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

THE PEOPLE OF THE STATE OF NEW YORK, by ERIC T. SCHNEIDERMAN, Attorney General of the State of New York,

Petitioner,

-against-

ARMOR CORRECTIONAL HEALTH MEDICAL SERVICES OF NEW YORK, INC. P.C. and ARMOR CORRECTIONAL HEALTH SERVICES OF NEW YORK, INC.,

Respondents.

VERIFIED PETITION

Index No.

IAS Part _____

Assigned to Justice _____

Petitioner, the People of the State of New York, by their attorney, Eric T. Schneiderman, Attorney General of the State of New York (the "State" or "NYAG"), allege upon information and belief:

INTRODUCTION

1. The NYAG brings this special proceeding against Armor Correctional Health Medical Services of New York, Inc. P.C. and Armor Correctional Health Services of New York, Inc. (together, "Armor" or "Respondent"), pursuant to New York Executive Law § 63(12) and Article 4 of the New York Civil Practice Law and Rules. Armor is a physician-owned, for-profit jail health services provider that was formed in Florida in 2004. Respondent is contracted to provide jail health services in 29 counties across eight states: Florida, Georgia, Oklahoma, Illinois, South Dakota, Wisconsin, Virginia and New York.

2. In New York, Armor has provided health care services to inmates at the Nassau County Correctional Center ("NCCC") since June 2011. From December 2012 through October 2015, Armor was also contracted to provide jail health services in Niagara County's jail.

3. NCCC is run by the Nassau County Sheriff's Department and houses both pre-trial and sentenced individuals (collectively, "inmates"). In 2015, NCCC housed an average of 1,188 inmates.

4. Providing appropriate medical treatment is particularly important in the prison population due to the high incidence of disease. A February 2015 report issued by the U.S. Department of Justice found that in 2011-12, approximately 40% of state and federal prisoners and jail inmates reported having a current chronic medical condition (such as cancer, high blood pressure, or asthma), and 14% of jail inmates reported ever having an infectious disease, such as tuberculosis, hepatitis B or C, or a sexually-transmitted disease.

5. Jail populations also evidence a high incidence of mental illness – for example, an estimated 25% of jail inmates in the New York City correctional system have been diagnosed with some form of mental illness while in jail and the overall burden of mental illness is approximately 38%.

6. From 2011 through July of 2016, a total of 14 deaths occurred at NCCC and Niagara County's jail. Of the latest four NCCC inmate deaths, one occurred just days ago in July (no causal information as yet), one occurred in June (death by suicide) and two occurred in March 2016 (the cause of each remains under investigation). The New York State Commission of Correction's Medical Review Board ("State Medical Review Board"), charged with the oversight of jail and prison health care and the investigation of related morbidity and mortality

incidents, found egregious lapses in medical care in seven of the 14 deaths, five of which occurred at NCCC.

7. The NYAG's investigation revealed that Armor has not met its contractual obligations to Nassau County as evidenced by the following: inadequate self-assessments (or "self-audits") and inadequate continuous quality improvement processes that would ensure quality of health care services; deficient sick call procedures; failure to provide access to medications; inadequate diagnostic services; deficient mental health services; inadequate referrals to specialists; failure to maintain (i) its equipment and (ii) accurate and complete medical records; and inadequate staffing.

8. The NYAG brings this special proceeding for injunctive relief, damages, civil penalties and costs. Armor has consistently failed to meet its contractual obligations with Nassau County, which were put in place to provide appropriate medical and mental health services for inmates. Armor's many failures appear to have resulted in avoidable harm to incarcerated persons at NCCC, who rely on Armor for medical care.

9. The deaths in Niagara County when Armor was the health service provider took place on December 25, 2012 (death from hypothermia complicated by hypertensive cardiovascular disease, bipolar disorder, and hypothyroidism; State Medical Review Board found that Armor failed to provide prescribed medication, initiate constant supervision, request records from community health provider and appropriately diagnose and treat) and on December 29, 2012 (death from acute untreated pulmonary edema secondary to heart failure; State Medical Review Board determined that Armor failed to order a specialty cardiac consult and prescribed medication that was contra-indicated in cardiovascular disease).

10. The deaths in Nassau County took place on June 11, 2011 (death from myocardial infarction; State Medical Review Board found that "care was grossly incompetent;" "death may have been prevented had [the inmate] received timely and appropriate emergency medical care"); February 24, 2012 (suicide by hanging; State Medical Review Board found that Armor failed to provide adequate psychiatric services and emergency procedures were poorly performed); February 10, 2014 (death from cardiac failure due to hypertensive cardiovascular disease; State Medical Review Board found that Armor failed to provide adequate medical and psychiatric care); July 14, 2014 (death from cardiorespiratory arrest due to laryngeal edema and angioedema; State Medical Review Board determined that Armor failed to provide proper medical treatment); and on May 2, 2015 (death from anoxic encephalopathy post cardio-respiratory arrest due to acute myocardial infarction; State Medical Review Board found that Armor did not perform an adequate admission exam and did not provide critical medications).

11. The records relating to each of these deaths demonstrate an array of deeply problematic practices, including Armor's failure to: provide timely medical care in response to inmate needs; provide adequate medical and psychiatric evaluations; perform diagnostic tests and timely dispense needed prescriptions drugs; refer inmates to specialist care where medically necessary; and carry out orders set forth by clinicians.

12. The four deaths of NCCC inmates that occurred in March, June and July 2016, while still under review, also raise serious concerns about the care being delivered by Armor.

13. The NYAG has an interest in (i) assuring appropriate healthcare to persons who are detained in jails within the State of New York, and (ii) protecting the economic interests and the public health of the citizens of Nassau County.

14. Armor's conduct is seriously detrimental to those interests.

JURISDICTION AND PARTIES

15. The NYAG brings this special proceeding pursuant to New York Executive Law § 63(12); New York State Finance Law § 189(1)(a) and (b), (3), and § 190 (1) ("NY False Claims Act"); and New York Executive Law § 63-c ("Tweed Law").

16. Executive Law § 63(12) empowers the NYAG to seek injunctive relief, restitution, disgorgement and damages when any person or business entity has engaged in repeated fraudulent or illegal acts, or has otherwise demonstrated persistent fraud or illegality in the carrying on, conducting or transaction of business.

17. The NYAG seeks an order and judgment: (a) declaring that Armor's practices and conduct violated NY False Claims Act § 189(1)(a)-(b) and Executive Law § 63(12), or, in the alternative, declaring that Armor has converted, disposed of, obtained, and/or received public funds without right, pursuant to Executive Law § 63-c; (b) permanently enjoining and restraining Armor from engaging in the illegal and fraudulent practices described herein, (c) appointing an independent monitor to oversee ongoing compliance with the contract, (d) permanently enjoining Respondent from bidding for future jail health contracts in New York State, (e) directing that Armor, pursuant to the NY False Claims Act § 189 pay: (i) an amount equal to three times the amount of damages sustained as a result of its violations and (ii) penalties of $12,000 for each violation, or, in the alternative awarding Petitioner the monies that Armor without right obtained as a result of its breach of contract; (f) requiring an accounting by Armor to determine the amount of Nassau County's damages, and (g) directing Armor to pay costs.

