IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
SOUTHERN DIVISION

ELIZABETH GILLESPIE,
507 Montgomery St.
Laurel, MD 20707, and

DAVID IRVINE
507 Montgomery St.
Laurel, MD 20707, and

ERIN WHITNEY
5019 Odessa Road
College Park, MD 20740, and

CARY BARBIN
327 Talbott Avenue
Laurel, MD 20707, and

KATHRYN ELIZABETH VADAKIN
14012 Vista Drive, Unit 16A
Laurel, Maryland 20707-5883, and

BRIAN LEFFLER
103 Bellevue Avenue East #409
Seattle, WA 89102, and

XIOMARA PORRAS
9035 - D North Laurel Rd.
Laurel, MD 20723, and

Plaintiffs,

and

THE UNITED STATES OF AMERICA,

Plaintiff-Intervenor,

v.

Civil File No.: DKC-05-CV-73

JURY TRIAL DEMANDED

DIMENSIONS HEALTH CORPORATION, d/b/a LAUREL REGIONAL HOSPITAL
7300 Van Dusen Road
Laurel, MD 20707,

Defendant.

COMPLAINT IN INTERVENTION FOR INJUNCTIVE RELIEF AND FOR COMPENSATORY DAMAGES AND CIVIL PENALTIES

Plaintiff-Intervenor, the United States of America ("United States"), alleges as follows:

1. This is a civil action brought to redress discrimination on the basis of disability in violation of title III of the Americans with Disabilities Act ("ADA"), 42 U.S.C. §§ 12181-12188, and the Department of Justice's implementing regulation, 28 C.F.R. Part 36. The United States alleges, inter alia, that Defendant Dimensions Health Corporation, d/b/a Laurel Regional Hospital, ("Defendant" or "Hospital") discriminated on the basis of disability against individuals who are deaf by repeatedly failing or refusing to provide appropriate auxiliary aids and services to ensure effective communication with them, thus denying them opportunities to participate in or benefit from the Hospital's services or facilities that are equal to those afforded to others without disabilities.

2. The Attorney General has instituted this action because it involves a pattern or practice of discrimination under title III of the ADA, 42 U.S.C. § 12188(b)(1)(B)(i), and it raises issues of general public importance, 42 U.S.C. § 12188(b)(1)(B)(ii).

JURISDICTION AND VENUE

3. This court has jurisdiction over this action under 42 U.S.C. § 12188(b)(1)(B) and (b)(2); and 28 U.S.C. §§ 1331 and 1345. The Court may grant declaratory and other relief

pursuant to 28 U.S.C. §§ 2201 and 2202.

4. Venue lies in this District pursuant to 28 U.S.C. § 1391 as the claims arose in, and the defendant does business in, the District of Maryland.

THE PARTIES

5. Plaintiff-Intervenor is the United States of America.

6. Defendant Dimensions Health Corporation, d/b/a Laurel Regional Hospital is a private entity that owns and operates a general acute care hospital. The defendant is, therefore, a public accommodation within the meaning of title III of the ADA, 42 U.S.C. § 12181(7)(F). Dimensions Health Corporation is located at 3001 Hospital Drive, Suite 4000, Cheverly, MD 20785. Laurel Regional Hospital is located at 7300 Van Dusen Road, Laurel, MD 20702.

FACTS

The United States alleges the following upon information and belief:

7. Elizabeth Gillespie, David Irvine, Erin Whitney, Cary Barbin, Kathryn Elizabeth Vadakin, Brian Leffler, Xiomara Porras and Janette Pokorski[1] (collectively "Victims") are deaf and use sign language for communication.

8. For effective communication with the victims in an emergency department setting or during a hospitalization, the provision of appropriate auxiliary aids or services is necessary.

Ms. Gillespie and Mr. Irvine

9. On November 1, 2003, Ms. Gillespie, accompanied by her husband, Mr. Irvine, went to the emergency department at the Hospital. She was experiencing severe abdominal pain,

[1]Ms. Pokorski is not one of the named plaintiffs in Gillespie v. Dimensions Health Corp., d/b/a Laurel Regional Hospital, Case. No. DKC-05-CV-73 (D. Md.). Paper 20.

nausea, and vomiting.

