AELE Monthly Law Journal

ISSN 1935-0007
Cite as: 2011 (3) AELE Mo. L. J. 301
Jail & Prisoner Law Section – March 2011

Avoiding Liability for Antibiotic Resistant Infections in Prisoners

Contents

Introduction

This article is being written for the purpose of aiding the management of prisons and jails in the U.S. in avoiding liability for antibiotic resistant infections in prisoners, specifically Methicillin-Resistant *Staphylococcus aureus* (MRSA) Infections.

It briefly examines the nature and scope of the problem, followed by a look at a court decision on the subject of how failure to take certain types of prophylactic measures to prevent such infections can lead to civil liability for deliberate indifference to a serious risk to prisoner health.

These topics are followed by a list of recommendations drawn from the court decision and from the federal Bureau of Prisons Clinical Practice Guideline on the subject of management of such infections.

After the conclusion of the article, there is a list of useful resources and references.

MRSA Infections in Jails and Prisons

MRSA is a bacterium that causes a number of infections in people that are hard to treat because it has developed resistance to many widely used antibiotics, including the penicillins and the cephalosporins.

Such infections can sometimes spread from the skin and soft tissues to affect vital organs, resulting in widespread infection or sepsis, as well as toxic shock syndrome, and even necrotizing ("flesh-eating") pneumonia.

Those at heightened risk for MRSA infection include persons with weak immune systems, such as persons with HIV/AIDS or cancer, diabetics, IV drug users, and those living in confined spaces with others, including prisoners.

Given the high number of prisoners who are HIV positive and/or present or past IV drug users, the impact of confinement in close quarters is further increased. Hundreds of reports of MRSA infection outbreaks have been reported since 2000. It is a serious health problem in many jails and prisons. It can also be a serious liability issue if not properly addressed.

MRSA infections can be transmitted from person-to-person by contaminated hands, as well as by sharing towels, personal hygiene items, athletic equipment, or other personal items, and is also spread during contact sports or through sharing tattoo or injection drug use equipment. Those infected can also transmit MRSA by coughing up large droplets of infection particles that contaminate the environment.

Liability Issues

The federal appeals court decision in Duvall v. Dallas Cty., #09-10660, 2011 U.S. App. Lexis 660 (5th Cir.), examines one instance of the impact of an MRSA infection on a detainee. In this case, Mark Duvall, while a pretrial detainee in the Dallas County, Texas, jail contracted Methicillin-Resistant Staphylococcus Aureus ("MRSA"), a staph infection resistant to usual penicillin-type antibiotics.

He sued the county in federal court, seeking damages for his resulting injuries. While he was only incarcerated for 15 days, around Christmas time in 2003, his injuries from the infection were severe, causing him great physical suffering, and eventually resulting in the loss of the use of one of his eyes.

His federal civil rights lawsuit claimed that the county subjected him to unconstitutional conditions of confinement in violation of due process of law, and a jury agreed, awarding him damages. The county appealed.

The appeals court noted that, as a pretrial detainee, the plaintiff could not be subjected to conditions of confinement that amount to "punishment," since he had not been convicted of any crime.

In a case like the plaintiff's, based on an allegedly unconstitutional condition of confinement, the court stated, he had to show that the condition allegedly causing the constitutional violation had no "reasonable relationship" to a legitimate governmental interest.

In a conditions of confinement claim, the court commented, "an avowed or presumed intent by the State or its jail officials exists in the form of the challenged condition, practice, rule, or restriction."

While the county stipulated that no legitimate governmental purpose was served by the "allowance" of the MRSA infection to be present in the jail, this did not result in "strict liability." The plaintiff still bore the burden of showing that there was an unconstitutional condition of confinement.

Duvall had to show:

> "(1) 'a rule or restriction or . . . the existence of an identifiable intended condition or practice . . . [or] that the jail official's acts or omissions were sufficiently extended or pervasive'; (2) which was not reasonably related to a legitimate governmental objective; and (3) which caused the violation of Duvall's constitutional rights."