18. Petitioner is the People of the State of New York by their attorney Eric T. Schneiderman, Attorney General of the State of New York.

19. Armor is a professional corporation organized under the laws of the State of New York, with its principal place of business at 4960 SW 72nd Avenue, Suite 400, Miami, Florida 33155.[1]

20. This Court has personal jurisdiction over Armor because it transacts business in New York State.

21. Venue is proper in this Court pursuant to CPLR § 503.

FACTS

Background

22. In May 2011, following a request for proposal process ("RFP"), Nassau County entered into a renewable two-year contract ("Contract") with Armor to provide health care services to inmates at NCCC. While the Contract limited contract extensions to two one-year renewals, Nassau County renewed the Contract in May of 2013 for a two-year period, and again in May 2015 for an additional two-year period. The current Contract will expire in May 2017.[2]

23. The Contract incorporates by reference several documents that set forth detailed standards for how Armor's services are to be performed including a 2002 settlement agreement

[1] Armor Correctional Health Services of New York, Inc. provided the first bid for the contract, and signed the initial contract. Armor Correctional Health Medical Services of New York, Inc. P.C., its successor, was incorporated in 2014.

[2] In March 2016, some three months after the NYAG commenced its investigation of Armor, Nassau County issued a new Request for Proposal for a new health service contract for NCCC. Bids for the contract are due on August 22, 2016 with selection to take place by October 17, 2016.

between Nassau County and the U.S. Department of Justice ("DOJ Settlement") that includes specific actions NCCC must take to provide adequate medical care to its inmates.

24. The Contract also explicitly incorporates Armor's response to Nassau County's RFP, dated October 13, 2009, and requires Armor to: provide medical, mental health, substance abuse treatment, dental, pharmacy, laboratory and diagnostic services, onsite specialty services (including orthopedic, physical therapy, obstetrics and gynecology, optometry, dialysis and infectious diseases); facilitate off-site specialty services and discharge planning; maintain an infirmary; establish a quality improvement program[3] overseen by a utilization review committee and to adhere to the National Commission on Correctional Health Care standards regarding jail health.

25. The initial Contract set forth Armor's annual contract price for the first twelve months of $10.5 million based on an average daily inmate population of 1,650. The current Contract provides for annual compensation to Armor of $11.6 million.

26. The Contract may be amended only with "prior written consent of the County Executive or his or her duly designated deputy." The Contract further states: "The failure of a party to assert any of its rights under this Agreement, including the right to demand strict performance, shall not constitute a waiver of such rights." Armor has never provided any evidence that any contractual requirements were formally amended for any of the requirements at issue in this Petition, except to change certain staffing levels.

[3] Armor's quality improvement program was to be developed and implemented in accordance with the DOJ Settlement.

27. The Contract sets forth that payments are contingent on Armor's submission of a claim voucher "that (a) states with reasonable specificity the services provided and the payment requested as consideration for such services, (b) certifies that the services rendered and the payment requested are in accordance with [the Contract], and (c) is accompanied by documentation satisfactory to the County supporting the amount claimed."

28. Each claim voucher contains a certification stating:

> I hereby certify that this claim voucher is just, true and correct; that the amount claimed is actually due and owing and has not been previously claimed . . . I further certify that all items and/or services were delivered or rendered as set forth in this claim, and for all items and/or services delivered or rendered in accordance with a purchase order or contract that the prices charged are in accordance with the reference purchase order or contract. For all claims made as reimbursement for employee expenses, I further certify that the amounts set forth were actually and necessarily expended for the benefit of Nassau County . . .

29. To support its claim vouchers, Armor is also required to provide Nassau County with monthly reports containing important information about Armor's provision of care to inmates.

30. Armor has submitted the claim vouchers on a monthly basis for one-twelfth of the annual Contract price for "medical health services" or "health services," but without setting forth any description of the services provided as the basis for the compensation claimed, and without submitting supporting documentation to evidence the claimed amount.

31. To support its claim vouchers, the Contract also requires that Armor submit monthly reports measuring the quality and quantity of its provision of care to inmates including on-site services, intake procedures, outpatient services, and hospitalization services.

32. However, while Armor prepared monthly reports, those reports only included approximately half of the twenty-four contractually required indicators and did not include key contractually required information, including: (a) the number of inmates who receive health screens at intake and the percentage of inmates who are seen within four hours, (b) the percentage of inmates transferred to acute care, and (c) the number of inmates who request access to medical or mental health care through sick call and the percentage who are then seen within 72 hours of their request.

33. The Contract also sets forth benchmarks for satisfactorily meeting select health services requirements under the contract (called "performance indicators") (including, for example, adherence to contractual requirements regarding medical and mental health screens; timely access to care, including sick call and medications; diagnostic services; and access to specialists), and financial reductions for failure to meet those benchmarks. The Contract requires that Armor include any such fee reduction in the subsequent month's claim voucher, and payments to Armor would be adjusted accordingly.

34. No fee reductions have ever been assessed or imposed on Armor, despite Armor's serial failings in meeting contractually required "benchmarks."

35. Despite its vouchers' certifications, Armor also never reduced the amount owed to reflect that its services were not performed consistent with its contractual requirements, including never providing the contractually-required financial reductions for not adequately performing its obligations under the Contract.

36. Moreover, Armor did not disclose, through any monthly reports sent to Nassau County or any other written documentation, its underperformance or non-performance of the

contractually-required services for each and every month in which adjustments to the fee were appropriate.

37. The OAG's investigation revealed that Armor has not met its contractual obligations to Nassau County as evidenced by: inadequate auditing and continuous quality improvement processes (including devising and implementing Continuous Quality Improvement ("CQI") corrective action plans) that would ensure quality of health care services; deficient sick call procedures; failure to provide continuous medications; inadequate diagnostic services; deficient mental health services; inadequate referrals to specialists; inadequate staffing; and failure to maintain equipment as well as accurate and complete medical records.

Armor Failed To Conduct Quality Improvement Systems or Create Corrective Action Plans Consistent With Its Contractual Obligations and Representations

38. An audit system (often called "Quality Assurance") together with a mechanism for implementation of corrective plans to address deficiencies (often called "Quality Improvement") are key to ensuring the quality of health care delivery in any health care institution.

39. According to the Contract, Armor is required to perform an array of assessments to monitor the quality of care provided to inmates as part of its continuous quality improvement program.

40. Specifically, the Contract requires three types of key periodic assessment reports: (1) annual reports; (2) semi-annual reports; and (3) monthly reports. .

41. These monthly, semi-annual, and annual reviews serve as a basis for evaluating and improving the quality of Armor's services and its compliance with various contractual requirements concerning the provision of health care services.

42. Without the required reports, there is no effective way to gauge the quality of health care delivery.

43. First, the Contract requires "an annual review of the [Quality Improvement Program] . . . to evaluate the program's effectiveness."