10. Ms. Gillespie and Mr. Irvine informed emergency department personnel that they were deaf and requested sign language interpreters.

11. Hospital personnel told Ms. Gillespie and Mr. Irvine that the Hospital did not have interpreters.

12. Ms. Gillespie and Mr. Irvine repeatedly asked for a sign language interpreter.

13. Hospital personnel attempted to communicate orally with Ms. Gillespie. Hospital personnel also often refused to communicate in writing with Ms. Gillespie, despite the fact that she repeatedly asked the personnel to transcribe their oral communications.

14. Approximately two hours after Ms. Gillespie's arrival at the Hospital, Hospital personnel told Ms. Gillespie and Mr. Irvine that the Hospital had a videophone to provide video interpreting services.[2]

15. Hospital personnel told Ms. Gillespie and Mr. Irvine that they would have to wait to use the videophone because the room housing the videophone was occupied by another patient. After waiting an additional period of time, Hospital personnel transferred Ms. Gillespie to the room with the videophone.

16. Initially, Hospital personnel did not know how to set up or use the videophone. Ms. Gillespie had to wait approximately 20 minutes before Hospital personnel connected the

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[2]A videophone connected to a television monitor allows people in separate locations to have live face-to-face communications. The videophone includes a camera and transmits images via a high-speed Internet connection. When the videophone is connected to a remotely located interpreter ("video interpreter"), the TV shows a split screen of two live images: the interpreter on one side and a patient on the other side. The patient and the video interpreter see and sign to each other while the attending physician or other personnel communicate by voice.

videophone to a video interpreter. Ms. Gillespie and Mr. Irvine communicated with a physician and staff through video interpreting services for approximately 10-15 minutes. The physician and staff said that they needed to take X-rays and run certain tests because they were concerned about Ms. Gillespie's enlarged heart. Hospital personnel then terminated the use of the video interpreting service.

17. After that time, Hospital personnel did not provide Ms. Gillespie and Mr. Irvine with video interpreting services again.

18. At a later point, in preparation for a CT scan, a Hospital staff member attempted to communicate with Ms. Gillespie by rudimentary gestures. Twice Ms. Gillespie gestured for him to write his instructions, but he refused.

19. Hospital personnel did not provide an interpreter or any other form of communication before or during the CT scan.

20. After another lengthy wait, a different doctor appeared and orally stated to Ms. Gillespie and Mr. Irvine that she should be admitted to the Hospital for additional tests to determine the source of her pain. After Mr. Irvine requested that the doctor use paper and pen to communicate with them, the doctor provided them with sparse written notes.

21. Ms. Gillespie and Mr. Irvine were confused about what the doctor said both orally and in writing. Ms. Gillespie informed the doctor through Mr. Irvine that she wanted to leave the Hospital. In response, the doctor turned and began to leave the room.

22. Mr. Irvine then asked about the earlier doctor's reference to his wife's heart being enlarged.

23. The doctor told Mr. Irvine that Ms. Gillespie might want to return to a hospital for

treatment in two to three days.

24. Mr. Irvine was confused and reluctant to have Ms. Gillespie discharged because of his concerns about her health. However, Ms. Gillespie was so frustrated with the Hospital and her inability to communicate with the Hospital or understand what was happening that she and Mr. Irvine left the Hospital.

25. The next day, Ms. Gillespie was rushed to another hospital, admitted for several days, and treated for congestive heart failure.

26. During Ms. Gillespie's November 1, 2003, hospital visit, the Hospital did not provide effective communication with Ms. Gillespie and Mr. Irvine.

27. Ms. Gillespie suffered physical and emotional injuries resulting from the Hospital's conduct.

28. Mr. Irvine suffered emotional injuries resulting from the Hospital's conduct.

Ms. Whitney

29. On December 24, 2003, Ms. Whitney sought emergency medical treatment at the Hospital for a dog bite.

30. Ms. Whitney and a deaf companion who accompanied her asked Hospital personnel for sign language interpreting services.

31. Hospital personnel attempted to use its videophone. After Hospital personnel could not set up the videophone, Ms. Whitney's deaf companion intervened, set up the videophone, and connected it to a video interpreter. The picture was blurry and Ms. Whitney could not clearly distinguish the arms and hands of the video interpreter and so did not understand the interpreter.

