>11</sup> By comparison, Taconic Correctional Facility, one of the State's female prisons, became DOCCS' first PREA-compliant facility in 2015 – four years earlier than RMSC. In fact, it was not until

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<sup>11</sup> Curiously, RMSC was declared PREA-compliant in 2019 despite DOC's 2018 annual PREA Assessment Report finding that RMSC had the highest incidence of sexual abuse and harassment allegations in the DOC system – nearly double the next three highest facilities. According to DOC's annual PREA Assessment Report dated August 14, 2018, there were 77 allegations of sexual abuse and harassment at RMSC between July-December 2017, representing 23.19% of all allegations at the City's jails. By comparison, AMKC and GRVC (both male facilities at Rikers Island) and the Brooklyn Detention Center (also a male facility) were in the second tier with 43, 42 and 44 allegations respectively. Between January-July 2018, 46 allegations of sexual abuse and harassment were made at RMSC, representing 20.09% of all allegations across the City's jails.



September 2014, the year prior to DOCCS' first PREA certification, that the City even began to assess its security practices in relation to PREA standards.

118. During the relevant period of time, Defendants City and Corizon were admittedly not PREA-compliant.

119. Between January and March 2015, The Moss Group, Inc. conducted Sexual Safety Assessments of seven DOC facilities, including RMSC, at the behest of the City. In its June 2015 report to the City, The Moss Group detailed the City and Corizon's deficiencies and failures to comply with PREA standards. The Moss Group Report detailed Defendants' lack of policies, training, investigations, and reporting when it came to sexual safety in their jails and clinics.

- No formal DOC PREA policy in place; Directive 5010R-A was a directive, not a policy, and failed to mention sexual harassment or "outline clearly the steps the agency will take to prevent or detect sexual abuse and harassment." Further, "it does not make clear that all...contractors must be notified of the agency's zero tolerance policy regarding sexual abuse and sexual harassment and how to report such incidents."
- There was "little PREA-specific training actually occurring...per the Training Director and staff interviewed."
- "[A]most no staff working with female inmates recalled any gender-specific training and could not articulate any actions or knowledge that differed from them in caring for their specific population."
- Refresher training every two years per PREA standards was not occurring.
- Training provided to staff was not sufficient to meet PREA expectations. "No staff at RMSC were able to articulate either the proper steps needed to respond to a sexual abuse allegation nor the ways to detect it may be occurring."
- Training of contractors (i.e., Corizon staff) did not include discussion of the agency's zero tolerance policy against sexual abuse and sexual harassment nor was there a system to ensure the training was tailored to the amount of time and access the contractor would have with prisoners.

- DOC Investigation Division investigators had not received specialized PREA training and were not well-qualified to conduct investigations of staff or inmates; any knowledge they did have in these areas appeared to have been learned from past experience or training elsewhere.
- Corizon staff who would conduct forensic examinations had not received appropriate training to do so and were not properly certified.
- Corizon's medical and mental health staff had not received overall PREA training mandated for employees or contractors.
- Facility methods provided for inmates to report abuse were few, the hotlines were ineffective (e.g., did not work, or were constantly busy, or were hung up on, or rang to the wrong number), 311 was only available outside the facility, and calls could not be made in a confidential manner.
- Clergy had little guidance from DOC as to what their reporting responsibilities were.
- Staff were uncertain how to privately report abuse.
- Complaints of assaults or harassment by staff were considered non-grievable.
- Prisoners did not have access to confidential support services as the City failed to enter into any MOUs or agreements with outside support or advocacy groups, rape crisis centers, or others who could be accessed by hotline or mail.
- "Reports from both inmates and staff were that they were not confident every allegation would be reported ... Staff often indicated they would "tell a Captain" but were not able to recount any steps beyond those that were required of them by Directive or PREA Standard if an inmate reported to them."
- Not all Corizon medical and mental health staff reported abuse allegations regularly or at all.
- All sexual harassment complaints and grievances were not reported to DOC's Investigations Division or DOI, as required by PREA Standard § 115.61(e).
- Staff noted that there was a culture of discussing inmate's personal information, that staff have "loose lips," and "nothing is a secret around here."