44. Notwithstanding the Contract's requirement, from 2011 through 2015, Armor has no record of performing any of the required annual reviews.[4]

45. Armor is also required to perform annually "at least two process and two outcome/quality improvement studies" each year. A process study examines the effectiveness of the health care delivery system, by investigating systemic problems, such as delayed sick call responses, failure to document behavioral health treatment plans, or failure to refer to specialists. An outcome/quality improvement study examines whether expected patient outcomes were met by analyzing a specific clinical area, such as asthma control, diabetes management or substance abuse treatment/detox.

46. Notwithstanding the Contract's requirements, from 2011 through 2105, Armor has no record of performing these critical studies to assess its services.

[4] "Self-audits" are characterized by service area (such as requests for medical care and outpatient referrals) and consist of evaluating various aspects of providing that service in a random sample of approximately ten medical records to determine if the service was adequately performed. For example, a mental health audit consists of an evaluation of 14 different aspects of providing mental health services, including timely screenings, timely consultations with appropriate staff, development of treatment plans when needed, and proper documentation of that patient's care. During the audit, an Armor employee reviews the randomly-selected medical records to determine if each of the elements comprising the audit were properly performed.

47. Second, the Contract requires Armor to conduct semi-annual operational reviews of certain substantive areas including: access to care; sick call; emergency care; off-site care and utilization; infirmary care; chronic illness care; mental health; intake or transfer screening; specialty care; infection control and safety; and CQI activities.

48. Notwithstanding the Contract's requirement, and the import of these reviews to gauging quality of its provision of services, Armor has no record of conducting these semi-annual reviews.

49. Third, in addition to the annual and semi-annual reviews, Armor is contractually required on a monthly basis to perform at least four to five quality assessment reviews (referred to herein as "self-audits") "to ensure continuous monitoring of key indicators at a frequency designed to comply with accreditation standards."[5]

50. Armor's own records reflect that it conducted far fewer than required monthly self-audits, which are critical to continuously monitoring the adequacy of its service delivery.

51. From 2011 through 2015, Armor conducted only 137 self-audits instead of the 240 - 300 required under the Contract -- barely half of the audits required.

52. Armor is further obliged to develop a corrective action plan ("CAP") if self-audit quality thresholds of 90% are not met.

53. A CAP identifies a problem found in a self-audit and sets out a plan of action to remedy the problem, including designating the appropriate staff to be engaged in the problem-solving tasks, monitoring and evaluation processes and the setting out the dates upon which

[5] These monthly self-audits are in addition to the monthly reports that Armor was contractually required to provide to Nassau County. *See supra* at ¶ 32.

delineated tasks are to be completed. Corrective action plans are crucial components of any health care provider's delivery of quality care.

54. Armor is required to design a CAP "within 30 days of the date of documentation of the deficiency" that results in a self-audit score below 90%.

55. In addition to conducting self-audits far less frequently than the Contract requires, Armor also seriously underperformed in the development of CAPs – the necessary action to address shortcomings found in the self-audits.

56. Specifically, from 2011 through 2015, Armor failed 70 of the 137 self-audits (51%), with these failures spanning across 27 of the 33 subject areas evaluated.

57. For example, Armor conducted self-audits in the following key health services over a five-year period on a very limited basis, with a substantial number of failures in most cases:

- Sick Call Response 2 self-audits; 1 failure
- Access to Diagnostic Services 6 self-audits; 4 failures
- Medication Administration/Access 11 self-audits; 8 failures
- Referrals to Specialty Care 5 self-audits; 5 failures
- Chronic Care Clinic Services 3 self-audits; 2 failures
- Mental Health Services 4 self-audits; 1 failure

58. Importantly, Armor only developed corrective action plans for 26 of the 70 failed audits, leaving 44 failed audits in significant health care areas without the required corrective action plan to improve the identified deficiency.

59. From 2011 to 2015, Armor only provided CAPs in some 37% of the instances where there were failed audits. Over 60% of audit failures went "uncorrected."

60. Thus, Armor, in violation of the contract, took no formal action to resolve problem issues its own staff identified concerning Armor's provision of medical care.

61. In key service areas, Armor never developed CAPs despite routinely failing most of the self-audits performed in those areas. For example, Armor only developed:

- *no* CAP addressing specialty consultation referrals in response to the *five* failed audits in that category, and
- *one* CAP addressing access to diagnostic services despite *four* self-audit failures.

62. Even when CAPs were developed, they were not consistently implemented.

63. While implementation should be documented in the Continuous Quality Improvement meeting minutes, these minutes do not reflect that CAPS were regularly implemented and their effectiveness re-evaluated, as required under the Contract.

64. For example, in September 2015, Armor devised its one and only corrective action plan to address its failure in performing diagnostic services (despite four self-audit failures).

65. There is no indication in Armor's records, however, that the plan was implemented or its effectiveness evaluated.

66. The Contract sets forth a fee reduction of $100 per day for each CAP not completed within 45 days from the date of the occurrence. Given that Armor never developed corrective action plans for some 44 failed self-audits, Armor should have reduced its fees at the very least by $528,000, if not by much more.

67. Because (i) Armor failed to consistently conduct CQI audits to assess the medical services provided to inmates and (ii) when Armor did audit, failed to design and implement CAPs to remedy health care service problems identified in CQI audits, it should have reduced its fees in its payment vouchers to Nassau County as required under the Contract.

68. These failures to address audit deficiencies as well as failure to audit consistently in any case, are significant failures in adherence to the Contract, and a disservice to both the inmates who bear the consequences of poor health services that are not improved through a quality improvement program, as well as the County taxpayers who are not receiving the services required under the Contract.

Armor Failed to Implement a Sick Call System Consistent With Its Contractual Obligations and Representations

69. The Contract requires that Armor implement and operate a sick call system through which patients request and obtain health care treatment.

70. Pursuant to the Contract, the sick call system is required to work as follows: (1) the patient completes a sick call form that may be placed in the sick call box that is located on each housing unit or given to the nurse during nurse's medication rounds, (2) a registered nurse then triages sick calls within 24 hours of pick-up, and (3) one of Armor's clinicians sees the patient within 72 hours of pick-up of the patient's sick call.[6]

[6] The Contract requires that inmates be seen by an Armor clinician within 48 hours from receipt of the sick call slip, and 72 hours when over a weekend. However, fee reductions are only imposed where the inmate has not been seen after 72 hours.

71. To ensure proper documentation of this sick call process, Armor's sick call logs ("Sick Logs") are required to include the following information: date and time of inmate's request; name of inmate and NCCC identification number; triage date; date seen; and medical complaint. Medical charts of each patient would also include a copy of the sick call request and show date that the patient was seen.

72. As evidenced by Armor's own CQI audit records, its Sick Log entries, a decedent's medical record and testimony of former inmates, Armor's medical personnel frequently failed to examine patients within 72 hours of a patient's submitting a sick call request form.

73. By failing to adhere to the time requirements set out in the Contract, Armor has routinely failed to address the medical needs of inmates.