32. The Hospital provided no other auxiliary aids to Ms. Whitney on December 24, 2003.

33. During Ms. Whitney's December 24, 2003, hospital visit, the Hospital did not provide effective communication with her.

34. Ms. Whitney suffered emotional injuries resulting from the Hospital's conduct during her December 24, 2003, hospital visit.

35. On April 25, 2004, Ms. Whitney sought emergency medical treatment at the Hospital when she experienced a high fever and vomiting.

36. Ms. Whitney was accompanied to the Hospital by another deaf companion. Ms. Whitney and this companion repeatedly requested on-site sign language interpreters.

37. Ms. Whitney was so ill she lay down on a nearby bed in the emergency department. Unable to communicate effectively that they did not want her on the bed, Hospital personnel treated her roughly, dragging her off the bed and forcing her to lie on the floor of the emergency department.

38. Ms. Whitney was required to wait quite some time before the room with the videophone was made available to her. After Ms. Whitney was transferred to the room, she waited approximately an additional 30-40 minutes while Hospital personnel struggled to set up the videophone.

39. Due to her illness, Ms. Whitney was unable to sit up.

40. Hospital personnel connected the videophone to a video interpreter but did not adjust the videophone for a prone patient. Ms. Whitney, who was in a prone position, was unable to see clearly the screen displaying the video interpreter, and the interpreter could not see

her.

41. Without asking either Ms. Whitney or her deaf companion whether Ms. Whitney's companion could be used as a relay interpreter, Hospital personnel used the companion to relay communication between Ms. Whitney and the video interpreter.

42. After receiving an anti-nausea medication and sleeping overnight, Ms. Whitney was discharged in the morning of April 26, 2004.

43. Hospital personnel did not provide nor request an on-site interpreter during Ms. Whitney's April 25-26, 2004, visit.

44. During Ms. Whitney's April 25-26, 2004, hospital visit, the Hospital did not provide effective communication with her.

45. Ms. Whitney suffered physical and emotional injuries resulting from the Hospital's conduct during her April 25-26, 2004, hospital visit.

46. On April 26, 2004, the day of Ms. Whitney's discharge, Ms. Whitney's symptoms worsened and she returned to the Hospital. She requested on-site sign language interpreters. Instead, Hospital personnel chose alternatives such as video interpreting services, lipreading, and handwritten notes. These alternatives did not ensure effective communication with Ms. Whitney.

47. After Hospital personnel examined Ms. Whitney, they told her they suspected meningitis and ordered a spinal tap.

48. Ms. Whitney underwent a spinal tap. Neither prior to, nor during, Ms. Whitney's spinal tap, did the Hospital provide her with any on-site interpreter, despite her repeated requests for one.

49. Neither the physician nor any other Hospital personnel ensured effective

communication with Ms. Whitney regarding what the spinal tap entailed, nor did they effectively communicate any post-procedure instructions. Because she was not aware that she should remain immobile for a period of time following the procedure in order for her fluid pressure to equilibrate, Ms. Whitney did move and so experienced, and continues to suffer from, headaches, nausea, faintness, and an imbalance in equilibrium.

50. Ms. Whitney tested positive for meningitis and was admitted to the Hospital as an inpatient in the early morning of April 27, 2004, and was discharged in the evening of April 29, 2004.

51. On April 27, 2004, Ms. Whitney repeatedly requested a sign language interpreter for communications with the treating doctor and other Hospital personnel regarding her condition and treatment.

52. In the morning of April 27, 2004, the Hospital attempted to use video interpreting services in Ms. Whitney's room, but the video interpreting service vendor was unable to provide an interpreter during that time.

53. During the daytime hours of April 27, 2004, the Hospital provided medical services to Ms. Whitney, but did not provide effective communication.

54. The Hospital obtained on-site interpreting services for Ms. Whitney for fewer than three hours in the evening of April 27, 2004, and for approximately ten hours on April 28, 2004.

55. Beginning in the evening of April 27, 2004, Ms. Whitney's hearing mother stayed with Ms. Whitney sporadically throughout the remainder of Ms. Whitney's hospitalization.