- “No staff interviewed were able to describe their PREA-required [first responder] duties should they come upon or be told about an allegation,” including but not limited to the preservation of evidence and protecting the victim. “[T]here was not one, coordinated, cohesive institutional plan that lists all affected parties and what each of their responsibilities is.”
- Investigations were not thorough. “In a majority of investigations reviewed, they did not contain interviews with all possible witnesses. Many actually did not even contain interviews with the staff involved in the case. Witnesses such as clinical staff, inmates in the area or in the unit, staff nearby, the accused staff ... were simply not interviewed at all, so no testimonial evidence could be collected.” Staff would not even speak with the Investigations Division, yet they suffered no adverse consequences. “One cannot take an inmate report and never take the statement of the accused staff and all other possible witnesses and conclude the allegation is unfounded.”
- “It is not clear that any sexual abuse allegation would be given the time, attention and seriousness it deserves, possibly due to a lack of resources in the [Investigations Division] and DOI and as well as a lack of appropriate training in contemporary correctional investigations techniques.”
- “Many areas do not have cameras or have cameras that ‘monitor, but do not record’ so video evidence was rare.”
- “In at least three cases, inmates described trying to report abuse and being re-directed to different people, usually Captains, as the party they reported to would not take their complaint.”

120. The Moss Group Report also detailed Defendants’ lack of leadership when it came to “awareness, knowledge, and messaging specific to PREA, sexual abuse and sexual harassment.”

- “[N]o agency vision, mission or strategic plan specific to PREA was in place. Few staff or inmates had heard of PREA, and training and orientation addressing PREA requirements did not appear to be occurring. Similarly, lacking a foundation in the PREA Standards, leadership and staff did not appear to understand what this federal law means to facility operations.”
- Incorrect belief at many levels of facility leadership and staff that sexual abuse and harassment of inmates rarely occurs and that, when it does, it is most prevalent among gay, lesbian, and transgender inmates.

- Lack of understanding by staff at all levels of their specific role in promoting sexual safety through prevention, detection, and response; captains were in the early stages of their careers and reported having little if any training in their role and little support from supervisors.
- Low staff morale contributes to a culture of reluctance or fear to act; “many staff are exhausted and overworked due to staff shortages.”
- “There appears to be a strong and culturally ingrained code of silence among staff and inmates. Staff described a fear based environment as evidenced by reluctance to report misconduct, reluctance to raise issues or ask questions, fear of retaliation ... Inmates described a fear based environment as evidenced by reluctance to report staff or inmate misconduct, reluctance to raise issues or ask questions due to the belief that they won’t be taken seriously or will be retaliated against.”
- Lack of collaboration between DOC and DOHMH on policy and training increases vulnerabilities for inmates.
- “Overall there was a lack of understanding of current policy; a lack of PREA policy updates to correspond with procedural changes within the DOC; and a lack of communication and training specific to the needs of line staff specific to procedural changes.”

121. Due to Defendants City and Corizon’s long-standing failures to implement mandated PREA reforms and standards, including but not limited to the policies, training, investigations, reporting and leadership from the top down, these Defendants were deliberately indifferent to the sexual safety and threats faced by their female inmate population in general and Plaintiffs in particular and were the moving force behind the sexual assaults suffered by Plaintiffs.

122. As a result thereof, Defendant Wilson was able to victimize the plaintiffs with impunity while his co-workers, supervisory personnel, and DOC staff opted to protect him from detection rather than Plaintiffs from further abuse.

