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THE LOCAL GOVERNMENT LIABILITY BEAT

Presented by Local Government Risk Management Services, Inc.
A Service Organization of the Association County Commissioners of Georgia and the Georgia Municipal Association Risk Management Programs

Private Health Care Contractors May Also Be Liable For A Civil Rights Violation

By Jack Ryan, Attorney, Legal & Liability Risk Management Institute

Editor's Note

This 2016 article by Jack Ryan on the liability of private health care contractors is as important today as when it was written. The current pandemic surrounding the COVID-19 coronavirus complicates every aspect of life – personal and work – and caring for those in our charge, such as inmates.

It is critical that jail staff have a plan to protect both the inmates and those who come in contact with them. Good communication with county health departments, local medical providers, and our employees will help ensure that we do all we can to prevent the spread of the virus, and, if we suspect infection, doing the right thing for all involved. We have also provided a CDC fact sheet on law enforcement and the coronavirus, which can assist in communicating the facts to our employees.

The Bottom Line:
Have a Plan, Communicate, and Educate.

The Constitution as a general matter only applies to government actors due to the fact that its creation by the founding fathers was to restrict the power of government. Lawsuits related to violation of constitutional rights generally only apply to those persons who act under color of law such as correctional officers, deputies, and police officers. However, when the government hires some outside vendor to fulfill what is generally a governmental function, those non-government actors may also be sued for violation of constitutional rights.

What law enforcement personnel need to know about coronavirus disease 2019 (COVID-19)

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. The outbreak first started in China, but cases have been identified in a growing number of other areas, including the United States.

Patients with COVID-19 have had mild to severe respiratory illness.

- Data suggests that symptoms may appear in as few as 2 days or as long as 14 days after exposure to the virus that causes COVID-19.
- Symptoms can include fever, cough, difficulty breathing, and shortness of breath.
- The virus causing COVID-19 is called SARS-CoV-2. It is thought to spread mainly from person-to-person via respiratory droplets among close contacts. Respiratory droplets are produced when an infected person coughs or sneezes and can land in the mouths or noses, or possibly be inhaled into the lungs, of people who are nearby.
  - Close contact increases your risk for COVID-19, including:
    - » Being within approximately 6 feet of an individual with COVID-19 for a prolonged period of time.
    - » Having direct contact with body fluids (such as blood, phlegm, and respiratory droplets) from an individual with COVID-19.

To protect yourself from exposure

- **If possible, maintain a distance of at least 6 feet**.
- **Practice proper hand hygiene**. Wash your hands with soap and water for at least 20 seconds. If soap and water are not readily available and illicit drugs are NOT suspected to be present, use an alcohol-based hand sanitizer with at least 60% alcohol.
- Do not touch your face with unwashed hands.
- Have a trained Emergency Medical Service/Emergency Medical Technician (EMS/EMT) assess and transport anyone you think might have COVID-19 to a healthcare facility.
- Ensure only trained personnel wearing appropriate personal protective equipment (PPE) have contact with individuals who have or may have COVID-19.
- Learn your employer's plan for exposure control and participate in all-hands training on the use of PPE for respiratory protection, if available.

Recommended Personal Protective Equipment (PPE)

Law enforcement who must make contact with individuals confirmed or suspected to have COVID-19 should follow CDC's Interim Guidance for EMS. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-for-ems.html.

Different styles of PPE may be necessary to perform operational duties. These alternative styles (i.e., coveralls) must provide protection that is at least as great as that provided by the minimum amount of PPE recommended.

The minimum PPE recommended is:

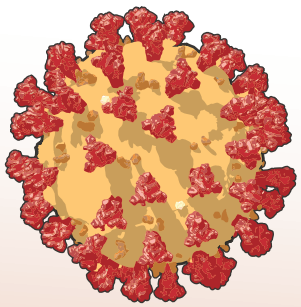
- A single pair of disposable examination gloves,
- Disposable isolation gown or single-use/disposable coveralls*,
- Any NIOSH-approved particulate respirator (i.e., N-95 or higher-level respirator), and
- Eye protection (i.e., goggles or disposable face shield that fully covers the front and sides of the face).