56. On April 29, 2004, the Hospital did not secure interpreting services.

57. On April 29, 2004, without asking Ms. Whitney if her mother was an interpreter

or if the Hospital could use her mother to facilitate communication between the Hospital and Ms. Whitney, Hospital personnel relied on Ms. Whitney's mother to provide communication between Ms. Whitney and the Hospital.

58. Ms. Whitney's mother was not fluent in sign language and interpreting. Ms. Whitney's mother was unable to interpret effectively, accurately, and impartially both receptively and expressively, nor could she interpret any specialized medical vocabulary.

59. On April 29, 2004, when Ms. Whitney was being discharged, the Hospital provided discharge instructions to Ms. Whitney's mother instead of providing them to Ms. Whitney directly, and requested that her mother sign the discharge papers.

60. At no time on April 26-28, 2004, did the Hospital, despite Ms. Whitney's requests, provide Ms. Whitney with a working telecommunication device for deaf persons ("TTY")[3], so she was unable to use a telephone.

61. During most of Ms. Whitney's April 26, 2004, emergency department visit, and April 27-29, 2004, hospitalization, the Hospital did not provide effective communication with her.

62. Ms. Whitney suffered physical and emotional injuries resulting from the Hospital's conduct during her April 26, 2004, emergency department visit, and April 27-29, 2004, hospitalization.

Mr. Barbin

63. On March 19, 2004, Mr. Barbin sought medical treatment at the Hospital after

[3]A TTY is a special device that lets people who are deaf, hard of hearing, or speech-impaired use the telephone to communicate, by allowing them to type messages back and forth to one another instead of talking and listening.

being bitten on the face by a dog. He was accompanied by a companion who is hearing. Both men asked for sign language interpreting services several times.

64. Hospital personnel did not provide Mr. Barbin with either on-site or video interpreting services.

65. Without asking Mr. Barbin or his companion if his companion could be used as his interpreter, the Hospital used Mr. Barbin's companion as a communication facilitator between Mr. Barbin and the Hospital.

66. Mr. Barbin's companion was not fluent in sign language and interpreting. The companion was unable to interpret effectively, accurately, and impartially both receptively and expressively, using any specialized medical vocabulary. In addition, the companion could not understand some of the medical terms used by Hospital personnel and would have to stop signing to ask what certain medical terms or phrases meant.

67. Mr. Barbin's companion repeatedly asked that the Hospital provide an interpreter for Mr. Barbin, but his requests were ignored. When, on Mr. Barbin's behalf, his companion again asked Hospital personnel for a sign language interpreter, Hospital personnel said, "We don't have interpreters."

68. When Mr. Barbin and his companion requested that the triage nurse obtain an interpreter, the nurse said that the Hospital did not have an interpreter. Despite repeated protests, Hospital personnel used Mr. Barbin's companion as a communication facilitator between Mr. Barbin and the personnel. The companion could not simultaneously interpret, but rather consecutively relayed to Mr. Barbin and Hospital personnel what was said or signed by the various personnel. Mr. Barbin's communication with the Hospital was compromised because of

the companion's limited signing skills, expressive and receptive, compounded by his being very nauseated by the sight of Mr. Barbin's blood.

69. Mr. Barbin was frustrated both by his companion's limited ability as an interpreter and because Mr. Barbin had to bring his own language level down so that his companion could convey Mr. Barbin's communication in simple terms more suited to the companion's limited interpreting skills. The companion did not understand some of the medical terms and phrases being used and often would have to stop interpreting to ask Hospital personnel what a phrase or term meant.

70. During Mr. Barbin's emergency department visit, the Hospital had a video interpreting service available but the Hospital did not offer to use it.

71. During Mr. Barbin's hospital visit, the Hospital did not provide effective communication with him.

72. Mr. Barbin suffered emotional injuries resulting from the Hospital's conduct during his March 19, 2004, emergency department visit.

Ms. Vadakin

73. On August 5, 2002, Ms. Vadakin drove herself to the Hospital's emergency department during the night. She was in a severe state of depression, and was feeling tired and ill. She had not slept well for days.