**FIRST CLAIM FOR RELIEF:  
CLAIMS AGAINST THE CITY OF NEW YORK AND CORIZON**

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123. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

124. As set forth above, Defendants City and Corizon acted with deliberate indifference to the safety of Plaintiffs by allowing a sexual predator to be and remain on staff; by allowing a sexual predator to have unfettered access to women on an unsupervised basis; by allowing a sexual predator to be with Plaintiffs in unmonitored clinic areas where he was free to abuse them; by failing to remove a sexual predator following prior allegations of abuse; by failing to install surveillance cameras in areas where sexual abuse was known to frequently occur; by failing to train staff to recognize the signs of coercion and sexual abuse; by failing to train staff to recognize and report patterns of certain staff that are engaging in sexually abusive tactics; by failing to recognize and appreciate the specific risks that females and sexual abuse victims face in jail and to implement policies and practices to improve their safety; by failing to identify a systemic problem of women being sexually victimized by RMSC staff; by allowing a custom and practice that permitted mandatory reporters to avoid reporting allegations of sexual abuse without consequences; by failing to timely implement policies consistent with PREA standards; by failing to screen employees through background checks and other methods; by permitting their supervisory officials and staff to operate in the manner alleged herein; by failing to monitor (through cameras or otherwise) known at-risk areas; by failing to implement meaningful consequences for officers and clinic staff who fail to report suspected and/or witnessed rape and sexual abuse; by failing to encourage victims to report rape and sexual abuse;

by failing to enforce the chaperone policy; by allowing unchaperoned medical examinations to occur; by failing to discipline medical staff who allow unchaperoned medical examinations to occur; by failing to post signs throughout each prison stating it is a felony for an officer or clinic staff member to have sexual intercourse or contact with a prisoner; by failing to take reasonable measures to ensure the safety and security of their female prisoner population; by failing to implement adequate and effective training, supervision and monitoring policies; and in being otherwise deliberately indifferent in their acts and omissions alleged herein.

125. In addition, these defendants' policymakers and supervisory personnel tolerated a code of silence such that officers, staff, and victims were encouraged to "hold it down" and avoid reporting allegations of sexual misconduct against inmates. Further, these defendants' policymakers and supervisory personnel tolerated the custom and practice of retaliating against staff and inmates who did not "hold it down."

126. By their policies, practices, acts, and omissions, the City and Corizon caused Plaintiffs to be subjected to forcible touching, sexual assault, rape and be otherwise sexually victimized, in violation of their due process rights under the Fourth, Eighth and/or Fourteenth Amendments to the United States Constitution.

127. The consistent ignoring by the City and Corizon's supervisory officials at the RMSC clinic of Wilson's persistent and widespread pattern of sexual abuse, rape, and assaults of Plaintiffs, transpiring over sixteen (16) months, demonstrates a custom and practice of actual, or at least constructive, acquiescence to Wilson's criminal misconduct.

128. Wilson's abusive conduct towards Plaintiffs, though it occurred within an examination cubicle, was hardly private or secluded and should have been readily apparent to all, including senior policy-making officials, as (a) the walls to the cubicle were approximately 5 feet

high (not to the ceiling), (b) there was no door (only a movable privacy screen), (c) the cubicles were located in the middle of the clinic area, (d) supervisors and staff were able to walk by as they pleased, (e) supervisors and staff were able to hear what was happening in the cubicle, (f) supervisors and staff were able to smell the contraband given to Plaintiffs by Defendant Wilson, (g) clinic staff and presumably others were aware that Wilson was spending too much time with Plaintiffs, and (h) chaperones were not present during Wilson's examinations of Plaintiffs.

129. The City and Corizon's failure to institute adequate safeguards in their hiring, screening and supervision practices demonstrates their deliberate indifference to the safety and well-being of inmates in their custody, care, and control.

130. The City, through DOC and DOHMH, was grossly negligent in failing to (a) conduct background checks of staff conditionally hired by Corizon, (b) conduct fingerprint checks of staff conditionally hired by Corizon, (c) oversee Corizon's hiring of clinical staff, and (d) conduct telephone, visitation history and inmate account checks for prospective Corizon employees and continue to perform periodic checks after employment.