*If unable to wear a disposable gown or coveralls because it limits access to duty belt and gear, ensure duty belt and gear are disinfected after contact with individual.

If close contact occurred during apprehension

- Clean and disinfect duty belt and gear prior to reuse using a household cleaning spray or wipe, according to the product label.
- Follow standard operating procedures for the containment and disposal of used PPE.
- Follow standard operating procedures for containing and laundering clothes. Avoid shaking the clothes.

For law enforcement personnel performing daily routine activities, the immediate health risk is considered low. Law enforcement leadership and personnel should follow CDC's Interim General Business Guidance. Search "Interim Guidance for Businesses" on www.cdc.gov.



For more information: **www.cdc.gov/COVID19**

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One type of non-government actor that is regularly sued in conjunction with sheriffs and jails is health care providers hired by the jail to provide health care for prisoners. A state court case from Georgia provides an excellent example.

So viewed, the evidence shows that Carol was arrested on a probation violation on January 23, 2012, and booked into the Effingham County jail. The jailer on duty completed a medical questionnaire, noting that Carol was exhibiting signs of alcohol withdrawal and had experienced seizures in the past. Shortly after Carol's arrival, Defendant Wanda Brady, the THRX nurse assigned to provide medical services during the week, conducted an intake evaluation. Nurse Brady noted that Carol had injured her foot, and she vomited on intake. Brady also noted that Carol was an alcoholic who drank 12 to 18 beers a day, she had emphysema, she had a history of alcohol-related seizures, and she was taking Dilantin for seizures. Carol was placed in an isolation cell in the section of the jail called the "horseshoe" so that the defendants could monitor her for any signs of detoxification. Nurse Brady also referred Carol to mental health services and alerted THRX's assigned physician, Defendant Myra Pope, by phone.

The next day, January 24, 2012, Nurse Brady examined Carol and took her vital signs. That same day, Dr. Pope wrote a progress note indicating that Carol was starting to sober up and would need to begin detoxing medications "because of impending DTs." Pope instructed the THRX medical staff to order the detoxing medications so that they would be available when Carol was in need. Pope, however, did not prescribe Dilantin or any other seizure medication for Carol, and she did not personally examine or observe Carol, even though she was in the facility at that time.

Carol refused to take any medications on January 24 and again on January 25. When Nurse Brady observed Carol during her rounds, she noted that Carol was pacing and refusing to communicate with staff. On January 26, Carol again refused to take her medication, and Brady noted that Carol was speaking loudly and had refused lunch. That same day, Defendant Rhonda Brown, who was hired by THRX to do administrative tasks and distribute medications over the weekend, observed Carol beating her head and shoes against the window of her cell. Brown spoke with her supervisor at THRX and, based on this discussion, Brown ordered that everything be removed from Carol's cell for her own safety. Carol was given only a paper gown and a mattress.

On Friday, January 27, Nurse Brady observed Carol pacing in her cell and talking to herself. She notified Dr. Pope that Carol refused medications again, and as a result, Pope discontinued Carol's medications. Carol refused dinner that evening.

Nursing staff was not in the facility over the weekends, but Brown was on site to distribute medications. Although Carol was not receiving any medications at that point, Brown nevertheless checked on Carol over the weekend. On Saturday, January 28, Brown observed Carol in her cell in no apparent distress, and Carol again refused her meals.

The following day, Brown observed Carol walking around her cell and noted that Carol was not speaking. Jail staff monitoring Carol noted that she was sitting or standing throughout the morning. That afternoon, Brown noted that Carol was standing in a corner of the cell, and Carol refused to acknowledge or respond when others spoke to her.