74. Upon her arrival, Ms. Vadakin asked for an interpreter. The Hospital chose to use video interpreting services.

75. Ms. Vadakin was then called into an emergency treatment room but the room did not have a videophone. She asked the treating doctor about the videophone, but the doctor

ignored her request. Instead, the doctor used lipreading and handwritten notes to communicate with Ms. Vadakin. The doctor often asked Ms. Vadakin to repeat what the doctor had said in order to ensure that she understood him. Ms. Vadakin was in poor condition, physically and mentally, which made it difficult for her to concentrate and attempt to understand, or to guess, what the doctor was saying.

76. Ms. Vadakin was still frustrated by her experience with the Hospital and she decided to leave the Hospital on the morning of August 6, 2002. She went home without either a prescription or a diagnosis.

77. Ms. Vadakin was not provided with either on-site or video interpreting services during her hospital visit of August 5-6, 2002.

78. During Ms. Vadakin's August 5-6, 2002, emergency department visit, the Hospital did not provide effective communication with her.

79. Ms. Vadakin suffered emotional injuries resulting from the Hospital's conduct during her August 5-6, 2002, emergency department visit.

80. On April 26, 2003, Ms. Vadakin drove to the Hospital because she needed medication for her depression and anxiety. She had been unable to sleep for several days.

81. Upon her arrival at the Hospital on April 26, 2003, Ms. Vadakin asked for an interpreter.

82. The Hospital elected to use video interpreting services.

83. Hospital personnel were unable to operate the videophone. Observing the difficulty the personnel faced with the videophone, Ms. Vadakin requested that the Hospital provide her with an on-site interpreting service. The Hospital denied her request. The attending

doctor used written notes to communicate with Ms. Vadakin but because of her medical condition and fatigue, as well as the difficult-to-read handwriting of the doctor, she was unable to understand fully the communication.

84. During Ms. Vadakin's April 26, 2003, emergency department visit, the Hospital did not provide effective communication with her.

85. Ms. Vadakin suffered emotional injuries resulting from the Hospital's conduct during her April 26, 2003, emergency department visit.

86. On August 12, 2004, Ms. Vadakin was transported by ambulance to the Hospital. She had asked the ambulance crew to take her to a different hospital because of her negative experiences with the Hospital but the crew insisted that she be taken to the Hospital.

87. Upon her arrival in the emergency department at the Hospital on August 12, 2004, Ms. Vadakin asked for an on-site interpreter.

88. The Hospital insisted on using video interpreting services.

89. Hospital personnel were unable to operate the videophone, though the personnel did attempt for approximately two hours to operate the videophone.

90. Observing the difficulty the Hospital personnel faced with the videophone, Ms. Vadakin then reiterated her request for an on-site interpreter. The Hospital denied her request.

91. After failing to operate the videophone, Hospital personnel used paper and pen to communicate with Ms. Vadakin, but the communication was limited to only basic and sparse information.

92. Ms. Vadakin became so frustrated with the ineffective communication, especially

given her medical condition, and the Hospital's failure to obtain an interpreter, that she informed the Hospital she was fine simply so that she could be discharged.

93. During Ms. Vadakin's August 12, 2004, emergency department visit, the Hospital did not provide effective communication with her.

94. Ms. Vadakin suffered emotional injuries resulting from the Hospital's conduct during her August 12, 2004, emergency department visit.

Mr. Leffler

95. On October 27, 2003, Mr. Leffler sought emergency medical treatment at the Hospital for his sore throat. He was accompanied by his two companions, one hearing, and one deaf. Both Mr. Leffler and his hearing companion asked Hospital personnel for an interpreter.

96. Hospital personnel said that they were not sure if the Hospital had an interpreter. Instead, the personnel offered the use of the videophone.

97. Despite Mr. Leffler's and the hearing companion's protests claiming that the hearing companion was not qualified as an interpreter, Hospital personnel used the hearing companion to interpret consecutively between the personnel and Mr. Leffler during triage.

98. After triage, because Mr. Leffler understood that the Hospital would be providing him with video interpreting services, he told his two companions to leave the Hospital. Mr. Leffler's companions left the Hospital at that time.