The county argued that its policymaker, the sheriff, did not establish a rule that brought the bacteria in question into the jail. But the court found that the law is well established that even when the government does not want to subject a detainee to abusive practices or inhumane conditions of confinement, the intent to do so is "presumed" by its incarceration of the detainee given "such known conditions and practices."

It was not enough for the plaintiff to show that there were isolated examples of illness, injury, or even death, since any "densely populated residence may be subject to outbreaks." He had to show a "pervasive pattern" of the problem.

The appeals court found that there was ample evidence in the record to show that the county knew of the complained of conditions, but continued to house prisoners in those conditions.

Evidence in the record showed that it could reasonably be said that the infection rate at the jail was ten to twenty times higher than in most comparable jails at the time the plaintiff was infected. The county was aware of it, as the outbreaks had occurred for at least three years before the plaintiff was incarcerated, and the jail experienced as many as 200 infections per month, an infection rate of close to 20%, which testifying doctors characterized as a "bizarrely high incidence of MRSA."

The jury found that the plaintiff's injury was caused by a policy or custom of the county, in that jail officials' acts were sufficiently extended or pervasive as to prove an "intended condition or practice."

There had been testimony that it was feasible to control the outbreaks through "tracking, isolation, and improved hygiene practices, but that the county was not willing to take the necessary steps or spend the money to do so."

What were the needed measures to control and eradicate MRSA? The appeals court found that they were "all known to jails in 2003." Further, the sheriff, it stated, knew that the few steps taken to attempt to control the infections had been ineffective.

The jail's manuals on sanitation and health care did not even mention MRSA, although it was a known problem. While the jail did promote hand washing, which does aid in reducing the spread of MRSA infection, it had refused to install hand washing and disinfecting stations, or to provide alcohol-based hand sanitizers. Such sanitizers are the recommended means of hand disinfection, the court commented, "especially in a jail setting," because of all the contact that occurs in cell areas.

In light of this, and clear evidence that MRSA infections created a risk of serious disease to detainees such as the plaintiff, the jury had sufficient grounds to find a custom or practice.

There was little doubt that the plaintiff contracted the infection in the jail, showing symptoms only after he arrived there.

The jury found that the county adopted or maintained its policy or custom with deliberate indifference to its known or obvious consequences, making "a conscious or deliberate choice to disregard pretrial detainees' constitutional rights to medical care, or to disregard the presence of MSRA." Based on this, the appeals court upheld the jury's award of damages.

Recommendations

The measures described in the ***Duvall*** case, such as hand sanitizing stations and the use of alcohol-based hand sanitizers, are not without their cost. But to fail to spend money for them is to be "penny wise" and "pound foolish," since the cost of increased prisoner medical care resulting from such infections, and the possible exposure to significant civil liability for failure to take such measures could quickly outweigh such expenses.

The federal Bureau of Prisons, in February of 2011, issued its Clinical Practice Guidelines for management of MRSA infections, indicating how seriously it regards this issue. This 40-page document, revised from a previous August 2005 version, contains

numerous recommendations concerning screening and surveillance of prisoners for such infections, diagnosis and treatment of those who are infected, infection control, including education, hand hygiene, and sanitation, correctional contact precautions, and issues involving visitors, activities, housing of the infected, inmate transfers and releases, and influenza prevention.

All jails and prisons should examine this document and the resources it contains and refers to. While the numerous guidelines in it cannot all be summarized here, some of the important recommendations include:

- Screening and surveillance of all inmates at intake for skin infection, as well as screening of inmates recently hospitalized, and periodic evaluation of prisoners with risk factors, such as diabetes, immunocompromised conditions, open wounds, recent surgery, etc.

- Special attention to such screening and surveillance of inmate food handlers, prisoners being transferred and employees.

- Monitoring of antibiotic prescribing practices to ensure that antibiotics are not used in lieu of recommended conservative treatments for uncomplicated MRSA, such as warm soaks or compresses or the drainage of lesions.

- Educational information on MRSA for both prisoners and employees.

- Precautions that assumes that all inmates are potentially contagious and particularly to be applied when contact is made with blood or body fluids.

- An emphasis on sanitation in housing based on an understanding that transmission of infection can occur through sharing towels, use of exercise benches, and participation in sweat lodges.