74. Notably, there is no record that Armor ever performed a single semi-annual review to assess its performance of its sick call processes and only performed two self-audits over the course of the contract (one of which it failed).

75. An analysis by the NYAG of Armor's January and February 2016 Sick Logs reveals that there were, respectively, 2,827 and 2,660 sick call requests, and Armor's clinicians failed to timely respond to approximately

- 37% of the sick call requests in January 2016, and
- 28% of the sick call requests in February 2016.

76. In some of these cases, inmates filed repeated sick call requests, and Armor delayed weeks before arranging for a clinician visit.

77. Armor's carelessness added to patients not being seen after making sick call requests. For example, in January and February of 2016, over 150 of the sick call requests were not attended to because patients' charts were simply not available. Moreover, Sick Logs evidence other inadequacies including failing to set forth the date on which patients were examined and illegible clinician signatures on the sick call forms.

78. In at least one instance in 2015, sick call slips were not picked up for many days because the key to the collection box was missing.

79. Armor's providers often noted in Armor's own sick logs that inmates were not receiving timely follow-up care, including, for example:

- "Patient requested treatment for painful laceration of face and was not seen for three days."
- "Patient requested medications on 4/23. None was given until 4/29 by which point, patient had numbness."
- "Patient requested treatment 4/24 for left side body pain, on 4/27 left side of chest pain. Patient was not seen until 4/30."
- "[K.A.] must be seen 6/1/15 per Dr. Marcos. Since 5/22 inmate placed numerous sick calls trying to obtain treatment." (June 1, 2015)

80. The failure to address sick call requests goes to the very heart of providing adequate medical care. Inmates at NCCC rely on the sick call system to afford them access to both urgent as well as non-urgent health care services. Failing to abide by the time constraints set forth in the Contract results in delayed care that can impact inmates to the detriment of their health.

81. Moreover, while the Sick Logs are to be triaged within 24 hours, there is no indication as to the process followed by reviewers to determine the order that inmates are seen based on their complaints.

82. Armor's standard "Sick Call Request" form includes a check-off for the nurse to mark "Urgent" or "Referral to HCP [health care provider]." Examples of inappropriate triaging of "Urgent" inmate sick call requests with the potential of dire consequences abound in Armor's own Sick Logs:

- An inmate submitted a sick call request form on May 22, 2015 stating that his knee was filled with fluid and required drainage. He was seen by a health provider *seven days* after submitting his first sick call request, and only after he filed six additional sick call requests.

- Another inmate suffered from a painful laceration on the right side of his face. His sick call request was logged on April 27, 2015. He was seen by a clinician *three days* later.

- On yet another occasion, an inmate complained on April 24, 2015 about pain that spanned the entire left side of his body. Since his first sick call request went unanswered, he filed a second sick call three days later stating that he was then suffering from pain in the side of his chest. Three days after the second sick call request and *seven days* after the first sick call request, the inmate was finally seen by a clinician.

- On yet another occasion, an inmate filed a sick call request on June 4, 2015 stating that he was experiencing increasingly pale and numb fingers. This inmate filed a second sick call request four days later indicating that his gait was then unsteady and his knee was swollen. The inmate was first seen by a clinician *six days* after his first sick call request.

83. The consequences of delay in providing care through sick call are evidenced by inmate examples. One inmate, J.G., who died in NCCC custody on July 14, 2014, filed a sick call request on June 5, 2014 to obtain medication that he had been taking at home. After no Armor medical staff heeded his request, he filed a second sick call request one day later to obtain

the medication and also complained of swelling in his arm. He was not examined until six days after filing his first sick call request, when he presented with difficulty breathing and swelling of his shoulder, neck, and throat.[7]

84. W.H., a former inmate who was incarcerated at NCCC from January 2015 until July 2015, filed a number of sick call requests over a period of days to obtain the prescription medications for mental health conditions that he was taking before his incarceration at NCCC. He experienced vomiting, diarrhea, shaking and chills for days before finally receiving the medications nearly a week after his admission to NCCC.

85. Another former inmate, J.A., presented to NCCC with a history of cardiac disease in July 2012 when he began his incarceration for a period of 16 months. J.A. filed multiple sick call requests weekly to complain about chest pain and numbness in his arm and hand. Ultimately, J.A. was forced to file a lawsuit – over a year after he had been requesting medical assistance -- to receive medical attention. Not long after he filed suit, he was given a stress test, the results of which were so serious that he was taken immediately to Long Island Jewish Medical Center for an emergency angioplasty procedure.

86. Armor disregarded its contractual obligation to file monthly reports on the timeliness of its sick call responses. *See supra* at ¶ 32. Thus, Armor's sick call delays have not been documented and its monthly claims for payments from Nassau County do not properly reflect that sick calls were not timely handled as required under the Contract.

[7] J.G. was at that point referred to a rheumatologist but the referral visit was never made. J.G. died on July 14, 2014 as a result of cardiopulmonary arrest that the State Medical Review Board determined was due to swelling of his airway.

87. Further, Armor is required to conduct semi-annual reviews to assess the quality of health care services it provides at NCCC. Responding to sick calls in a timely manner is one of the key service categories requiring consistent review. Armor has no record of conducting these semi-annual reviews.

88. Additionally, as noted *supra* at ¶ 57, Armor failed to continuously monitor its sick call processes through monthly self-audits, having conducted only two sick call self-audits since the inception of the contract in June 2011.

89. Each Sick Log violation (where a clinician does not see an inmate within 72 hours of a sick call) subjects Armor to a $50 fee reduction under the Contract.

90. No penalties for Sick Log violations have been documented in the monthly vouchers from Armor to Nassau County. Based on the NYAG's analysis of the January and February 2016 Sick Logs, Armor should have been assessed a deduction of at least $123,450, just for the months of January and February 2016 alone.

91. Upon information and belief, the fee deduction would equal some $3.7 million extrapolating the fee reduction for the recent two-month sample to the 60-month course of the Contract.

92. In sum, Armor has failed to provide an adequate sick call system in violation of the Contract.

Armor Failed to Provide Inmates Access to Medications and Diagnostic Services Consistent with Its Contractual

Obligations and Representations

A. Inmate Access to Medications

93. Given that jails house a large percentage of inmates with health problems, both chronic and acute, jail health service providers must ensure timely access to medications, as well as diagnostic services to discern inmate health issues and make a treatment plan to address issues that have been diagnosed.

94. The Contract requires Armor to maintain a stock of approved medications and arrange for a back-up pharmacy so that new medication orders are timely administered to inmates. Medications are to be given in a timely, continuous and clinically appropriate manner so as to maintain therapeutic treatment levels and avoid adverse consequences to inmates' health. Specifically, the Contract requires that inmates receive medication within 24 hours of the written prescription.