Beginning at 5:00 p.m. on Sunday, January 29, officers Merlin Ward, John Reinhart, and William Gibson were on duty. Gibson was assigned to the horseshoe unit and was responsible for checking on Carol. Gibson marked his observations on a visual check sheet posted on Carol's door, and he checked on Carol by glancing through the slit window in the door to her cell, but he did not mark down all of his observations. From 8:45 p.m. until 10:45 p.m., Gibson did not enter any observations. At 10:45 p.m., Gibson noted that Carol was quiet and sitting on the floor. Gibson also observed that Carol was naked and shivering, and he witnessed her hand shake as she reached out to touch the wall, but he did not alert anyone to Carol's condition. Gibson further noted that the cell was dirty and smelled of body odor.

At about 11:30 p.m., Gibson moved to the control room. From there, he observed Carol from a window that looked down into her cell. At about 1:30 a.m., Gibson suggested that a female guard take Carol for a shower, which would enable staff to clean the cell. When the female guard approached Carol's cell, Carol was naked and slumped over. The guard called Carol's name several times, with no response. The guard and another officer then entered the cell and, when the female guard reached for Carol, she found that Carol's entire body was stiff, Carol had no pulse, and Carol's lips were turning blue. None of the guards performed CPR, and Carol was pronounced dead at 2:15 a.m. The medical examiner concluded that the cause of death was cardiac arrest, chronic ethanolism, hypertensive heart disease, and coronary vascular disease. [i]

Under state law, the plaintiff was required to have a qualified expert to prove their medical malpractice claim. The court found that plaintiff's expert was not qualified

and therefore upheld the trial court's dismissal of that claim. The court also dismissed all of the jail personnel and other medical people on the Constitutional Claim of being deliberately indifferent to the serious medical needs. However, the court found that the lawsuit for being deliberately indifferent to serious medical needs by Doctor Pope should go forward.

The court noted:

- Deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain, proscribed by the Eighth Amendment. This is true whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or delaying access to medical care or intentionally interfering with the treatment once prescribed. Regardless of how evidenced, deliberate indifference to a prisoner's serious illness or injury states a cause of action under § 1983 . . .
- "A serious medical need is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Bingham v. Thomas,* 654 F3d 1171, 1176 (11th Cir. 2011); *Youmans v. Gagnon,* 626 F3d 557, 564 (II) (B) (11th Cir. 2010).
- There is no dispute that alcohol withdrawal is a serious medical need . . .
- Thus, a prison official may be "deliberately indifferent" so as to give rise to a 42 USC § 1983 action if the official intentionally denies or delays a prisoner's access to medical care and the official's conduct results in substantial harm.

The court noted that it was troubled by some of the actions with respect to some of the correctional officers, particularly one that was on duty when Carol McKuhen died. The court noted that this officer failed to fill out the log documenting his checks on McKuhen. But, because the lower court determined that this officer did not know the risk of alcohol withdrawal, he was not deliberately indifferent.

In finding that there was enough evidence for the lawsuit to go forward against Doctor Pope, the court cited Pope's conduct with respect to Carol McKuhen as follows:

Dr. Myra Pope worked for THRX, providing on-site chronic and sick care to inmates for half a day each week. Pope was in the facility on January 24, the day after Carol was placed in an isolation cell. Based on the intake information from Brady, Pope determined that they needed to begin a detoxification regimen "because of impending DTs" and withdrawal, which she suspected Carol would experience. Pope, however, did not know that Carol had a history of seizures or that Carol had taken Dilantin in the past, although she admitted that this would have been important to know. Had she known, Dr. Pope would have prescribed Dilantin while Carol was incarcerated. Although Pope never actually saw or physically examined Carol herself, and she made no clinical assessment, on January 27, Pope discontinued Carol's medications due to Carol's refusal to take them.