131. The City, through DOC and DOHMH, was grossly negligent in failing to supervise Corizon to ensure, among other things, that Corizon (a) hired employees that were properly vetted, (b) properly supervised and reviewed employee performance, (c) verified applicant's backgrounds and professional licenses prior to employment and continued to monitor same during their employment, (d) that its employees were not smuggling contraband into Rikers Island for inmates, and (e) that its employees were not calling prisoners' families or depositing funds into their inmate accounts.

132. The City, through DOC and DOHMH, was grossly negligent in failing to adopt policies, practices and procedures and/or enforce those already in place that (a) require Corizon

to follow strict professional and character standards when assessing and vetting applicants for employment in DOC facilities, (b) require the City and Corizon to conduct follow-up background investigations into disclosures that call an applicant's judgment and character into question, (c) require Corizon to screen applicants specifically for vulnerability to corruption, contraband smuggling, and committing sexual abuse, (d) require Corizon to compel candidates to disclose and describe the circumstances of all prior convictions and arrests and prior employment disciplinary history, (e) set training and re-training requirements for Corizon staff working in DOC facilities, (f) set performance requirements for Corizon staff working in DOC facilities, and (g) require the DOC and Corizon to perform pre-employment and periodic post-employment checks to ensure Corizon employees are not calling prisoners' families or depositing funds into inmates' accounts.

133. Corizon was grossly negligent in that it (a) hired employees that were not properly vetted, (b) failed to supervise and review employee performance, (c) failed to verify applicant's professional licenses prior to employment and continue to monitor same during their employment, (d) failed to ensure that its employees were not smuggling contraband into Rikers Island for inmates, (e) failed to conduct adequate background checks on employees resulting in employment of numerous individuals with serious criminal convictions including Second Degree Murder and drug possession, (f) knowingly hired individuals that did not fully disclose prior misdemeanor and felony convictions, including one individual who was hired despite disclosing 13 prior convictions, (g) knowingly hired individuals despite having evidence of their prior criminal activity, (h) failed to conduct any background check of any kind nearly half the time, (i) failed to follow strict professional and character standards when assessing applicants for employment in DOC facilities, (j) failed to conduct follow-up background investigations into



disclosures that call an applicant's judgment and character into question, (k) failed to screen applicants specifically for vulnerability to corruption, contraband smuggling, and committing sexual abuse, (l) failed to compel candidates to disclose and describe the circumstances of all prior convictions and arrests and prior employment disciplinary history, and (m) had an otherwise substantially flawed and deficient application, interview and screening process of candidates, and (n) failed to adopt policies, practices and procedures and/or enforce those already in place regarding the foregoing.

134. The City, through DOC and DOHMH, was grossly negligent in its responsibility to (a) conduct background checks and fingerprint checks of Corizon applicants, (b) review Corizon staff files to ensure Corizon was properly supervising and reviewing employee performance, and (c) prevent contraband from being smuggled into its facilities.

135. The City and Corizon know that clinical staff have more frequent, largely unrestricted, and lengthier private interaction with inmates than DOC staff. These defendants are also aware, based upon prior allegations and investigations, that clinical staff have ample opportunities to engage in misconduct with inmates and smuggle contraband. Yet, despite the foregoing, the City and Corizon subject clinical staff candidates to a much less extensive pre-employment application and screening process than correctional officers and do not have equivalent post-employment training, re-training, monitoring and supervision requirements.

136. Due to prior allegations and investigations, the City and Corizon knew that officers and clinical staff subject female prisoners (victims of prior sexual assault in particular) to recurrent and ongoing acts of rape and other sexual abuse, including forced sexual intercourse, oral sexual acts, sexual touching, gratuitous internal pelvic examinations, demeaning sexual comments, and physical and verbal intimidation to deter inmates in custody from reporting such

sexual abuse, but have failed to take reasonable measures to prevent or curb this pattern of abuse.