95. Armor is subject to a $50 fee reduction for every inmate delay.

96. Upon admission to NCCC, inmates are to be assessed by a registered nurse who obtains the inmate's medical history, including medications, performs a mental health screen, obtains vital signs, such as blood pressure, and orders laboratory tests, such as drug screens and urinalysis and administers a test for tuberculosis. If the inmate presents with a history of having a medical illness, such as diabetes or hypertension, the inmate is to be examined by an Armor clinician within seven days of admission. If the nurse's admission assessment of the inmate is unremarkable, the inmate is not seen by a clinician. If an inmate is in jail for two years without any medical complaints, that inmate would not see a clinician and would only be examined by a nurse for annual health assessments.

97. Contrary to its contractual obligations, Armor's own audits reveal significant problems in inmates' access to medication. Of 11 medication audits over the course of five years, eight, or 73%, failed.

98. In addition, the records of inmates who died at NCCC together with the statements of former inmates attesting to substandard treatment by Armor clinicians, demonstrate that inmates with chronic illnesses did not receive even the most rudimentary care: they were not examined in a timely manner by a clinician, did not receive necessary medications, and did not receive prescribed laboratory examinations as ordered.

99. For example, decedent A.M. was incarcerated at NCCC on April 24, 2015 with a history of drug and alcohol abuse, asthma, and a herniated disc. According to a nurse's "Health Assessment" notes, A.M. presented with a productive cough and reported that he was taking Proventil and albuterol. A full admission examination was never performed, however, by a clinician.

100. Armor's clinician wrote orders for A.M. to receive albuterol, Qvar, and Levaquin, and a chest X-ray. Notwithstanding these orders, A.M.'s medical chart does not evidence that A.M. received the medications as prescribed (since the required medication administration record was not contained in A.M.'s chart), or that a chest X-ray was ever performed.

101. As confirmed by the State Medical Review Board findings, Armor did not perform an adequate admission exam on A.M. and did not provide him with critical medications.

102. In another example of inadequate care, decedent W.S. was incarcerated at NCCC on March 17, 2016 with a history of hypertension for which he was taking Amlodipine daily. His

medication administration record indicates that W.S. *did not receive any medication* until on or about March 20, 2016. The admitting nurse administered a test for tuberculosis. On March 20, 2016, the inmate was unresponsive to verbal stimuli; a blood pressure reading could not be obtained and his respirations were noted as shallow.

103. The Armor clinician called 911, but for reasons not explained in W.S.'s medical record, the inmate was not transferred to the hospital but was instead placed in the NCCC infirmary. A urinalysis screen and blood work performed on March 21, 2016 indicated that the inmate was diabetic, and he was placed on insulin on that day. W.G.'s EKG, performed on March 21, 2016, read as "abnormal." The medical record progress notes, dated March 22 and March 23, 2016, are illegible as is the signature of the clinician.

104. On March 23, 2016, W.S. was again found in an unresponsive state and transferred to Nassau University Medical Center where he died a day later on March 24, 2016. His death was attributed to cardio-pulmonary arrest.

105. Evidencing Armor's failure to provide inmates with required diagnostic services, *see infra,* there is no indication that a routine urinalysis screen was performed at the time W.S. was admitted to NCCC as required under the Service Contract. A urinalysis screen at the time of intake would have likely revealed that the inmate was diabetic and should have prompted a more thorough physical examination with diagnostic laboratory tests.

106. Because of Armor's failure to conduct an appropriate health assessment at the time of admission, W.S.'s diabetes could have been – but was not – uncovered until five days later, when he experienced an adverse medical event. Thus, Armor's failure to appropriately screen W.S. resulted in the delay of his treatment for diabetes.

107. Former inmates describe Armor's denials of necessary medication. For example, Armor failed to provide former inmate W.H. the medications he was regularly taking prior to his detention in January 2015 (even where he brought all of his prescription bottles). At about the eighth day following his admission to NCCC, Armor's medical director at NCCC, Dr. Morcos, told him that he had been prescribed too many medications by his community providers and would not be getting the same medications while at NCCC.

108. W.H. also reported an incident in March 2015 when he fell after showering and lost consciousness. He sustained a cracked tooth, cuts on his head and forearm and complained of headache, ear pain and sensitivity to light. The Armor physician refused to send him to the hospital. He was instead placed in the infirmary for observation overnight where he threw up three times. The following day he was sent to NUMC where he was diagnosed with having a concussion caused by syncope.[8] NUMC prescribed vitamin D, folic acid, thiamine, a multivitamin, Tylenol, Effexor XR and Zocor for W.H. However, Dr. Morcos told W.H. that he would only receive the multivitamin, telling him "just because it is written on the hospital discharge doesn't mean that you will get it."

109. County of Nassau Criminal Court, Honorable Jerald S. Carter, has made findings on the record that Armor does not provide necessary medications to inmates. In one case, he attached to the defendant's commitment order her medical condition and the list of her

[8] Syncope "is defined as a short loss of consciousness and muscle strength, characterized by a fast onset, short duration and spontaneous recovery. It is due to a decrease in blood flow to the entire brain usually from low blood pressure." https://en.wikipedia.org/wiki/Syncope_%28medicine%29

prescriptions and requested that the prosecutor and defense counsel monitor defendant's medical care at NCCC.

110. In another matter before Judge Carter, the Judge called for an Article 78 with an Order to Show Cause as necessary to determine the reason for Armor's decision to withhold anti-psychotic medication from a twenty-one year old inmate who had been taking since the age of eight. For over a year, Armor had withheld the medication from the inmate.

B. Inmate Access to Diagnostic Services

111. Also pursuant to the Contract, Armor is required to perform X-ray, laboratory, ultrasound, peak flow respiratory and EKG services on-site as needed. Critical findings are to be reported to clinicians within three hours and non-critical results are to be reported to clinicians within five days and documented in inmate's medical record.

112. The Contract requires that Armor provide lab services and radiology services on-site whenever possible and "provide as many of these diagnostic and treatment services on-site as possible."

113. Armor's own self-audits of its provision of laboratory and X-ray services, completed only six times over a five-year period, demonstrate that Armor did not provide these diagnostic services in an effective and timely manner: Armor failed four of the six self-audits (67%).

114. And while Armor was contractually required to create corrective action plans for each self-audit failure, Armor failed to do so for three out of four self-audit failures.

115. In September 2015, Armor devised one corrective action plan ("CAP") to address its failures in performing diagnostic services. However, there is no indication that the plan was implemented or its effectiveness evaluated.

116. Notwithstanding its failure to create corrective action plans for the six self-audits (or for its failure to implement its sole 2015 corrective action), Armor did not reduce its fees as required by the Contract.

117. One of Armor's self-audits of diagnostic services showed that in 67% of the sampled cases, Armor failed to document in the medical record the time and date that a laboratory test or X-ray was obtained. This information is necessary to ensure that lab results are timely retrieved and reviewed, and next steps are taken.

118. Even where documentation evidences the lab tests were performed, Armor has failed to *collect* laboratory specimens within 72 hours of being ordered by a clinician. The failure to collect a specimen within the proper timeframe may result in the delay of necessary care.

119. Similarly, audit records show that Armor has failed to consistently ensure that the laboratory and/or X-ray services performed matches those ordered by the clinician.