99. After Mr. Leffler had been sitting in the waiting room for approximately 30 minutes, Hospital personnel advised him that the videophone was not available and asked him if he was able to read lips. Mr. Leffler told the personnel that he did not read lips well and that writing would be better. Hospital personnel nevertheless insisted on trying to communicate with

Mr. Leffler through lipreading.

100. Hospital personnel wrote on the triage form that Mr. Leffler "needs interpreter"; however, the personnel made no attempt to secure interpreting services for Mr. Leffler.

101. When the attending doctor arrived to examine Mr. Leffler, the doctor first asked Mr. Leffler if he could read lips. Mr. Leffler indicated that his lipreading skills were "not great" and he wrote a note to the doctor requesting an interpreter. The doctor ignored this request.

102. The doctor examined Mr. Leffler without an interpreter. The doctor tried to communicate with Mr. Leffler though written notes, but this method of communication was ineffective.

103. The doctor became frustrated and impatient having to communicate with Mr. Leffler in this fashion, and rushed through his examination.

104. When Mr. Leffler tried to ask the doctor questions, the doctor cut him short. Instead, the doctor simply wrote him a prescription and abruptly ended the examination.

105. Because the communication provided to Mr. Leffler by the Hospital was so ineffective, he left the Hospital unsure of his diagnosis and whether he had strep throat, which generally requires follow-up care, or simply a sore throat.

106. During Mr. Leffler's October 27, 2003, emergency department visit, the Hospital did not provide effective communication with him.

107. Mr. Leffler suffered emotional injuries resulting from the Hospital's conduct during his October 27, 2003, emergency department visit.

Ms. Porras

108. On May 5, 2003, Ms. Porras' adult hearing son was taken to the emergency department at the Hospital because of recurrent seizures. During Ms. Porras' visit to the emergency department, her son was in and out of consciousness and, at times, unable to respond to Hospital personnel.

109. Upon arriving at the Hospital, Ms. Porras, through her hearing daughter, requested an interpreter in order to communicate with Hospital personnel regarding Ms. Porras's son's condition and care. Hospital personnel denied this request, and explained that sign language interpreting services were available only for deaf patients and that since Ms. Porras was not a patient, the personnel would not provide Ms. Porras with an interpreter. Ms. Porras's daughter, who is a certified sign language interpreter, volunteered to provide interpreting services to facilitate communication between Ms. Porras and Hospital personnel. The personnel refused the daughter's offer for interpreting services.

110. Ms. Porras' daughter again asked Hospital personnel to allow her to accompany Ms. Porras into her son's room in order to provide interpreting services for Ms. Porras and Hospital personnel. Hospital personnel, apparently enforcing a one-person-at-a-time visitation policy, refused this request.

111. Ms. Porras' daughter informed Hospital personnel that Ms. Porras would not be able to understand written communication because her English skills were so basic.

112. Ms. Porras' daughter asked the Hospital to utilize video interpreting services, but the Hospital refused this request.

113. Ms. Porras entered her son's room alone, but she was completely unable to

communicate with Hospital personnel.

114. Ms. Porras was frustrated and angry that Hospital personnel did not communicate with her.

115. Because the Hospital did not provide any auxiliary aids or services for effective communication with Ms. Porras, Ms. Porras was excluded from any discussions regarding her son's medical history, medical tests, diagnosis and follow-up care.

116. At the time of Ms. Porras' son's discharge, the Hospital chose Ms. Porras' daughter, who was not allowed in the room with her brother most of the time, instead of Ms. Porras, to sign the son's discharge papers.

117. Ms. Porras left the Hospital confused about what tests and procedures had been administered to her son, as well as his diagnosis and requisite follow-up care. Ms. Porras was very concerned that her son was being discharged, given his poor condition.

118. Ms. Porras' son subsequently was hospitalized at a different hospital for approximately one week with brain abscesses.

119. During Ms. Porras' May 5, 2003, emergency department visit, the Hospital did not provide effective communications with her.

120. Ms. Porras suffered emotional injuries resulting from the Hospital's conduct during her May 5, 2003, emergency department visit.