137. Due to prior allegations and investigations, the City and Corizon knew that officers and clinic staff who rape and sexually abuse inmates routinely leave their assigned posts, allow the abused inmates into areas where they are not permitted, congregate in the facility's clinic and other areas that are known to be outside the view of monitored security cameras, and engage in open and public behavior that is obviously suggestive of inappropriate personal relationships and sexual abuse of inmates. The abusing officers and clinic staff often provide their victims with contraband items. These behaviors are known and visible to officers, clinic staff and prisoners alike. The City and Corizon failed to take action despite knowledge of these activities and has not enforced policies intended to identify, address, and prohibit sexual abuse of inmates by clinic staff.

138. The City and Corizon permit clinic staff virtually unfettered access to inmates and unmonitored areas where they can rape and sexually abuse inmates with minimal risk of detection.

139. The City has failed to ensure that security cameras are installed in these high risk areas and, where cameras are installed, has failed to ensure that they are functional.

140. The City and Corizon have failed to employ obvious measures to reduce the risk of rape and sexual abuse of inmates, such as heightened monitoring of behavior indicative of ongoing sexual abuse, appropriately placed and functional surveillance cameras installed and maintained without staff knowledge, exit interviews of incarcerated inmates upon transfer or release, random interviews of staff, and more frequent, unannounced rounds by supervisory officials.

141. The City and Corizon's system for the reporting and investigation of rape and

sexual abuse is grossly inadequate. It relies almost entirely on inmates reporting their own rape and sexual abuse and then fails to take appropriate action to protect those who do come forward or to punish their abusers.

142. The City and Corizon have failed to train correction officers, mental health staff, and clinic staff to take reports of rape and sexual abuse seriously and to give adequate weight to the credibility of inmate witnesses.

143. Pursuant to City and Corizon policy and practice, inmates who report rape and sexual abuse are not protected from retaliation.

144. The City and Corizon do not consistently investigate reports of rape or sexual abuse in a prompt or thorough manner, if at all. Once an inmate reports that he or she has been raped or otherwise sexually abused, weeks can pass before an investigation begins, if at all. Regardless of what an investigation reveals, the subjects are rarely disciplined, and inmates are rarely informed of the outcome.

145. The City and Corizon treat inmates as adversaries rather than allies. In the case of Plaintiffs, for example, these defendants failed to document or investigate allegations made to officers and clinic staff.

146. The City and Corizon's long-standing failure and/or refusal to supervise the corrections officers and clinical staff under its/their control, and their own supervisory staff, is now so institutionalized as to constitute a policy or custom of tolerating and authorizing the type of abuse alleged herein. It is this policy or custom of abuse and cover-up that has caused or contributed to the deprivation of the plaintiffs' rights.

147. Said policy or custom is further evidenced by frequent and significant findings of misconduct over a period of years by commissioners, command personnel, supervisors, site

medical directors, and the officers and clinical staff they supervise.

148. The failures and refusals by the City and Corizon to hold their officers and clinic staff accountable is a proximate cause of the injuries and abuses sustained by the plaintiffs, and undoubtedly dozens of other women.

149. Through promotions and other financial and status incentives, the City and Corizon have the power to reward officers and clinic staff who perform their jobs adequately and to punish – or at the very least fail to reward – those who do not. The City and Corizon’s actions and omissions have created and maintained the perception that supervisors, officers and clinic staff who turn a blind eye towards evidence of sexual harassment, intimidation, abuse and rape, and/or contraband smuggling by staff for inmates, and fail to report or investigate these incidents, will suffer no damage to his or her career or financial penalty.

150. The pattern of unchecked sexual abuse by clinic staff and the persistent failure or refusal of the City, DOC, DOHMH, and Corizon to adequately supervise these persons and to take action to curb the misconduct, demonstrates a policy of deliberate indifference which tacitly authorized the abuses claimed by the plaintiffs.