120. And in some instances, the test ordered by an Armor clinician was never performed. For example, the medical record of decedent A.M., an inmate who presented with a history of a respiratory ailment (*see supra* at ¶ ¶99-100), shows that Armor's clinician ordered an X-ray but the X-ray was never performed. The State Medical Review Board noted A.M.'s symptomatic underlying respiratory condition in citing Armor's failure to perform a "crucial diagnostic exam [X-ray]."

Armor Failed to Provide Mental Health Services
Consistent With Its Contractual Obligations and Representations

121. Armor failed to provide mental health services as required under the Contract by failing to monitor quality through a continuous quality improvement ("CQI") process, including consistent auditing and corrective action plans ("CAPs") where required, by failing to develop and implement treatment plans for inmates with mental illness, and by failing to staff its mental health section adequately.

122. There is no record Armor ever performed a semi-annual review to assess its provision of mental health services, and over the five-year course of its Contract, Armor conducted only four mental health audits and conducted no mental health audits in 2013 and 2015.

123. Two of the four audits document Armor's failure to complete mental health treatment plans for inmates receiving mental health services.

124. The Contract, through its incorporation of Nassau County's settlement with the U.S. Department of Justice, specifically requires the development and implementation of treatment plans for inmates with special needs, including inmates with mental illness.

125. Armor is also required, for inmates on continuous supervision related to their mental health, to have "contemporaneous treatment plan(s) reflecting the patients' continuous supervision status, the intervention(s) and the reason for placement on and/or continuation/discontinuation of continuous supervision."

126. In its bid for the NCCC contract (incorporated into the Contract), Armor repeatedly represented that it would provide treatment planning to guide mental health treatment and care. For example, the bid states: "Armor develops an initial Treatment Plan during the mental health evaluation. The plan will follow Armor's guidelines and will be reviewed regularly by a multi-disciplinary team." Further, one of the "key components" of its mental health/behavioral service program is "Multidisciplinary Treatment Plans."

127. Importantly, mental health treatment plans typically detail inmates' problems, therapeutic interventions, including timing of such interventions and persons who will be responsible for carrying out such interventions.

128. Notably, Armor's own clinicians have noted on Sick Logs Armor's failure to appropriately refer inmates for mental health evaluations.

129. Importantly, the medical records of two NCCC decedents who were both under Armor's care, B.R. and K.B., evidence that Armor's mental health assessments and planning were inadequate. The inadequacies were confirmed by the State Medical Review Board, which found that in each of these cases, Armor provided substandard mental health care.

130. Both B.R. and K.B. presented at NCCC with histories of mental illness, and one, K.B., exhibited clear signs of mental instability.

131. Despite psychiatric initial assessment where clinicians observed a clear need for psychiatric care, in neither case were psychiatric follow-ups planned.

132. B.R. was an Iraq war veteran with a history of post-traumatic stress disorder, bi-polar disorder and opioid abuse. K.B. presented with a history of traumatic brain syndrome and was observed to be actively hallucinating at the time of his admission to NCCC. However,

Armor's psychiatrist overlooked or otherwise neglected to document the presenting mental health histories of B.R. and K.B.

133. In B.R.'s case, a licensed practical nurse conducted an initial screen and noted B.R.'s flat affect, and Armor placed B.R. accordingly in mental health housing to be seen urgently by a psychiatrist. B.R.'s health assessment was conducted by a registered nurse who also noted that a referral for behavioral health was indicated. On February 24, 2012, the day following his incarceration at NCCC, B.R. was seen by a psychiatrist whose sparsely written documentation did not mention B.R.'s substantial mental health history, noting only B.R's history of opioid use. The psychiatrist discontinued B.R.'s mental health housing and specifically assessed that he had no need for mental health treatment. The psychiatrist referred B.R. to behavioral health for opiate withdrawal. Within hours of being seen by the psychiatrist and removed from mental health housing, B.R. committed suicide – by hanging – in his cell.

134. The State Medical Review Board determined that patient's psychiatric examination was inadequate in light of B.R.'s history of PTSD, Bipolar Disorder and Anxiety Disorder.

135. K.B. was seen by Armor's psychiatrist on the date K.B. was incarcerated, and the psychiatrist ordered K.B. to be removed from constant supervision, noting that K.B. was to be followed by a mental health counselor in accordance with the "post constant supervision" protocol.

136. The psychiatric note evidencing the examination contained no details regarding K.B.'s significant psychiatric history. Instead, the note was limited to the assessment of K.B.'s immediate presentation at time of evaluation.

137. On January 27, 2014, a corrections officer ("CO") noted that K.B.'s behavior had deteriorated and that he was confrontational. The CO noted that he referred K.B. to the mental health unit in lieu of instituting disciplinary action. A plan for mental health counseling was requested the next day, February 3, 2014. K.B. was then seen by a psychiatrist who drafted a sparse and illegible note ordering that K.B. be kept on constant supervision. The psychiatrist noted that psychiatric medications, however, were not indicated at that time.

138. The Armor records show that K.B. had other medical needs: K.B. reported at intake that he had a history of hypertension. However, K.B.'s medical record does not reflect that he was referred to the chronic care clinic for follow-up of his hypertension. K.B. was found dead in his cell on February 10, 2014. According to the State Medical Review Board, the cause of death was cardiac failure due to hypertensive cardiovascular disease.

139. As set forth above, the State Medical Review Board found that in each of these cases, Armor provided inadequate psychiatric care.

140. Finally, Armor failed to fill contractually required clinical staff positions in the mental health section (*see infra* at ¶¶ 176-77 showing that *inter alia*, the Mental Health Clinical Coordinator position was vacant for approximately 19 months and the Mental Health Psychiatric Advanced RNP/PA position was vacant for over a year, then understaffed from 2014 through 2015). Inadequate staffing leads to a decrease in services overall as well as the quality of those services.

Armor Failed to Refer Inmates to Specialist
Care Consistent With Its Contractual Obligations and Representations

141. The Contract requires that Armor provide certain specialty services on-site (orthopedic, physical therapy, optometry, dialysis and infectious disease), and for those inmates whose medical needs are not able to be addressed by Armor's on-site resources, that Armor will refer inmates for off-site specialist consultation and care.

142. When requests from inmates to Armor for off-site specialty care are "deferred," the requesting provider must "then outline[] an alternative plan of care or submit[] further information," and the inmate will be reevaluated within thirty days.

143. As reflected in the medical records of medically compromised inmates who have died at NCCC, testimony of a former inmate and Armor's own CQI audit reports, Armor failed to properly refer and follow-up on inmates for whom off-site specialist care was medically indicated by Armor's own clinicians at NCCC.

144. Armor's CQI audits reflect that requests for specialty consultation services were subject to its own "utilization review" at Armor's Florida headquarters and even when Armor's own clinicians' referrals to specialists were supported with documentation, Armor frequently simply failed to render a utilization decision to deny or approve the specialty referral request. Armor's inaction effectively resulted in the inmate not seeing a specialist, where even the Armor clinician has recommended it.