- Hand hygiene and sanitation, with the supplying of needed hand washing supplies for both prisoners and staff members in contact with them.

- Inmates with MRSA pneumonia can generally be housed with other inmates; however, decisions about their housing should be made on a case-by-case basis. If an inmate with MRSA pneumonia has copious respiratory secretions, or has poor hygiene habits and is likely to contaminate the environment, they should be housed in a separate room and contact precautions utilized.

- Prioritize the cleaning of rooms that are used to house inmates who are placed on contact precautions—with focus on cleaning and disinfecting frequently touched

surfaces (e.g., bedrails, bedside commodes, bathroom fixtures in patient room, and door knobs). All rooms of infected inmates should be decontaminated (terminally cleaned) prior to occupancy by another inmate.

In addition to these recommendations, we would suggest that there be an auditing mechanism for the placement of cleaning supplies in the housing units. Rarely are there records of this occurrence. How often is the water changed in the mop buckets? Is the same mop bucket entering numerous units - becoming ever blacker, ever more contaminated? Who documents that clean water is actually placed in the unit? What about actually teaching the inmates how to clean, rather than making the assumption they know how? A quick video on this topic could be effective in providing defensibility.

Attention should be paid to officer to inmate contamination, officer to officer contamination, and officer to family contamination. Officers often wear latex gloves to provide protection, but do they change them between searching inmates? Are efforts made to clean the counter top or wall where hands are placed? Paying attention to such details can help protect everyone's health and avoid liability.

Wooler v. Hickman, #09-5394, 2010 U.S. App. Lexis 9905 (Unpub. 6th Cir.), provides an example of a jail successfully defending itself against civil liability for MRSA infections developed by a detainee, as well as preventing the spread of infection. In that case, once a doctor treated the detainee for several skin infections, a nurse immediately took additional precautionary measures.

Measures adopted included the cleaning of every cell in the jail, as well as giving each prisoner anti-bacterial soap and requiring them to shower. The nurse personally checked each inmate for infections and ensured that each of them read a flyer about MRSA. Those precautions stopped the spread of MRSA to other inmates.

Conclusion

Failure to take the problem of preventing and controlling MRSA infections in jails and prisons seriously can adversely affect the health of prisoners and detainees, as well as correctional employees and their families, and visitors. Prisoners and detainees who are infected while detained also can spread such infections widely in the community when released.

Given the difficulties and expense of treating such infections, and the dire and often life threatening danger they present, it is imperative that jails and prisons adopt effective measures to prevent and control them. Such measures can help reduce expenses for

prisoner medical care, and may also be beneficial in avoiding civil liability for deliberate indifference to a known risk of serious harm.

Resources

The following are some useful resources related to the subject of this article.

- Management of Methicillin-Resistant Staphylococcus Aureus (MRSA) Infections, Federal Bureau of Prisons Clinical Practice Guideline (Feb. 2010).
- Medical Care. Summaries of cases reported in AELE publications.
- MRSA. U.S. National Library of Medicine.
- MRSA Infection. Mayo Clinic.
- Prisoner Death/Injury. Summaries of cases reported in AELE publications.
- Resources on MRSA. National Institute of Corrections.

Prior Relevant Monthly Law Journal Articles

- Civil Liability for Inadequate Prisoner Medical Care, 2007 (9) AELE Mo. L.J. 301.
- Transsexual Prisoners: Medical Care Issues, 2009 (8) AELE Mo. L. J. 301.
- Civil Liability for Inadequate Prisoner Dental Care, 2009 (9) AELE Mo. L. J. 301.
- Mental Health Care of Prisoners, 2009 (11) AELE Mo. L. J. 301.

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- Siegel JD, Rhinehart E, Jackson M, Chiarello L; Healthcare Infection Control Practices Advisory Committee. Management of multi-drug resistant organisms in healthcare settings, 2006. US Centers for Disease Control and Prevention.
- "Public Health Dispatch: Outbreaks of Community-Associated Methicillin-Resistant Staphylococcus Aureus (MRSA) Skin Infections --- Los Angeles County, California, 2002--2003" (February 7, 2003 issue of CDC's Morbidity and Mortality Weekly Report).

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