151. The foregoing customs, policies, usages, practices, procedures and rules of the City and Corizon constituted deliberate indifference to the safety, well-being and constitutional rights of the plaintiffs and were the direct and proximate cause of the constitutional violations suffered by the plaintiffs as alleged herein.

152. The foregoing customs, policies, usages, practices, procedures and rules of the City and Corizon were the moving force behind the constitutional violations suffered by the plaintiffs as alleged herein.

153. As set forth above, the City and Corizon failed to protect Plaintiffs from known

and foreseeable harm.

154. As set forth above, the City and Corizon failed to intervene, mitigate and/or stop the events alleged herein.

155. As set forth above, the City and Corizon knew of and consciously disregarded an excessive risk to Plaintiffs' health and safety.

156. Due to the City and Corizon's practices and policies aforesaid, the plaintiffs suffered and continue to suffer physical, psychological and emotional injuries, pain and suffering.

**SECOND CLAIM FOR RELIEF:  
CLAIMS AGAINST SIDNEY WILSON**

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157. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

158. At all relevant times, Sidney Wilson was an employee of Corizon, the City's contracted medical provider at Rikers Island.

159. At all relevant times, Defendant Wilson was acting under color of state law.

160. As set forth above, Defendant Wilson forcibly touched, sexually assaulted, and raped the plaintiffs.

161. As set forth above, Defendant Wilson performed medically unnecessary and gratuitous physical examinations on Plaintiffs for his own sexual gratification.

162. As a result of the foregoing, Plaintiff suffered and continues to suffer severe and permanent physical, psychological and emotional injuries, pain and suffering.

163. As set forth above, Defendant Wilson did violate Plaintiffs' constitutional rights

and was deliberately indifferent to and/or consciously disregarded an excessive risk to Plaintiffs' health and safety.

### **PENDANT STATE CLAIMS**

164. This action is commenced, including all applicable tolls, within the applicable statutes of limitations.

165. This action falls within one or more of the exceptions set forth in N.Y. C.P.L.R. §1602.

### **FIRST CLAIM FOR RELIEF UNDER NEW YORK STATE LAW: SEXUAL ASSAULT, RAPE, FORCIBLE TOUCHING AND BATTERY**

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166. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

167. As set forth above, Defendant Wilson did perform nonconsensual sexual acts on Plaintiffs; did engage in nonconsensual sexual acts with Plaintiffs; did forcibly touch Plaintiffs; did sexually harass, intimidate, and threaten Plaintiffs; and did sexually assault Plaintiffs.

168. As set forth above, Defendant Wilson did perform unnecessary and gratuitous medical examinations on Plaintiffs for his own sexual gratification.

169. Pursuant to New York Penal Law §130.05(3)(f), Plaintiffs, as a matter of law, are incapable of consenting to engaging in sexual acts with Defendant Wilson.

170. As a result of the foregoing, Plaintiffs suffered and continue to suffer severe and permanent physical, psychological and emotional injuries, pain and suffering.

**SECOND CLAIM FOR RELIEF UNDER NEW YORK STATE LAW:  
NEGLIGENCE**

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171. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

172. Corizon, its agents, servants and employees, were negligent in the instances alleged herein in their operation, supervision, enforcement, maintenance, management and control of the RMSC clinic in the general and as it relates to the plaintiffs in particular; in failing to act reasonably in the instance; in failing to have nurses present during examinations; in permitting Defendant Wilson to conduct examinations on female prisoners without a nurse present; in failing to protect the health and welfare of the plaintiffs; in failing to provide the plaintiffs with reasonably safe conditions; in failing to quickly and diligently intercede on behalf of plaintiffs; in failing to protect plaintiffs; in setting a trap for the plaintiffs; in failing to take cognizance of a dangerous and escalating situation; in failing to be truthful and consistent in reporting sexual violence and victimization; in violating the plaintiffs' civil, statutory and common law rights; in infringing upon the freedoms afforded to the plaintiffs; in being reckless with the plaintiffs' health, safety, and security; in causing, creating and/or allowing unlawful conditions to be and remain; in being disinterested, indifferent, apathetic and/or uninvolved during incidents of sexual violence or victimization; in failing to timely prevent and/or mitigate the subject incidents despite having notice, time and opportunity to do so; in failing to give the plaintiffs notice and/or warning; in causing and/or allowing the plaintiffs to be raped, sexually assaulted and abused; in causing and creating a dangerous condition conducive to causing harm; in causing and allowing a dangerous and hazardous condition to exist; in creating and allowing a

