UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF KENTUCKY
LOUISVILLE DIVISION

[Filed Electronically]

MARTEL CHAPMAN, et al.,	)	
Individually and on behalf of	)	
All Others Similarly Situated,	)	
	)	
PLAINTIFFS	)	
	)	**C. A. NO. 3:05-CV-00433-S**
v.	)	
	)	
HARDIN COUNTY, et al.,	)	
	)	
DEFENDANTS.	)	

MEMORANDUM IN SUPPORT OF MOTION FOR CLASS CERTIFICATION

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MARTEL CHAPMAN, et al., **Individually and on behalf of** **All Others Similarly Situated,** **PLAINTIFFS**	)))))	
	)	**C. A. NO. 3:05-CV-00433-S**
v. **HARDIN COUNTY, et al.,** **DEFENDANTS.**	)))))	

MEMORANDUM IN SUPPORT OF MOTION FOR CLASS CERTIFICATION

Plaintiffs have moved the Court to certify this case as a class action under Federal Rules of Civil Procedure 23(b)(2) (for injunctive and declaratory relief) and 23(b)(1) or (3) (for recovery of actual and punitive damages). The classes Plaintiffs seek to represent would be composed of (a) all persons who, since August 1, 2004, contracted methicillin-resistant *Staphylococcus aureus* ("MRSA") at the Hardin County Detention Center ("the Jail"), and (b) all persons who are or will be confined at the Jail. Plaintiffs respectfully file this memorandum in support of their motion.

BACKGROUND FACTS

I. Introduction.

MRSA is an antibiotic-resistant bacterium that flourishes in skin and mucous membranes. It can be chronic, and it can be fatal. It is always painful and often disfiguring. It can be highly infectious, and can significantly and negatively impact a person's health, employability, insurability, and relations with friends and loved ones.

Public health authorities have documented an alarming rise in the incidence of MRSA both nationwide and locally. Recent studies have shown that jails and prisons are "incubators" of the disease as a consequence of overcrowding and substandard sanitation and hygiene, and may be contributing to community outbreaks generally. It is thus essential that jails like the one in this case take the steps necessary to protect healthy inmates from MRSA, to effectively treat those who contract the disease, and to prevent any MRSA outbreak in the correctional environment from spreading to the outside community.

Since at least September 2004, Defendants and the Jail have known about MRSA, and have known the steps that needed to be taken to protect healthy inmates and the outside community and to treat infected inmates. Defendants even adopted internal policies that acknowledged their duty to the Jail's inmates and to the surrounding community. But Defendants then failed to implement and enforce such policies. Incoming inmates were not screened for the disease. Inmates were not educated about the disease or its prevention, treatment or consequences. Infected inmates with open, draining lesions were not isolated. Treatment was haphazard, at best. On release, inmates were provided no information on their condition, nor were they given any medication even to complete a course of treatment they had been prescribed.

As a result, since the summer of 2004, more than 80 inmates, and possibly *significantly* more, have been infected with MRSA while incarcerated at the Jail. The Jail reported none of this to correctional or local or state public health authorities. Defendants' conduct, in light of their knowledge of the seriousness of MRSA, was abhorrent and caused severe harm to the inmates of the Jail and very likely harmed the community in which they were released.

Defendant Jailer Louis Lawson continues to assert that there has been no outbreak of MRSA infections in the Jail. Even after multiple Jail *employees* were diagnosed with MRSA, Lawson did

nothing to investigate how those employees had become infected. As recently as April 23, 2007, Defendant Lawson declined to categorize MRSA as one of the communicable diseases he considers to be "real serious." The Jailer's indifference to this problem is, in a word, staggering.

The Court must certify a class in this case in order to begin the process of bringing the Jail and Defendants into compliance with their duty to the Jail's inmates and to the Hardin County community as a whole.

II. MRSA: A Serious And Growing Public Health Threat.

A. *Staphylococcus aureus*.

Staphylococcus aureus, a type of bacterium often referred to as "staph," is quite common, according to government and medical literature. It is estimated that it can be found in the nostrils of between 25 and 30 percent of the U.S. population.[1]

Staphylococcus aureus was first identified by Sir Alexander Ogston, a Scottish surgeon and bacteriologist, in 1880. Abscesses he studied that were warm to the touch, he found, often were associated with the same organism that appeared under the microscope as a clustered mass of golden orbs. To name the bacterium, Ogston chose words reflecting that appearance -- the Greek word *staphyle*, meaning "bunch of grapes," and *aureus*, a gold coin of ancient Rome. Thus, *Staphylococcus aureus* was given its permanent, and rather vivid, identity.