Pope explained that an inmate experiencing alcohol withdrawal would likely suffer symptoms that, if untreated, could transition into DTs, which were a serious and life-threatening condition. Dr. Pope knew that a patient experiencing DTs could become incoherent, lose bodily function abilities, and suffer hallucinations requiring hospitalization and sedation. Other symptoms included lack of appetite, agitation, incoherency, and loss of bowel and bladder control. Additionally, difficulty communicating, beating one's head against a window, pacing, disorientation, and talking to one's self were also signs that an inmate was experiencing DTs.

THRX had protocols for handling inmates experiencing alcohol withdrawal, including prescribing medications in decreasing amounts to minimize the symptoms. THRX's policy also required that detoxification be carried out only under medical supervision with physician overview. THRX required its doctors to see and review any inmate showing signs of withdrawal. Doctors were also required to continuously monitor inmates using the Clinical Institute Withdrawal Assessment scale. Medical staff relied on jail staff to help monitor those inmates on a detoxification program, and jail staff could complete the assessment form. It was also important to have routine vital signs taken and noted in the inmate's records.

The trial court granted summary judgment to Pope, finding that her conduct did not rise to the level of deliberate indifference and instead sounded in medical malpractice. We disagree.

The evidence shows that Pope was on-site after Carol was placed in the isolation cell, yet she did not read Brady's full intake notes, and she never actually saw or assessed Carol's status. Even after learning that Carol was refusing medications, Pope failed to personally examine or evaluate Carol's condition.

Pope also assumed that jail staff would monitor Carol without ensuring that jail staff knew what signs and symptoms were cause for concern. Pope also ignored the fact that no routine withdrawal assessments were done and that no one took vital signs routinely.

On these facts, we conclude that there is a genuine issue of material fact as to whether Dr. Pope's inaction constituted deliberate indifference. Pope knew of the life-threatening risks associated with DTs, she anticipated that Carol could experience such symptoms, and yet she failed to follow up with any medical care. Moreover, although THRX policies required physician supervision over detoxification, Pope assumed that jail staff could provide monitoring. Such action – or inaction – rises above mere negligence, and a jury could find that it constitutes grossly inadequate care or was so cursory that it effectively amounted to no treatment at all. See *Bingham,* supra, 654 F3d at 1176 ("grossly inadequate care" and "medical care that is so cursory as to amount to no treatment at all" constitute more than mere negligence). We therefore find that the McKuhens have raised a genuine issue of material fact with regard to Pope's conduct.

Thus, because the doctor failed to take appropriate action with respect to reading the nurse's full intake notes and her failure to examine Carol McKuhen even after learning of her refusal to take medication a jury could find that she was deliberately indifferent to Carol McKuhen serious medical needs.

Of note is the fact that throughout the court's decision, it reported that Dr. Pope's position was that she thought the correctional officers would supervise McKuhen and take appropriate action if necessary. The court noted that the doctor's assumption that the correctional officers would monitor McKuhen's condition, was made without Pope determining if the correctional officers even knew what to look for.

Citations

i. *McKuhen v. TransformHealthRX, Inc.,* 338 Ga. App. 354 * (Ga. Ct. App. 2016).

Twelve Critical Tasks for the New Police Chief

By James Westbury, Georgia Municipal Association

You are no longer a uniform patrol officer. You are a police executive.

You are now the policymaker for your department. Every action you take can create liability for your agency under federal law. What you say matters, and what you do matters. You should be insulated to an extent from hands-on law enforcement because you are the officer whose actions represent municipal or county policy.

Adopt good policies for the 12 High Risk Critical Tasks.

Train on your policies regularly. Understand that officers have perishable skills, and they should think through how your policies will apply before they get into a real situation.

Be above reproach. You set the tone for your entire department. You should conduct yourself in word and deed with perfection, even in private situations. And if you were not always perfect, be prepared to explain what you did and said under oath in a deposition.

Hire well. The most important risk management function is the selection of your subordinate officers. Never hire an officer without conducting a thorough background investigation. This includes reviewing every personnel file and talking to someone at every prior employment.