nuisance to be and remain; in failing to provide for the safety of the plaintiffs; in failing to seek proper training; in failing to be adequately trained; that the alleged incidents could not have occurred but for the negligence, in whole or in part, of Corizon, its agents, servants and employees; in failing to protect the plaintiffs in each and every instance; in causing, permitting and/or allowing the plaintiffs to be sexually harassed, threatened, menaced, sexually assaulted, and raped; in denying and/or delaying the plaintiffs' access to timely, due and adequate medical care for the injuries they suffered; in failing to fully, faithfully and reasonably investigate Plaintiffs allegations and prior allegations made against Defendant Wilson; in failing to have an adequate policy to ensure the truthful and consistent reporting of sexual violence and victimization; in being deliberately indifferent to the plaintiffs' health, safety, and security; in causing and allowing clinic areas to be and remain a violent and dangerous place for prisoners; in causing, creating and/or allowing unlawful conditions to be and remain; in having a policy, either written or by custom, which accepts and/or promotes disinterest, indifference, apathy and/or uninvolved during incidents of sexual violence and victimization; in failing to adequately train their clinic staff; in failing to have trained personnel; and Corizon, its agents, servants and employees, were otherwise negligent, careless and reckless in the instance.

173. As a result of the foregoing, Plaintiffs suffered and continue to suffer severe and permanent physical, psychological and emotional injuries, pain and suffering.

**THIRD CLAIM FOR RELIEF UNDER NEW YORK STATE LAW:  
NEGLIGENT HIRING, TRAINING, SUPERVISION AND RETENTION**

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174. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.



175. As set forth above, Corizon was negligent, careless and reckless in the hiring, screening, training, retention, and supervision of Defendant Wilson in that said employee lacked the character, mental capacity, experience, ability, maturity, sensibility and intelligence to be and remain employed by Corizon; in failing to exercise due care and caution in its hiring, screening, training, retention, and supervision practices; in failing to suspend and/or terminate employees when such action was either proper or required; and in being otherwise careless, negligent and reckless in the instance.

176. Corizon's failure to enforce the laws of the United States of America, the State of New York and the Charter, rules and regulations of the City of New York, is evidence of the reckless lack of cautious regard for the rights of the prisoners in their care and Plaintiffs in particular and exhibited a lack of that degree of due care which prudent and reasonable individuals would show.

177. Corizon knew or should have known in the exercise of reasonable care the propensities of Defendant Wilson to engage in the wrongful conduct alleged herein.

178. Corizon knew or should have known that its policies, customs and practices, as well as its negligent hiring, screening, retention, supervision, training, appointment and promotion of its agents, servants and employees, created an atmosphere where the most prominent offenders felt assured that their most brazen acts of abuse, misconduct and neglect would not be swiftly and effectively investigated and prosecuted.

179. That the mistreatment and abuse of the plaintiffs set forth above was the reasonably foreseeable consequence of Corizon's negligent conduct.

180. The aforesaid negligence of Corizon in its hiring, screening, retention, supervision, training, appointment and promotion practices resulted in the sexual harassment,

intimidation, assault and rape of Plaintiffs; the abuses of Defendant Wilson being trivialized, minimized and/or covered up; the cause, nature and extent of the plaintiffs' injuries being trivialized, minimized and/or covered up; the plaintiffs' constitutional, statutory and common law rights to be violated; and Plaintiffs to suffer severe and permanent physical, psychological and emotional injuries, pain and suffering.