"In 1928, penicillin was discovered and was found effective in treating *S. aureus.* In 1959, the first semi-synthetic penicillin, methicillin, was produced by altering the chemical composition of penicillin. Two years later, the first methicillin resistant strains of *S. aureus* were reported."[2]

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[1] U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR DISEASE CONTROL AND PREVENTION, COMMUNITY-ASSOCIATED MRSA INFORMATION FOR THE PUBLIC, available at http://www.cdc.gov/ncidod/dhqp/ar_mrsa_ca_public.html (last visited July 29, 2007).

[2] MRSA TASK FORCE OF THE GREATER OMAHA CHAPTER OF THE ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTROL & EPIDEMIOLOGY, INC., GUIDELINES FOR THE CONTROL OF MRSA 9, available at

Staphylococcus aureus often does no harm, or only little harm. The 25 to 30 percent of the population who studies say carry it in such places as their noses or on their skin are described in medical literature as having been "colonized" with the bacterium -- meaning, colonies of staph live in or on them, and many of them "do not know they are carrying it. They do not get skin infections. They do not have any sign or symptoms of illness."[3] Those who do develop symptoms often develop only simple, unremarkable skin infections. "Most of these skin infections are minor (such as pimples and boils) and can be treated without antibiotics."[4] However, there are types of *Staphylococcus aureus* that are dangerous -- particularly MRSA, an antibiotic-resistant staph first reported in 1961.

B. MRSA.

MRSA is far less common than staph. MRSA is found only in approximately one out of every 100 people.[5] MRSA "is resistant to a family of antibiotics related to penicillin that includes antibiotics called methicillin and oxacillin, but it is often resistant to many other antibiotics as well."[6] More so than with infections caused by a form of staph that is susceptible to antibiotics, MRSA infections are likely to lead to serious and painful symptoms. "Inmates with MRSA skin infections commonly complain of 'an infected pimple,' 'an insect bite,' 'a spider bite,' or 'a sore.' … however,

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http://goapic.org/MRSA.htm (last visited July 29, 2007). (The MRSA Task Force report was the work of 13 doctors and 10 nurses and was intended to advise local institutions in Nebraska on proper strategies for preventing the spread of MRSA.)

[3] COMMONWEALTH OF MASSACHUSETTS DEPARTMENT OF PUBLIC HEALTH, MRSA AND CORRECTIONAL HEALTH, ¶ 4, available at http://www.mass.gov/dph/cdc/antibiotic/mrsa_correctional.htm (last visited July 29, 2007).

[4] *Id.* at ¶ 1.

[5] U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR DISEASE CONTROL AND PREVENTION, *supra* note 1, at ¶ 2. "While 25% to 30% of the population is colonized with staph, approximately 1% is colonized with MRSA."

[6] *Id.* at ¶ 1.

even otherwise healthy individuals can develop very serious MRSA infections, such as cellulitis, deep-seated abscesses, necrotizing fasciitis, septic arthritis, necrotizing pneumonia, and sepsis."[7] ("Sepsis is a severe illness caused by overwhelming infection of the bloodstream by toxin-producing bacteria. .... Sepsis is often life-threatening, especially in people with a weakened immune system or other medical illnesses."[8]) The symptoms of more serious staph infections may include rash, shortness of breath, fever, chills, chest pain, fatigue, muscle aches, malaise and headache, and the "outcome varies with the severity of the infection, and the general condition of the person who has the infection. MRSA pneumonia and blood poisoning have high death rates."[9]

Betsy McGaughey, a former lieutenant governor of New York and founder of the Committee to Reduce Infection Deaths, describes MRSA more succinctly: It is, she wrote in *The New York Times*, a "killer."[10] Hardin County Jailer Louis Lawson recognizes this, too. "If it's untreated it could be deadly," he said in his deposition on April 23, 2007.[11]

A study published in 2005 of 348 hospital patients in Boston with staph infections of their blood illustrated the death rate from such infections, and measured what it found to be "significant" costs caused by MRSA. Those costs, to patients, hospitals and society, are exacted in the form of higher hospital charges and longer hospital stays, the study found. "*S. aureus* is the most common cause of nosocomial (hospital-acquired) infections reported to the National Nosocomial Infections

[7] U.S. BUREAU OF PRISONS, CLINICAL PRACTICE GUIDELINES, MANAGEMENT OF METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) INFECTIONS, (2005) 1. Attached as Exhibit A.

[8] NATIONAL INSTITUTES OF HEALTH, U.S. NATIONAL LIBRARY OF MEDICINE, MEDLINEPLUS, SEPSIS, available at http://www.nlm.nih.gov/medlineplus/ency/article/000666.htm (last visited July 29, 2007).