Inspire your officers to be professionals. Police officers must aspire to resist the natural reaction to a situation. Think first. Fall back on training. This will require superhuman effort in some circumstances, but superhuman is the standard that the modern police officer will be held to. Always fall back on professionalism and training.

Someone is always watching (and recording). *Everything* is on record. The truth will set you free – or not.

The "e" in e-mail stands for "evidence." This goes for all electronic communications.

Ban the "F" word. Encourage your officers to remove this word from their vocabulary. (See Rules 7 and 8.) An officer who uses the F-word on tape will always look and sound out of control.

The one cop in any department who should not be involved in a pursuit is the chief. Good pursuit policies always require that a supervisor monitor the chase and be able to call it off. No one is above you.

If an IA investigation is to be performed, do it immediately. If there is a problem, it needs to be investigated immediately and not after a lawsuit is filed. Otherwise, you are just creating evidence for the plaintiff to prove their case. Remember that your officers who are acting within the scope of employment create liability for your department under state law regardless of whether they violate policy or create liability under federal law.

Editor's Note: Coronavirus Sample Policy

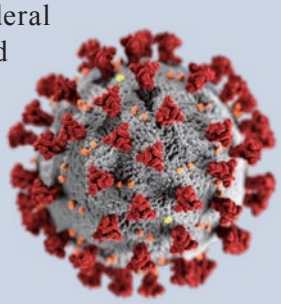
As we are all confronted with the challenges presented by novel coronavirus (COVID-19), you should consider developing a plan and policy for how to address sick or contagious employees in the workplace. The attached Form Pandemic Policy has been created as a means of allowing employers to make determinations as to the health and safety of the workplace when encountering sick or contagious employees, and specifically, to send them home in order to prevent the spread of illness.

As a cautionary note, you will see that the policy provides that employees must utilize any accrued leave time for absences that are necessitated by their viral illnesses or contagious symptoms. If the employee needs to be out of work (or is being sent home) and does not have any accrued leave time, the policy provides that the employee will be on approved unpaid leave. Typically, unpaid leave is not available to employees in the absence of an extended leave of absence or some accommodation associated with FMLA or ADA.

As such, it is important to be aware of creating an opportunity for an unpaid leave status that could have negative ramifications. In order to compensate for this risk of abuse, the policy provides for the city or county to review and address extended unpaid leaves after a certain period of time, which could be adapted based upon your concerns and risk tolerance.

We are hopeful that this policy will be useful to you as you consider these issues. However, as with any sample policy, it is important that you consult with your own city or county attorney and ensure consistency with the remainder of your personnel policies.

It is also important to follow legislative action at both the state and federal level. Temporary and permanent changes or fixes to current law can happen swiftly during national emergencies such as we are facing now.



Sample Policy

Conditions Involving Pandemic or Influenza

Sick employees who report to work with Contagious Symptoms and/or a Contagious Condition, as those terms are defined in this Section, may significantly impact city/county operations due to the potential for spreading sickness, diminished productivity, and lack of quality or attention to safety.

Employees should consider options and practices that will reduce the risk of contracting a contagious condition or passing on a contagious condition by observing healthy practices such as: receiving flu vaccinations, covering their noses or mouths when coughing or sneezing, washing or sanitizing their hands, using sanitizers on common work areas, and other health practices that are designed to reduce infection and the spread of disease. Employees should also refrain from reporting to work with Contagious Symptoms and/or a Contagious Condition, so as not to spread a condition or disease.

In the interest of maintaining a safe and healthy workplace, the city/county may require persons with Contagious Symptoms and/or a Contagious Condition not to report to work and/or may send employees with Contagious Symptoms and/or a Contagious Condition home.