145. Moreover, when such referrals were deferred, Armor did not reliably plan and implement an alternate plan for follow-up care.

146. In the case of decedent J.G., *see supra* ¶ 83, the Armor clinician referred the inmate to rheumatology for his intermittent swellings (including throat swelling), but Armor never arranged for the rheumatology consultation to the detriment of J.G. The State Medical Review Board determined that had J.G. been seen by the rheumatologist and received a correct diagnosis and medical treatment, his death may have been prevented.

147. Decedent S.L., who was detained at NCCC on October 3, 2015 until his death on March 7, 2016, filed frequent sick call requests throughout his incarceration relating to pain in association with his non-reducible inguinal hernia. In October 2015, Armor's Medical Director denied Armor's health care provider's request that an inmate be sent off-site for a surgical evaluation because the hernia was non-reducible. Whenever he presented with a complaint about his hernia, the Armor clinician noted that the surgical consult was deferred. The inmate was found unresponsive in his cell on March 7, 2016.

148. But even when specialty referral requests were approved, Armor did not always schedule such off-site specialty services within 30 days of the approval as required under the Contract, delaying needed care and jeopardizing health of inmates.

149. And where an inmate was successfully referred to a specialist, in many instances, Armor failed to (i) review the off-site specialists' recommendations and (ii) establish a plan of patient care based on the specialists' directives.

150. Armor's CQI audits reflect a consistent pattern of inappropriate and failed practices relating to off-site specialty referrals. Such failures are noted in Armor's CQI audits from September 2011 through September 2015.

151. Notwithstanding these deficiencies, Armor developed only one corrective action plan, in December 2015, not in response to a self-audit, but upon finding that an inmate's referral to an off-site specialist was delayed because there was no follow-up on the utilization manager's request for supporting documentation. Armor determined that there was no process in place to handle consult requests that were incomplete or pending information.

153. In this case, a patient with a complex fracture of the jaw saw an Armor health care provider who recommended that he be seen for follow-up in two days. However, the inmate was seen nine days later and only after he generated a sick call request. On re-examination by an Armor health care provider, an off-site consult for Oral and Maxillofacial Surgery evaluation was requested and approved. However, the appointment was never made for him to be seen by the off-site specialist.

154. Following this incident and its development of an appropriate CAP, Armor outlined a process to log and follow-up on requests for off-site specialists.

155. Moreover, from September 2011 through September 2015, Armor has only performed five self-audits and there is no evidence it performed a single semi-annual review concerning access to specialty care.

156. Consistent with the narratives of former inmates, Armor's self-audits reflect a consistent pattern of inappropriate and failed practices relating to off-site specialty referrals, demonstrating non-compliance with the contract: over the course of the contract, Armor has failed all five of its self-audits in this area. There is no documentation that CAPs were developed and implemented as required under the Contract.

157. The NCCC houses inmates who have chronic illnesses and other health issues that may require a specialist's assessment and care. In violation of its Contract, Armor has not adequately referred and followed through in referring inmates who require off-site specialty services to those medically necessary services.

Armor Failed to Create and Maintain Medical Records
Consistent With Its Contractual Obligations and Representations

158. Under the Contract, Armor is required to properly create and maintain comprehensive medical records for each inmate. Such medical records are to include current notes from all health care providers, including medication administration records and diagnostic reports.

159. The Contract also includes the requirement that Armor install an electronic record system that would reduce the probability of error, eliminate legibility issues, and have easily-accessible data, in addition to a host of other benefits. The cost for this service is included in the County's monthly payment: for the first year of the Contract, electronic health record implementation was to cost some $78,668, while for the second year, the cost to the County as part of the Contract was $81,056.

160. An electronic health record system was never implemented, but there has been no deduction for the related costs of the system.

161. Medical records should accurately document inmates' histories, medical assessments and progress relating to care in an organized and chronological manner to enable inmate's needs to be assessed accurately and treated effectively.

162. Poor record-keeping can result in adverse patient care whereby, for example, medications are duplicated or missed and signs or changes in patients' conditions are neglected.

163. In violation of its obligations under the Service Contract and to the detriment of inmates, Armor failed to maintain (i) complete and legible medical charts for all inmates, and (ii) accurate Sick Logs (*see supra* at ¶ 69).

164. Indeed, as noted *supra* at ¶ 77, many Sick Logs document that medical records were not available at the times patients were to be seen. The sample of sick logs from two months in 2016, found that over 100 sick call requests were simply not available at the times that inmates were to be seen, making continuity of care, or any care, much more difficult and potentially dangerous, given no written record of previous care.

165. Additionally, Sick Logs evidence other inadequacies; including failing to set forth the date on which patients were examined and illegible clinician signatures on the sick call forms.

166. Inmate charts similarly exemplify these shortcomings. For example, both the charts of W.S. and J.G. contain illegible entries and purported signatures (but no stamps) of health care providers such that subsequent treating clinicians would not be able to read the medical history nor know the clinician who had treated the inmate.

167. Relatedly, the position of medical records director was understaffed, and at times vacant, from July 2013 through mid-May 2015.

168. The State Medical Review Board has also noted Armor's disorganized, illegible and improperly signed medical records.

Armor's Failed To Maintain Medical Equipment
Consistent With Its Contractual Obligations and Representations

169. NCCHC standards require "at a minimum" certain equipment for the examination and treatment of patients, including an automated external defibrillator, and that such emergency equipment are available and checked regularly.

170. Notwithstanding the import of functioning equipment, Armor conducted only one equipment audit from 2011 through 2015 and there is no record that it ever performed any semi-annual reviews in this area.

171. In its sole self-audit of equipment, in September 2015, its self-audit revealed that Armor failed to check its AED defibrillator as recommended by the manufacturer and, significantly, failed to check the emergency crash cart every shift.

172. The minutes of Armor's CQI November 24, 2015 meeting reflect that Armor scored a passing grade of 94% on its Equipment self-audit while noting the failed AED and crash cart areas. It was also noted that the documentation of the checks was missing.

173. Despite these critical failings with respect to emergency equipment, Armor did not devise nor implement a corrective action plan.

Armor Failed To Staff NCCC Consistent
With Its Contractual Obligations and Representations

174. The contract sets forth jail staffing requirements, including specific positions that must be provided and the number of full-time equivalent ("FTE") employees that must be staffed in those positions.

175. Armor's staffing records for the period covering June 2011 to November 2015 show that Armor did not fulfill its staffing obligations under the contract, even for clinicians and the most senior management positions.