[9] NATIONAL INSTITUTES OF HEALTH, U.S. NATIONAL LIBRARY OF MEDICINE, MEDLINEPLUS, MRSA INFECTION, available at http://www.nlm.nih.gov/medlineplus/ency/article/007261.htm (last visited July 29, 2007).

[10] Betsy McGaughey, *To Catch a Deadly Germ,* N.Y.Times, Nov. 14, 2006, available at http://www.nytimes.com/2006/11/14/opinion/14mccaughey.html?ex=1184299200&en=91.

[11] Dep. of Louis Brown Lawson 129, attached as Exhibit S.

Surveillance System. It is the leading cause of nosocomial pneumonia and surgical-site infections and the second leading cause of bloodstream infections in the United States."[12] Staph infections of the blood, the researchers reported, are associated with death rates of between 15 and 60 percent.[13] Of the 348 patients studied, 252 were infected with staph that was susceptible to methicillin, and 96 had MRSA.[14] The death rates within the two groups were comparable -- 19.8 percent of the patients with methicillin-susceptible staph died, while 22.9 percent of the patients with methicillin-resistant staph died[15] -- but those MRSA-infected patients who did not die needed to stay in the hospital an average of two days longer[16] and incurred additional average charges of $7,212 more than their counterparts infected with methicillin-susceptible staph.[17] This translated into an annual cost attributable to MRSA at the 630-bed Boston hospital where the study was conducted of $122,752.[18] It is not difficult to see that society's economic stake alone in controlling MRSA is substantial.

A sampling of accounts from inmates of the Hardin County Jail, provided to Plaintiffs' attorneys and attached as Exhibit C, tell the specifics of what some of the inmates there experienced:

- "Knots under my skin that open and drain. Sometimes 1 large one or several small ones in various spots all over my body."
- "Sore on right breast with a knot bigger than a golf ball. Very painful!"

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[12] Sara E. Cosgrove, Youlin Qi, Keith S. Kaye, Stephan Harbarth, Adolf W. Karchmer & Yehuda Carmeli, *The Impact of Methicillin Resistance in* Staphylococcus Aureus *Bacteremia on Patient Outcomes: Mortality, Length of Stay, and Hospital Charges,* 26 INFECTION CONTROL AND HOSP. EPIDEMIOLOGY 2 (2005), 166, 171. Attached as Exhibit B.

[13] *Id*. at 166.

[14] *Id.* at 168.

[15] *Id.*

[16] *Id.* at 170.

[17] *Id.* at 171.

[18] *Id.* at 173.

- "My leg swelled up with big boils that were oozing green stuff fever and lots and lots of pain."

- "Bump on my left ear, nausea and vomiting. Left ear very sore to touch, swollen and pus drainage."

- "My arm swelled up real bad and hurt real bad. I couldn't close my hand or bend my fingers."

- "A bite that swelled up and immobilized me. I got headaches and was very sick."[19]

C. MRSA infections represent a growing health risk to the community, and jails contribute to the spread of MRSA infections in the community.

Researchers report that MRSA in the past decade has advanced rapidly from a problem largely associated with hospitals to become, now, a fast-emerging problem in communities at large. It also is one increasingly associated with jails.

The first hospital outbreak of MRSA documented in the United States was at Boston City Hospital in 1968[20] -- and since then, the prevalence of antibiotic-resistant staph has ballooned throughout the country, not just in hospitals (where infections are commonly referenced in literature as hospital-acquired, or HA-MRSA) but outside hospitals (where infections are commonly referenced in literature as community-acquired, or CA-MRSA) as well. "Sixty percent of staph infections are now drug resistant …, up from 2 percent in 1974."[21] The Boston study by Cosgrove et al. in 2005 reported a similar, recent trend: "Resistance to methicillin in *S. aureus* isolates is a growing problem; 55% of nosocomial (hospital-acquired) infections in U.S. intensive care unit (ICU) patients are due to methicillin-resistant *S. aureus* (MRSA), representing a 29% increase in the

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[19] Attached as Exhibit C. (These Questionnaires and Affidvits are being filed under seal in compliance with the Agreed Protective Order signed by Magistrate Judge Dave Whalin on March 13, 2006.)

[20] MRSA TASK FORCE OF THE GREATER OMAHA CHAPTER OF THE ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTRON & EPIDEMIOLOGY, INC., *supra* note 2, at 9.