**FOURTH CLAIM FOR RELIEF UNDER NEW YORK STATE LAW:  
INTENTIONAL AND NEGLIGENT INFLICTION OF EMOTIONAL DISTRESS**

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181. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

182. As set forth above, Defendant Wilson's aforesaid conduct was intentional, malicious and excessive, and served no reasonable or legitimate medical or penological interest.

183. As set forth above, Corizon's aforesaid conduct was negligent and served no reasonable or legitimate medical or penological interest.

184. These defendants' intentional, reckless and/or negligent infliction of emotional and mental distress constituted misconduct of an egregious and outrageous nature that exceeds all bounds usually tolerated by society and unreasonably endangered Plaintiffs' physical, psychological and emotional wellbeing.

185. As a result of the foregoing, Plaintiffs suffered and continue to suffer severe and permanent physical, psychological and emotional injuries, pain and suffering.

**FIFTH CLAIM FOR RELIEF UNDER NEW YORK STATE LAW:  
FAILURE TO INTERVENE**

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186. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the

preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

187. As set forth above, Corizon, its agents, servants and employees, failed to protect Plaintiffs from known and foreseeable harm.

188. As set forth above, Corizon caused and created the dangerous conditions which gave rise to the incidents and injuries alleged herein.

189. As set forth above, no one attempted to intervene, mitigate, stop or prevent the subject incidents at any time during the happening of the incidents or thereafter.

190. As set forth above, no one attempted to investigate the subject incidents or Defendant Wilson upon same being reported to them.

191. As set forth above, Corizon, its agents, servants, and employees, knew of and consciously disregarded excessive risks to Plaintiffs' security, health and safety.

192. That due to said defendant's failure to protect the plaintiffs, they suffered and continue to suffer severe and permanent physical, psychological, and emotional injuries, pain and suffering.

**SIXTH CLAIM FOR RELIEF UNDER NEW YORK STATE LAW:  
VIOLATION OF NEW YORK CITY ADMINISTRATIVE CODE § 10-1105  
"VICTIMS OF GENDER-MOTIVATED VIOLENCE PROTECTION LAW"**

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193. Plaintiffs repeat, reiterate and reallege each and every allegation contained in the preceding paragraphs of this Second Amended Complaint with the same force and effect as if same were fully set forth herein.

194. As set forth above, Defendant Wilson's actions against Plaintiffs constituted felonies under New York State law and presented a serious risk of physical and emotional injury

to Plaintiffs, and were crimes of violence motivated by gender, committed because of gender or on the basis of gender, and due, at least in part, to an animus based on Plaintiffs' gender.

195. As set forth above, Defendant Wilson's conduct complained of herein violated the Victims of Gender-Motivated Violence Protection Law, New York City Administrative Code § 10-1101 *et seq.*, and as such, Wilson is liable to Plaintiffs for compensatory and punitive damages, attorney's fees and costs, and such other relief as this Court may deem appropriate.

196. As a direct and proximate result of Defendant Wilson's violation of New York City Administrative Code § 10-1101 *et. seq.*, known as the "Victims of Gender-Motivated Violence Protection Act," Plaintiffs sustained in the past, and will continue to sustain in the future, physical injury, pain and suffering, serious and severe psychological and emotional distress, mental anguish, embarrassment, and humiliation.

### **JURY DEMAND**

Plaintiffs hereby demand a trial by jury of all issues in this matter.

### **RELIEF**

Plaintiffs request the following relief jointly and severally as against all of the defendants:

1. An award of compensatory damages against all defendants in an amount to be determined at trial;
2. An award of punitive damages against Corizon and Sidney Wilson in an amount to be determined at trial;

3. An award of attorney's fees, expert's fees, costs, and disbursements; and
4. Such other and further relief as this Court deems just and proper.

Dated: Brooklyn, New York  
April 8, 2022

Yours, etc.,

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