176. Armor left key positions vacant for significant periods of time, thereby failing to meet its contractual staffing obligations for the indicated months, including:

- Director of Nursing: The contract requires one FTE in this position, which is responsible for guiding and directing the nursing staff, including ensuring that relevant policies and procedures are current and properly followed, yet it was vacant from June 2012 through part of February 2013 (7.5 months);
- Mental Health Clinical Coordinator: The contract requires one FTE in this position, which is responsible for coordinating mental health services, yet it was vacant from April 2014 through November 2015 (19 months);
- Psychiatric Advanced Registered Nurse Practitioner/Physician Assistant ("ARNP/PA"): The contract requires .6 FTEs in this position, which is part of the mental health treatment team, yet it was vacant for over one year, from June 2013 through November 2014 (16 months);
- Utilization manager: The contract requires at least one FTE for this position, which is responsible for managing patients' access to off-site and on-site specialty care, yet it was vacant from June 2013 through November 2015 (2.5 years);
- Continuous Quality Improvement and Nurse Educator: The contract requires at least one FTE in this position, which has many responsibilities relating to nurse education and the

continuous quality improvement program, yet it was vacant from November 2014 through November 2015 (1 year).

177. Nassau County's estimated overpayment for these vacancies is $484,795. In addition to the above-listed vacancies, Armor also understaffed other important positions, providing fewer FTEs than contractually required, including:

- Masters-level Mental Health Professionals: Armor was contracted to provide 4.8 masters-level MHPs, but in the 2014-2015 contract year, it understaffed that position every month out of the year, staffing this position at 84.64% of the required FTEs for that year;
- Psychiatric ARNP/PAs: Armor was required to provide .6 psychiatric ARNP/PAs, and yet, in addition to leaving the position vacant for over a year, it then understaffed the position from November 2014 through November 2015, with an average percent staffed for the 2014-2015 contract year of 31.31% and an average of 50% for June 2015 through November 2015; and
- Medical Records Director: Armor was required to staff one FTE for the position of medical records director, yet this position was understaffed, and at times vacant, from July 2013 through mid-May 2015, with an average staffing percentages of just 32.43% and 39.11% for the 2013 – 2014 and 2014 – 2015 contract years, respectively.

178. Moreover, since the staffing levels are established to ensure adequate care for the persons housed in the jail, Armor's inadequacies demonstrate its lack of adherence to the Contract.

FIRST CAUSE OF ACTION
VIOLATIONS OF NY FALSE CLAIMS ACT §§ 189(1)(a) and (b)

179. Petitioner re-alleges and incorporates by reference all allegations in all preceding paragraphs.

180. NY False Claims Act § 189(1)(a) makes it unlawful to knowingly present a false or fraudulent claim for payment or approval.

181. NY False Claims Act § 189(1)(b) makes it unlawful to knowingly make, use, or cause to be made or used, a false record or statement material to a false or fraudulent claim.

182. Respondent's acts and practices, described above, violated NY False Claims Act § 189(1)(a).

183. Respondent's acts and practices, described above, violated NY False Claims Act § 189(1)(b).

SECOND CAUSE OF ACTION
EXECUTIVE LAW § 63-c: BREACH OF CONTRACT

184. Petitioner re-alleges and incorporates by reference all allegations in all preceding paragraphs.

185. By reason of the conduct alleged above, Respondent has breached its contractual obligations to Nassau County, including inadequate performance of numerous obligations under the contract and failing to provide discounts owed under the contract.

186. As a result of Respondent's breach of contract, Respondent without right obtained and received of money held and owed by Nassau County.

187. As a result of Respondent's breach of contract, the County suffered damages in excess of $1 million or an amount to be determined at trial.

188. Pursuant to New York Executive Law § 63-c(1), the State may maintain an action to recover the monies, funds, credits, and other property without right obtained, received, converted, and disposed of and damages or other compensation for so obtaining, receiving, converting, and disposing.

THIRD CAUSE OF ACTION
VIOLATIONS OF EXECUTIVE LAW § 63(12)
FRAUD AND ILLEGALITY

189. Petitioner re-alleges and incorporates by reference all allegations in all preceding paragraphs.

190. Pursuant to Executive Law § 63(12), it is illegal for a business to engage in repeated fraudulent business conduct.

191. By reason of the conduct alleged above, Respondent has engaged in repeated and persistent fraudulent conduct in violation of Executive Law § 63(12).

192. By its actions in violation of NY False Claims Act §§ 189(1)(a) and (b) Respondent has engaged in repeated and persistent illegal conduct in violation of Executive Law § 63(12).

PRAYER FOR RELIEF

WHEREFORE, Petitioner, the Attorney General of the State of New York, on behalf of the People of the State of New York, seeks the following relief against Armor, and requests an order and judgment pursuant to Executive Law § 63(12), NY False Claims Act §§ 189(1)(a) and (b), and Executive Law § 63-c:

(a) Declaring that Respondent's practices and conduct have violated State Finance Law § 189(1)(a)-(b) and Executive Law § 63(12), or, in the alternative, declaring that Respondent has converted, disposed of, obtained, and/or received public funds without right, pursuant to New York Executive Law § 63-c;

(b) Permanently enjoining Respondent from violating State Finance Law § 189(1)(a)-(b) and Executive Law § 63(12) and from engaging in the illegal and fraudulent acts and practices alleged in the Verified Petition;

(c) Appointing an independent monitor to oversee ongoing compliance with the contract;

(d) Permanently enjoining Respondent from bidding for future health services contracts in New York State;

(e) Directing Respondent, pursuant to the New York State False Claims Act, State Finance Law §§ 187 et seq., to pay an amount equal to three times the amount of damages sustained as a result of its violations of the New York False Claims Act;

(f) Directing Respondent, pursuant to State Finance Law §§ 187 et seq., to pay penalties of $12,000 for each violation of State Finance Law § 189, or at least $6,000 per violation;

(g) In the alternative to damages under the State Finance Law, awarding Petitioner the money, funds, damages, credits, or other property without right obtained, received, converted, or disposed of, and any damages or other compensation for so obtaining, receiving, paying, converting, or disposing of same in an amount to be determined;

(h) Awarding Petitioner reasonable attorneys' fees and costs, including additional

costs in the amount of $2,000 pursuant to CPLR § 8303(a)(6); and

(i) Granting such other and further relief as the Court deems just and proper.

Dated: New York, New York
July 11, 2016

Respectfully submitted,

ERIC T. SCHNEIDERMAN
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LISA LANDAU
Health Care Bureau Chief

By: Dorothea Caldwell-Brown
_____
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(212) 416-6305

ELIZABETH CHESLER
Assistant Attorney General

VERIFICATION

STATE OF NEW YORK)
COUNTY OF NEW YORK) ss.:

Dorothea Caldwell-Brown, being duly sworn, deposes and says: She is an Assistant Attorney General in the office of Eric T. Schneiderman, Attorney General of the State of New York, and is duly authorized to make this verification.

He has read the foregoing petition and knows the contents thereof, and the same is true to her own knowledge, except as to matters therein stated to be alleged on information and belief, and as to those matters she believes them to be true.

The reason this verification is not made by petitioner is that petitioner is a body politic. The Attorney General is its statutory representative.

Dorothea Caldwell-Brown

DOROTHEA CALDWELL-BROWN
Assistant Attorney General
of the State of New York

Sworn to before me this
11th day of July, 2016

Yueh-ru Chu

YUEH RU CHU
Notary Public, State of New York
No. 02CH4998793
Qualified in Kings County
Commission Expires ~~08/31/2000~~ 11/8/2019