[21] McGuaghey, *supra* note 10.

incidence of MRSA infections during the past 4 years. Community-acquired MRSA infections are increasingly recognized as an emerging problem."[22]

Another authority in 2003 explained the growth of MRSA this way: In 1941, *Staphylococcus aureus* was "almost invariably susceptible to penicillin," while today, "fewer than 5 percent" are. "When physicians started using methicillin in the 1960s, methicillin-resistant *Staphylococcus aureus* (MRSA) emerged. … By 1992, nearly 40 percent of isolated strains … in the United States were MRSA. … Many strains of MRSA are susceptible to only one antibiotic, the very expensive vancomycin. … In 1997, three isolates of MRSA from different areas of the world responded poorly even to vancomycin."[23]

In other words, researchers now recognize that while it has been identified as a hospital management and hospital patient concern for 45 years, MRSA has recently emerged as a threat in other places in our society. "(I)n the past decade new strains of MRSA have emerged in the community, causing aggressive infections in young, otherwise healthy people. … The increasing prevalence of community-acquired MRSA in multiple countries and the substantial morbidity and mortality associated with these infections suggest that community-acquired MRSA will continue to develop into a challenging public health problem."[24] Another researcher agreed with the assessment that MRSA's community spread has been on about a 10-year sprint. "Since 1998, community-acquired methicillin-resistant *Staphylococcus aureus* (CA-MRSA) infections have emerged among patient groups with risk factors unassociated with health care, including sports exposure,

[22] Cosgrove et al, *supra* note 12, at 166.

[23] Devesh Tiwary, *Drug Labeling: FDA Requires New Label for Antibiotics to Prevent Overuse*, 31 J.L. Med. & Ethics 458, 459 nn. 16-21 (Fall 2003). Attached as Exhibit D.

[24] Nicola Zetola, John S. Francis, Eric L. Nuermberger, William R. Bishai, *Community-acquired methicillin-resistant* Staphylococcus aureus*: an emerging threat*, 5 LANCET INFECTIOUS DISEASE (May 2005) 275-86, 275. Attached as Exhibit E.

incarceration, intravenous drug use, overcrowded housing, tattooing and poor hygiene."[25] The latter researchers, Hota et al., found that the rate of community-acquired MRSA infections had risen roughly seven-fold in Chicago's main public hospital between 2000 and 2005 -- rising from 24 per 100,000 to 164 per 100,000 -- and concluded that jails were at least in part responsible. "Incarceration and residence at some public housing complexes increased the chance of infection with CA-MRSA."[26] Co-authors Hota and Weinstein, in a recent letter to a medical journal, described community-acquired MRSA bluntly as "a global emerging threat."[27]

Hota, Weinstein and their colleagues were not the first researchers to connect the upsurge in community-acquired MRSA infections with the conditions inside jails. A group of researchers at the University of Maryland in 2006 described the spread of MRSA infections as an increasing threat and raised the specter of an "MRSA pandemic" to which short-term correctional facilities can be expected to be significant contributors.[28] The researchers, referring to MRSA specifically, said:

> "Given this organism's association with skin and soft-tissue infections, a reasonable working hypothesis is that institutions that house large numbers of individuals in small areas support intense MRSA transmission. If such institutions release colonized individuals (i.e., carriers) into the community at high rates, they may contribute disproportionately to the MRSA pandemic. ....
>
> " … our results illustrate that institutions with high acquisition and turnover rates contribute substantially to the transmission of MRSA and should represent a key focus for prevention and control efforts."

Hartley et al., *supra* note 28, at 170, 173.

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[25] Bala Hota, Charlotte Ellenbogen, Mary K. Hayden, Alla Aroutcheva, Thomas W. Rice & Robert A. Weinstein, *Community-Associated Methicillin-Resistant* Staphylococcus aureus *Skin and Soft Tissue Infections at a Public Hospital*: *Do Public Housing and Incarceration Amplify Transmission?*, 167 ARCHIVES OF INTERNAL MED. 1026 (May 28, 2007), 1026. Attached as Exhibit F.

[26] *Id.* at 1032.

[27] Bala Hota and Robert A. Weinstein, *Community-associated Methicillin-resistant* Staphylococcus aureus, 12 EMERGING INFECTIOUS DISEASES 9 (September 2006) 1469. Attached as Exhibit G.

[28] David M. Hartley, Jon P. Furuno, Marc O. Wright, David L. Smith & Eli N. Perencevich, *The Role of Institutional Epidemiologic Weight in Guiding Infection Surveillance and Control in Community and Hospital Populations,* 27 INFECTION CONTROL AND HOSP. EPIDEMIOLOGY 2 (2006) 170. Attached as Exhibit H.

A study in Los Angeles, Calif., in 2002 of a MRSA outbreak in that county's very large jail confirmed that confinement in jail puts one at risk for acquiring MRSA. The Los Angeles County Department of Health Studies concluded that "the longer a person is in the jail system, the greater their risk is of developing an MRSA wound infection.. … Due to the severity of MRSA skin infections and the difficulty in eliminating the spread of this disease in large incarcerated populations, it is important for jail and prison medical staff to be vigilant in monitoring MRSA infections in their institutions."[29]

Clearly, in the breeding of so-called community-acquired MRSA, the jail is increasingly being recognized as a community petri dish.