Ms. Pokorski

121. In preparation for inpatient surgery on March 2, 2004, Ms. Pokorski called the Hospital during the second week of February 2004, using an interpreter in her office, to arrange for interpreting services for her surgery and subsequent recovery in the Hospital. Ms. Pokorski asked the Hospital if the Hospital would cover the costs of Ms. Pokorski's own interpreter.

122. The Hospital refused to cover the costs of Ms. Pokorski's own interpreter and stated that it had its own contract interpreting service. The Hospital gave Ms. Pokorski the wrong name of the contracting service; Ms. Pokorski was not familiar with any service by that name, nor the reputation of its interpreters. When Ms. Pokorski asked for additional information about the contractor and its interpreting service, the Hospital refused to provide her with that information. The Hospital also offered to use video interpreting services, but Ms. Pokorski had heard negative things about these services and, not understanding how to use them, declined. The Hospital informed Ms. Pokorski that she should contact the Hospital if she wanted it to provide an interpreter from its contracting service.

123. After that date and prior to the day of her surgery on March 2, 2004, Ms. Pokorski did not again request that she be provided with an interpreter by the Hospital because she thought it would be futile to make such a request, nor did the Hospital raise it with her.

124. On March 2-4, 2004, Ms. Pokorski was operated on and recuperated in the Hospital without the provision of any interpreting services or other auxiliary aids and services by the Hospital.

125. At no time while she was in the Hospital did any Hospital personnel or physicians ask her whether she wanted or needed an interpreter.

126. Without asking Ms. Pokorski if her mother was an interpreter, or whether she could serve as an interpreter, the Hospital used Ms. Pokorski's mother as a communication facilitator between the Hospital and Ms. Pokorski.

127. Ms. Pokorski's mother is hearing and was not fluent in sign language and interpreting. Ms. Pokorski's mother was unable to interpret effectively, accurately, and impartially both receptively and expressively, nor could she use any specialized medical vocabulary.

128. Ms. Pokorski's mother had difficulty comprehending Hospital personnel's communication regarding her daughter's condition and treatment.

129. Hospital personnel did not attempt to communicate with Ms. Pokorski in any way, instead communicating solely with her mother regarding Ms. Pokorski's condition and treatment.

130. Ms. Pokorski felt frustrated, angry, and ignored by the Hospital.

131. During Ms. Pokorski's hospitalization, the Hospital did not provide effective communications with her.

132. Ms. Pokorski suffered emotional injuries resulting from the Hospital's conduct during her March 2-4, 2004, hospitalization.

133. On information and belief, the Hospital has discriminated against others who are deaf and use sign language for communication by failing to provide effective communication with them; and, as a result, they suffered similar injuries.

CAUSE OF ACTION

134. As described above, the defendant discriminated against the victims and other individuals who are deaf, by excluding them from participation in and denying them the benefits

of its services, programs, or activities, and by subjecting them to discrimination on the basis of disability, in violation of section 302 of title III of the ADA, 42 U.S.C. § 12182, and its implementing regulations at 28 C.F.R. Part 36.

135. The defendant has discriminated against the victims and other individuals who are deaf by, inter alia:

(A) Failing to provide the victims and other individuals who are deaf appropriate auxiliary aids and services, including qualified interpreters and exchange of written notes, when necessary to afford the individuals an equal opportunity to enjoy the benefits of the services, programs, or activities of the Hospital, in violation of section 302(b)(2)(A)(iii) of title III of the ADA, 42 U.S.C. § 12182(b)(2)(A)(iii), and its implementing regulation at 28 C.F.R. § 36.303(c);

(B) Providing a service that is not as effective in affording equal opportunity to obtain the same result as that afforded to others by failing to provide appropriate auxiliary aids and services to the victims and other individuals who are deaf and who seek hospital services at the Hospital, in violation of section 302(b)(1)(A)(ii) of title III of the ADA, 42 U.S.C. § 12182(b)(1)(A)(ii), and its implementing regulation at 28 C.F.R. § 36.202;

(C) Failing to provide TTYs upon request by plaintiffs in violation of section 302(b)(1)(A)(ii) of title III of the ADA, 42 U.S.C. § 12182(b)(1)(A)(ii), and its implementing regulation at 28 C.F.R. § 36.202; and

(D) Failing to make reasonable modifications in policies, practices, and procedures that restrict the availability of appropriate auxiliary aids and services, including the policies of one-person-at-a-time visitations and of interpreters-only-for-patients, as necessary to ensure effective communication with individuals who are deaf, in violation of section 302(b)(2)(A)(ii)

of title III of the ADA, 42 U.S.C. § 12182(b)(2)(A)(ii), and its implementing regulation at 28 C.F.R. § 36.302.