(a) Contagious Symptoms and/or Condition

For purposes of this Section, Contagious Symptoms and/or a Contagious Condition exist when:

(1) An employee exhibits influenza-related symptoms (e.g., fever, vomiting, diarrhea, headache, cough, sore throat, runny or stuffy nose, muscle aches) or other symptoms, described by a public health organization as indicative of other contagion, such as coronavirus; and/or

(2) An employee is diagnosed with an infectious/ contagious condition (e.g., influenza, strep throat, tuberculosis, bacterial meningitis, mononucleosis, mumps, measles, rubella, chicken pox, etc.); or

(3) An employee and/or family member/household member has recently traveled or plans to travel to a geographic area or has been subjected to a confined area, such as cruise ship or airplane, actively identified by a recognized health organization to

present a high degree of contagion health risk or an area for which the CDC has issued a Level 2 or 3 travel advisory.

(b) Workplace Requirements

The city/county and its employees bear responsibility for a safe and productive workplace environment. Accordingly, an employee with Contagious Symptoms and/or a Contagious Condition:

- Will not report to the workplace so as not to infect other employees or members of the public.
- Will not report to the workplace until his/her symptoms have subsided and the employee has been cleared with a health care provider's statement that the employee may return to work. (Such statement must be submitted to Personnel Services for approval as provided in subsection (d), below, in advance of returning to the workplace.)
- Will not report to the workplace after returning from, or after a family/household member has returned from, a geographic area or confined area recently identified by a recognized health organization to present a high degree of contagion health risk or an area for which the CDC has issued a Level 2 or 3 travel advisory. In such case, the employee cannot return to the workplace until completion of the incubation period as identified by a public health organization and until the employee has been cleared with a health care provider's statement that the employee may to return to work. (Such statement must be submitted to Personnel Services for approval as provided in subsection (d), below, in advance of returning to the workplace.)
- May be sent home, with or without the opportunity to work from home, based on observations of symptoms of a Contagious Condition.

(c) Absence Due to Contagious Symptoms or Conditions

An employee who has been sent home by the County and/or has not reported to work due to Contagious Symptoms and/or a Contagious Condition, or who has been quarantined, will be required to use accrued Paid Time Off ("PTO") and/or accrued compensatory time. If PTO or compensatory time is unavailable or exhausted, the employee will be recorded as absent with approved unpaid leave. In the event that an employee's absence pursuant to an approved unpaid leave extends beyond five (5) days and/or an employee's absence pursuant to an approved unpaid leave becomes a recurring issue, and such absences are deemed to constitute an undue burden upon the City/County Department or Elected Office, the Department Head/Elected Official may request that the employee provide a doctor's certification as to the employee's current condition. Ultimately, any prolonged absences will be addressed in compliance with all federal and state laws and regulations, including the ADA and the FMLA (where a serious health condition is involved).

The Department Head/Elected Official may approve an employee to work from home or another private location while recuperating. Such approval is dependent upon consideration of factors, including the employee's position, the severity of the illness, and other safety and logistical considerations. Notification that an employee will be allowed to work from home must be provided to Personnel Services.

Any employee subject to absence due to Contagious Symptoms or a Contagious Condition must contact Personnel Services to determine if the employee and medical condition qualifies for Family Medical Leave. In such case, the policy covering Family Medical Leave Act shall apply.

(d) Return to Work from Contagious Symptoms or Contagious Condition

As a condition for return to work, the employee will be required to provide certification from a professional health care provider stating the Contagious Symptom or Contagious Condition that the employee experienced has been cleared and the employee may return to work without risk to other employees. The written statement must be submitted electronically to Personnel Services, which shall review and must approve the release before the employee may return to work. An employee failing to provide a written return to work authorization prior to reporting to work will be immediately sent home and may be subject to disciplinary action for failure to comply with this requirement.

(e) Compliance

Due to the seriousness of the ramifications of non-compliance, any violation of the policy as set forth will subject the employee to disciplinary action, up to and including termination.

This Section will be administered in accordance with all federal and state laws and regulations, including the ADA and the FMLA (where a serious health condition is involved).

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