III. The Hardin County Jail Has Known In Detail Since At Least September 2004 How To Protect Its Inmates And The Surrounding Community From MRSA.

Being "vigilant," as the Los Angeles report urged, means following a clearly-drawn road map. Abundant literature is readily available telling institutions such as jails how to stem outbreaks of MRSA, and the Hardin County Jail has had such literature since at least September 2004.

The Los Angeles report in 2002 provided a laundry list of steps:

> "Recommendations include increasing surveillance for MRSA infections, educating (sic) for staff and inmates on MRSA infections, increasing opportunities for inmate hygiene including removal of disincentives for maintaining personal hygiene, immediate cell cleaning for inmates with suspect MRSA infections, increasing laundry changes for all inmates and limiting facility transfers for inmates with open wounds. Additionally, a plan was developed for the treatment of soft tissue infections. The plan stressed sound drainage and subsequent wound care as the first line of treatment for a soft tissue infection. If drainage did not cure the infection or if drainage was not possible, appropriate antibiotics should be provided to the inmate."

County of Los Angeles, *supra* note 29, at 37.

[29] COUNTY OF LOS ANGELES DEPARTMENT OF PUBLIC HEALTH SERVICES, ACUTE COMMUNICABLE DISEASE CONTROL SPECIAL STUDIES REPORT 2002, 35-37, 37. Attached as Exhibit I.

In 2004, when evidence developed thus far in this case indicates that MRSA was first recognized in the Hardin County Jail, the Jail received two directives, or protocols, that clearly stated the means by which MRSA is transferred from person to person. The two protocols also clearly stated what steps should be taken to minimize chances of its transfer. One protocol, according to Jailer Lawson, was the result of information provided by Hardin Memorial Hospital,[30] and the other was from the Kentucky Department of Corrections.[31]

The latter was mailed on Sept. 1, 2004, by the state Corrections Commissioner, John D. Rees, to all Kentucky jailers, including Defendant Lawson in Hardin County. The eight-page "Health Care Services Protocol" announced that it is the state's policy "to address the clinical and security issues associated with" MRSA.[32] In line with medical literature and other government advisories, the protocol advised Lawson and other jailers that MRSA is transmitted by people with contaminated hands, by the sharing of "towels, personal hygiene items, athletic equipment, through close-contact sports, by sharing injection drug use equipment, and through food-borne outbreaks."[33] "MRSA pneumonia," it said, can be spread by coughing. The protocol also mentioned hazards of unsanitary tattooing practices. Advice in the protocol for inmates included recommendations to wash one's hands thoroughly and regularly, particularly after using the toilet and before eating; to never touch another's wounds or dirty bandages; to shower regularly, keep living space clean and launder bed linens regularly; to not share personal hygiene items; to clean recreational equipment, such as weight benches, or to use a shirt or towel as a buffer to avoid contact with the equipment; to

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[30] Attached as Exhibit J, "MRSA PROTOCOL."

[31] Attached as Exhibit K, "Kentucky Corrections Health Care Services Protocol."

[32] *Id.* at 1.

[33] *Id.*

shower after playing contact sports; and to not get a tattoo in prison, use injection drugs or have sex with another inmate.[34]

Similarly, Jailer Lawson said in his deposition that in 2004 he asked a Jail medical department employee to solicit advice on MRSA from Hardin Memorial Hospital, and the employee in turn received a 10-point "MRSA Protocol."[35] The Jail's contract physician signed the protocol, Lawson said, and it was Lawson's understanding that the protocol had to be followed in order to protect the inmates of the Jail from MRSA.[36] The protocol, echoing much of the state Corrections department's advice, called for:

> ● cultures to be performed of inmates' sores, and for any inmate with a suspected MRSA infection to be given antibiotics and put in isolation from other inmates;
>
> ● inmates who are isolated because of infections to shower twice daily, receive clean linens and clothing daily, to eat with disposable kitchenware, to place dirty linen, clothing and food trays in biohazard bags, and to remain in isolation until the wound has stopped draining and a doctor has approved returning to the jail's general population;
>
> ● inmates' living areas to be cleaned with disinfectant weekly, and for tables, sinks and toilets to be wiped down daily; and
>
> ● inmates to be given instruction in the importance of hygiene and frequent hand washing. [37]

Therefore, by the late summer of 2004 at the latest, Lawson and the Jail's medical staff were well versed in measures to stem the spread of MRSA.

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[34] *Id.* at 7.

[35] Lawson dep. 102, attached as Exhibit S.

[36] *Id*. at 109 (Exhibit S).

