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SULLIVAN, C. J., concurring. I concur in the majority's judgment that human immunodeficiency virus (HIV) ''is an occupational disease for correction officers who, like the decedent, are members of the defendant's correctional emergency response unit, and that, therefore, the plaintiff's notice of claim was timely filed under § 31-294c.'' I write separately to express my disagreement with the majority's determination that it need not decide in this case whether HIV is an occupational disease for correction officers who are not members of the emergency response unit.

The majority agrees with the workers' compensation review board's determination that ''the fact that HIV is unusually prevalent in the average [United States] prison population does not lead inexorably to the notion that a correction officer's risk of being exposed to HIV is so high that it constitutes an occupational disease for that particular group of workers.'' The majority concludes, however, that the board improperly ignored ''the fact that the specific duties of employment for correction officers who are members of the emergency response unit [require] them not just to be in the presence of inmates with a high HIV infection rate, but to interact with them in a manner that greatly increases their risk of contracting the disease—including breaking up fights, dealing with homemade weapons, and responding to medical emergencies.'' Because the record shows that *all* correction officers, not only those who also serve in the emergency response unit, are responsible for breaking up fights, dealing with homemade weapons, and responding to medical emergencies, I disagree with the majority's decision to limit its holding that HIV is an occupational disease to those correction officers who are also members of the emergency response unit.

In a deposition subsequently entered as an exhibit in the workers' compensation commission hearing, the decedent testified that he worked as a correction officer in the maximum security prison area for approximately one year[1] before he became an emergency response unit member. In this area, the decedent was responsible for, among other things, responding to disturbances. Although he became an emergency response unit member in 1987, the decedent's primary job duties as a correction officer did not change after he became a member of that unit.[2] Those duties had required and continued to require the decedent to have physical contact with inmates on a daily basis. In addition, the decedent explained that, as a correction officer, he had worked in all of the living areas in the prison, including maximum, medium, and minimum security. In each area, the decedent had been and continued to be respon-

sible for, among other things, ''stepping between people'' and ''physically removing [inmates who were] either assaulting an officer or another inmate . . . .''

The decedent stated that he had been exposed to inmates' blood on several occasions when he had intervened during fights. On one particular occasion in 1986, during his first year as a correction officer and before he became an emergency response unit member, the decedent was exposed to a significant amount of blood when he was one of the first officers to respond when an inmate, who was a known male prostitute, assaulted a prison shift commander. The decedent also was exposed to inmates' blood when responding to medical emergencies. In one instance, the decedent held pressure on an inmate's open wound. In addition, the decedent had received a puncture wound when his hand struck a razor blade during a cell shakedown.[3]

Further testimony before the workers' compensation commissioner (commissioner) at the hearing bolsters the decedent's claim that, as a correction officer, he was subject to a high risk of exposure to inmates' blood. Fred Poole, a captain with the department of correction, worked at the Bridgeport correctional center from 1981 through 1987. He stated that it was common for correction officers to come into contact with inmates' bodily fluids, especially blood, when they responded to fights. Not all of these officers were members of an emergency response unit.

Edward Blanchette, the clinical director for the defendant department of correction since 1990, testified that correction officers are frequently called upon to break up inmate fights, which occasionally expose the officers to blood. He estimated that, on average, he responds two or three times per week to incidents involving bodily fluids and blood contact from fights in the inmates' quarters. He stated that ''blood contact where an officer is involved [in] breaking up a fight and there's blood being spilled . . . or the officer has been cut and blood is an issue'' is considered a ''significant exposure'' warranting the administration of antiretroviral medications (ARV therapy) for prophylactic purposes.[4] He explained that studies have indicated that ARV therapy administered immediately after a very significant exposure would, if the virus had in fact entered the body, attenuate the virus' activity to such a degree that infection would not take place. He estimated that during the year 2000, three correction officers were exposed significantly enough to merit ARV therapy.[5]

The commissioner's factual findings also bolster the proposition that the decedent, while serving as a correction officer, before he joined the emergency response unit, was at high risk of exposure to inmates' blood. The commissioner determined that the decedent's ''duties *as a correctional officer* required him to maintain [the] security and safety of the public, inmates, and

staff and to respond to emergency codes and break up fights.'' (Emphasis added.) In addition, the commissioner concluded that ''[*c*]*orrectional officers* could be exposed to blood and bodily fluids of inmates during the course of their employment.'' (Emphasis added.) The commissioner also concluded that, while serving as a correction officer, the decedent would ''break up fights between inmates'' and ''could also get involved with inmates who were having medical emergencies'' and that therefore he ''could be exposed to their blood.'' Although it found that the decedent ''was a member of a special team of correctional officers that responded to major disturbances and riots,'' the commissioner did not conclude in his factual findings that the decedent was potentially exposed to inmates' bodily fluids only while responding to incidents as an emergency response unit member, but not while responding to incidents as a correction officer.

Finally, even the majority concedes that the decedent's employment duties as a correction officer required him to respond ''to medical emergencies, altercations and other disturbances'' and that a ''correction officer's duties of employment . . . distinctly require intimate physical contact with the inmates, often in situations where blood and other bodily fluids that transmit HIV are present.'' The majority also concludes, and I agree, that the decedent's risk of exposure to such situations was increased by his involvement with the special response unit. The fact that the risk was increased for special response unit members does not mean, however, that the risk was not sufficiently high to constitute an occupational disease for correction officers who were not part of a special response unit.

Given the evidence presented at the workers' compensation hearing that intimate interaction with inmates is an employment responsibility for all correction officers, coupled with the commissioner's factual findings regarding that evidence, I disagree with the majority's decision to limit its holding that HIV is an occupational disease for correction officers solely to those officers who are also members of the emergency response unit. I note that the parties in this case, the workers' compensation commissioner and the workers' compensation review board, considered the issue as involving all correction officers, not only officers who are emergency response unit members. I do not believe that it is appropriate for this court to create a subclassification within the class of correction officers when no one has advocated that position and it is not compelled by the evidence.

Assume, hypothetically, that two correction officers, only one of whom is also an emergency response unit member, contract HIV after responding to an incident and file claims beyond the one-year limitation period set forth in § 31-294c for accidental injuries. Under the

majority's opinion, the correction officer who is not an emergency response unit member may be required to litigate whether his HIV infection is an occupational disease, and therefore subject to a three-year limitation period. I believe that it is wrong to leave correction officers in a state of uncertainty and to create the need for additional future litigation, with its attendant anxiety, delay, and expense, to obtain the answer to a question that already has been fully addressed in the present case.

[1] The decedent stated that he was employed as a "line officer" for his entire term of service with the department of correction. He explained that a "line officer" is a correction officer who deals "one-on-one with the . . . inmate population."

[2] The decedent explained that his duties as a correction officer were not altered, but rather supplemented, after he received his emergency response unit training. He stated that he was "a regular officer by day and, as needed . . . [an emergency response unit] member by night."

[3] The decedent stated that a "cell shakedown" consisted of "having any inmate that may be in the cell at the time removed from the cell [and] patted down for any weapons [and] illegal contraband within the jail."

[4] Sandra Tanguay, a registered nurse employed by the department of correction as a nurse educator, also explained that correction officers may experience "significant exposure" to "blood-to-blood contact should they be breaking up a fight."

[5] Blanchette explained that this figure was limited to employees, including correction officers and guards, who were not in the health care field.