136. The victims and other individuals who are deaf and use sign language for communication have been and will continue to be harmed if they return to this Hospital for hospital services if the Hospital does not comply with the requirements of title III of the ADA, 42 U.S.C. §§ 12181-12188, and 28 C.F.R. Part 36.

PRAYER FOR RELIEF

WHEREFORE, the United States prays that the Court grant the following relief-

(A) Declare that the practices, policies, and procedures of the defendant, as set forth above, violate title III of the Americans with Disabilities Act, 42 U.S.C. §§ 12181-12188, and the Department of Justice's implementing regulation, 28 C.F.R. Part 36;

(B) Enjoin the defendant, its officers, agents, and employees, and all other persons in active concert or participation with any of them, from violating the requirements of title III of the ADA;

(C) Order the defendant to provide individuals who are deaf with appropriate auxiliary aids and services, including qualified sign language and oral interpreters, TTY's, writing materials, and written communications, when necessary for effective communication;

(D) Order the defendant to ensure that video interpreting services deliver high quality, clear, delay-free full-motion video and audio over a dedicated high-speed Internet connection; provide clear and sharply delineated pictures of the heads, arms, hands, and fingers of the deaf individual, regardless of body position, and the video interpreter; and ensure that voices being transmitted are clear and easily understood;

(E) Order the defendant to ensure that Hospital personnel are trained and able to operate and connect the videophone quickly and efficiently and are available at the Hospital at all times; and that Hospital personnel are trained regarding the limitations of the videophone;

(F) Order the defendant to develop and implement a plan to provide all appropriate auxiliary aids and services when required for effective communication with individuals who are deaf;

(G) Order the defendant to design and implement appropriate staff training programs to ensure that all Hospital personnel who have contact with members of the public are knowledgeable about the policies related to the provision of services to persons who are deaf, including that each such person knows how to secure appropriate auxiliary aids and services for persons who are deaf;

(H) Enjoin the defendant, its officers, agents, and employees, and all other persons in active concert or participation with any of them, from discriminating against any individual because that individual has opposed any act or practice which is unlawful under the ADA, or because that individual made a charge, testified, assisted, or participated in this action;

(I) Enjoin the defendant, its officers, agents, and employees, and all other persons in active concert or participation with any of them, from coercing, intimidating, threatening, or interfering with any individual in the exercise or enjoyment of the civil rights at issue in this action;

(J) Award monetary damages to the victims, and all other persons who where harmed by the defendant, to compensate them for injuries resulting from such discrimination, including damages for pain and suffering.

(K) Assess a civil penalty against the defendant as authorized by 42 U.S.C. § 12188(b)(2)(C), to vindicate the public interest; and

(L) Order such other appropriate relief as the interests of justice may require.

DEMAND FOR JURY TRIAL

The United States demands a trial by jury.

Dated this 14th day of July, 2006

ALBERTO R. GONZALES
Attorney General of the United States

ROD J. ROSENSTEIN
United States Attorney

WAN J. KIM
ASSISTANT ATTORNEY GENERAL
Civil Rights Division

JOHN L. WODATCH, Chief
L. IRENE BOWEN, Deputy Chief
PHILIP L. BREEN, Special Legal Counsel
Disability Rights Section
Civil Rights Division

JAMIE M. BENNETT
Assistant United States Attorney

Office of the U.S. Attorney
District of Maryland
36 South Charles Street
Fourth Floor
Baltimore, Maryland 21201
Tele: 410-209-4800

ROBERT J. MATHER
KATHLEEN S. DEVINE
Trial Attorneys
Disability Rights Section
Civil Rights Division
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, D.C. 20530
Telephone: (202) 307-2236 (Mather)
Telephone: (202) 307-0480 (Devine)