[37] *See* Exhibit J, *supra* note 30.

IV. Jail Records And Inmate Accounts Both Show That The Hardin Jail Was Deliberately Indifferent To The Serious And Obvious Risks Posed By MRSA To Healthy Inmates And The Surrounding Community.

A. The Jail failed to isolate infectious inmates.

The Hardin County Jail's "MRSA Protocol" calls for any inmate with open wounds or skin conditions to be subjected to a culture of the wounds, and to begin receiving antibiotics "as per HCDC physician's orders."[38] Item No. 3 of the Protocol then says: "ANY INMATE WITH SUSPECTED MRSA TO BE PLACED IN ISOLATION UNTIL CULTURE REPORTS SHOW NEGATIVE RESULTS."[39] Additionally, Jailer Lawson sent a memorandum to Jail staff dated August 2, 2004, which said that "inmates that are diagnosed with MRSA should be placed in a single cell in order to reduce the risk of MRSA transmissed (sic) to other inmates."[40] And, the state Corrections department's Sept. 1 Health Care Services Protocol said that "inmates with potentially contagious infections … should be assigned to single-cell housing."[41]

Indeed, Lawson said in his deposition that it was the practice of the Hardin County Jail to place inmates diagnosed with MRSA in isolation,[42] "and once we culture it and find out, that we isolate that inmate and get that person on their medicines."[43] Lawson further said that he was personally unaware of any instances in which an inmate with a MRSA infection was not isolated.[44]

[38] *Id.*

[39] *Id.*

[40] Attached as Exhibit L, Memo from Louis Lawson date Aug. 2, 2004.

[41] Exhibit K, *supra* note 31, at 5.

[42] Lawson deposition, 100, attached as Exhibit S

[43] *Id.* at 99, Exhibit S

[44] *Id.* at 162, Exhibit S

The record, however, reveals a reality at odds with Jailer Lawson's characterizations. For example, records show that after Plaintiff Martel Chapman entered the jail on June 17, 2004, she was placed in Pod 137 with multiple other female inmates, where she remained exclusively for more than three months.[45] One inmate in that cell, Judy Williams, said that more than 20 inmates were in cell space containing eight beds, and as a result most slept on the floor.[46] Among the other inmates in overcrowded Pod 137 with Chapman in June 2004 was an inmate who Chapman said proceeded to show the other inmates a boil and to tell them that she had "a staph infection."[47] Jailer Lawson was aware that the inmate Chapman described, who had been brought from the Nelson County Jail, had been previously diagnosed with MRSA. "As soon as she was booked," Lawson said of the inmate from Nelson County, "she said something about it, and the booking officer referred to medical and the medical brought it to my attention."[48] That, Lawson said, was "the first I had ever heard" of MRSA.[49]

Subsequently, Chapman said in her deposition, she observed "a huge boil"[50] on the back of inmate MRSA Patient No. 1,[51] and a draining sore on the neck of inmate MRSA Patient No. 2.[52] In the case of inmate MRSA Patient No. 2, Chapman said, "she was in our cell for quite a while with it

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[45] Attached as Exhibit M, Chapman Medical Records.

[46] Dep. of Judy Williams 10, attached as Exhibit Y.

[47] Chapman dep. 22, attached as Exhibit T.

[48] Lawson dep. 80, attached as Exhibit S.

[49] *Id* (Exhibit S).

[50] Chapman dep. 24, attached as Exhibit T.

[51] Attached as Exhibit N, "Plaintiffs' Reference List Under Seal In Support of Memorandum." (The names of this inmate and others are being filed under seal in compliance with the Agreed Protective Order of March 13, 2006.)

[52] Chapman dep. 27 (Exhibit T), and Exhibit N, *supra* note 51.

draining without them taking her out" to isolation.[53] "I believe that they cultured it, but they left her in the pod until it came back, you know, positive or negative …" Chapman said.[54]

Chapman herself experienced the following sequence of events, according to records produced by the Jail:

> ● On Sept. 18 -- six weeks after Lawson's August 2 memo and 17 days after the Corrections department's advisory -- Chapman filled out a Medical Request form complaining that "I have a boil under my arm." The same day, the medical staff at the jail saw her. It appears from the record that the medical staff member initiated an antibiotic, Keflex, and wrote: "if draining, report to Med. for culture." Chapman was not isolated, but was left in Pod 137.[55]
>
> ● On Sept. 20, Chapman, still in Pod 137, filled out another Medical Request form. "I need to see the doctor," she wrote. "I have a boil under my arm."[56]
>
> ● On Sept. 21, the jail's contract physician saw her, reported that the sore had "minimal drainage," changed antibiotics, and ordered a culture. She remained in Pod 137.[57]
>
> ● On Sept. 23 -- five days after she first reported her boil, in a crowded cell where Lawson knew at least one MRSA-infected inmate had been housed -- Chapman was sent from Pod 137 to an isolation cell "per medical."[58] This was the same day that the culture results were returned, confirming that Chapman had a "heavy growth" MRSA infection.[59]

Clearly, for those five days, Chapman was not taken to isolation, as the Jail's MRSA Protocol calls for in the case of inmates with even *suspected* cases of MRSA *while culture results are pending*. Instead, she was left in the pod in contact with other inmates. "It kept getting bigger, and

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[53] Chapman dep. 27, attached as Exhibit T.

[54] *Id.* at 28 (Exhibit T).

[55] *See* Exhibit M, *supra* note 45.

[56] *Id.*

[57] *Id.*

[58] *Id.*

[59] *Id.*

I wrote medical requests -- I think I wrote two or three of them before they came back to look at me," she said in her deposition. "And it ended up popping. They cultured it and came back maybe two days later and put me in isolation because it was a staph infection."[60] Chapman's account and the Jail record agree: She was left in contact with other inmates after her boil had been draining to a degree sufficient to permit a culture, and while the culture was pending, in violation of the MRSA Protocol.

In Chapman's three months-plus in Pod 137 before being moved briefly to isolation, she maintained that four women were left in the pod for days at a time while suffering obvious skin infections -- MRSA Patient No. 1, MRSA Patient No. 2, the Nelson County inmate and Chapman herself.

Numerous other inmates maintain that, like Chapman, they were not isolated during times when their infections were active and draining. Counsel for Plaintiffs have attempted to contact all 80-plus people identified as having been treated for MRSA in the Jail. Forty-two of those inmates have signed and returned questionnaires. In their responses, those potential class members report failure by the Jail to incorporate a wide array of recommended preventive measures, including the isolation of inmates. Twenty-six of the 42 respondents reported having shared a cell with someone with open sores -- logically, a highly likely source of many of their exposures -- and eight said they were not put in isolation after developing open sores of their own.[61] Five of the respondents said they worked in the Jail's kitchen *after* they had developed symptoms of MRSA, and four said they

[60] Chapman dep. at 30, attached as Exhibit T.

[61] *See* Exhibit C, *supra* note 19.

continued to work there after having been *diagnosed* with MRSA. One reported working in the Jail's laundry after both the onset of symptoms and diagnosis with MRSA.[62]

In depositions, inmates related similar experiences. Annette Borges, for example, said that after entering the Jail in July 2005 -- nearly a year after the Jail had had its first experience with MRSA -- she was isolated only upon her first two outbreaks, and not during multiple other outbreaks.[63] Inmate Jolene Hazelwood said that other inmates were upset because Borges was not isolated during some of her outbreaks of sores. "She was in the pod with the MRSA and wanted to be put in medical lock-down to make sure nobody else could catch it," Hazelwood said. "People in the pod were talking junk, they didn't want to catch it."[64] Borges maintains that she once complained for three days before officers finally took her to the medical department.[65]

The Jail records and inmate responses to Plaintiffs' counsel provide an abundant bank of similar tales. Clearly, there is a reasonable conclusion to be drawn that this practice of the Jail -- leaving infectious inmates in intimate contact with healthy inmates and not responding promptly to complaints of infections -- caused the healthy inmates to become infected and caused the spread of MRSA in the inmate population generally.

B. The Jail failed in its duty to educate inmates about proper hygiene.

The Hardin County jail's "MRSA Protocol" says: "INMATES TO BE INSTRUCTED IN IMPORTANCE OF PROPER HYGIENE AND NEED FOR FREQUENT HAND WASHING."[66]

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[62] *Id.*

[63] Dep. of Annette Borges 73-78, attached as Exhibit V.

[64] Dep. of Jolene Hazelwood 98-99, attached as Exhibit W.

[65] Borges dep. 65-67 (Exhibit V).

[66] *See* Exhibit J, *supra* note 30.

The state Department of Corrections' Health Care Services Protocol says: "Correctional staff and inmates should be periodically provided education on the importance of hand hygiene and effective hand hygiene techniques."[67]

It is abundantly clear from discovery in this case that the Jail's efforts to communicate with inmates about MRSA were woefully deficient. In his deposition, Jailer Lawson said he knew of only one effort by Jail staff over two and a half years to speak with inmates about proper hygiene to curb MRSA. In that instance, Lawson said that he asked a Jail medical staff member to speak directly to inmates about hygiene once in either the summer of 2004, or perhaps as late as September or October of 2004.[68] Asked if anyone had spoken to inmates about the importance of hygiene since then, Lawson said, "This new stuff, I don't know about that."[69] And he exhibited a breathtaking lack of awareness of educational measures by his own staff. He said he did not know what that employee told inmates in September or October of 2004:[70] he did not know whether inmates were given any other information beyond that;[71] he did not know what written information was provided them;[72] and in fact said he had no policies in place in the Jail concerning inmate education on infection control, nor were there any policies concerning what inmates should be told.[73] There was no inmate

[67] Exhibit K, *supra* note 31, at 3.

[68] Lawson dep. 130, attached as Exhibit S.

[69] *Id* (Exhibit S).

[70] *Id.* at 130-132. (Exhibit S).

[71] *Id.* at 131 (Exhibit S).

[72] *Id.*at 132 (Exhibit S).

[73] *Id.* at 249 (Exhibit S).

education beyond what they might be told by the medical staff, Lawson said, and he said he did not know what in fact inmates are told by the medical staff.[74]

When asked again whether inmates are told orally or in writing about good hygienic practices, Lawson asserted that "we encourage good personal hygienes." Asked how the Jail does that, he said, "Just tell them to bathe regular." Asked if they are told anything other than that, he replied in the negative.[75]

Plaintiff Martel Chapman said in her deposition that when she was finally placed in isolation following her diagnosis of MRSA infection, she was not regularly given an opportunity to shower. She said: "When I was in lockdown cell, they didn't give me no gauze, no tape, no soap. I mean I went -- I remember specifically one time that I was in lockdown three days with no shower.[76] … and if you have an infectious disease that spread it, you have to keep good hygiene. How can you keep good hygiene if they don't let you have a shower?"[77]

The responses of the 42 infected individuals surveyed by Plaintiffs' attorneys show that even as the Jail was in the throes of an outbreak of MRSA, but before the onset of their symptoms, 36 of the respondents said they were told nothing about the advisability of hand washing; 31 said they were told nothing about the need to change sheets and towels; 39 said they were not told to change their clothes daily; 41 said they were told nothing about covering their noses and mouths; 37 said they were told nothing about the need to bathe or shower daily; 36 said they were told nothing about the hazards of sharing towels or razors; 39 said they were told nothing about the need to report

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[74] *Id* (Exhibit S)..

[75] *Id.* at 271 (Exhibit S).

[76] *See also* 501 KAR 3:080 Section 1(1)(13), JAIL STANDARDS FOR FULL SERVICE FACILITIES; SANITATION; HYGIENE: "Prisoners shall be permitted to shower daily."

[77] Chapman dep. 54, attached as Exhibit T.

apparent symptoms; 40 said they were told nothing about the dangers of touching sores or wounds; and 41 said they were told nothing about the need to clean recreation and exercise equipment after use.[78]

Later, once they developed and reported symptoms but before they had been diagnosed with MRSA, 25 of the 42 responding inmates said, Jail medical and corrections staff minimized their symptoms by telling the infected individuals that their symptoms were simply spider bites, boils, or infected or ingrown hairs.[79]

Then, after having been diagnosed with MRSA, the respondents said, the Jail's cautionary conduct on those points improved only somewhat. Of the 42 respondents, 15 reported still having been given no advice on hand washing; 20 reported still having received no advice on the need to change sheets and towels; 24 said they still were told nothing about the need to change clothes daily; 31 said they still were told nothing about the need to cover their noses and mouths; 19 reported still having received on advice on the need to bathe or shower; 21 said they still were told nothing about the need to avoid sharing towels and razors; 19 said they still were not advised of the need to report symptoms; and 32 said they still were told nothing about the need to clean exercise or recreation equipment after use.[80]

One inmate, Tina Spears, said in a deposition that discussion of MRSA was so minimal that she was given the assignment of cleaning isolation cells "unaware that there were people in there with staph infection."[81] Spears said her MRSA infection has affected her profoundly, and discussed that effect in her deposition. "For the rest of my life I'll worry about being sick," she said.[82]

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[78] See Exhibit C, *supra* note 19.

[79] *Id.*

[80] *Id.*

[81] Tina Spears Dep. 33, Attached as Exhibit U.

Once an outbreak occurs among jail *employees*, one might expect a jail manager to inquire into the exact place or means within the jail that the infection was being transferred to jail staff, in order to better educate staff members about workplace dangers. Lawson said during his deposition on May 29, 2007 that "probably three or four" of his employees had acquired MRSA.[83] Asked if the Jail conducted an investigation to see if or how the workers might have acquired it at work, Lawson said it had not, and explained, apparently referring to one of the employee-victims: "He could have caught it at work. He could have caught it at any place he was."[84] In other words, the depth of Lawson's knowledge about the extent of MRSA education given to inmates is matched by his curiosity about how and where his employees contracted the same infection.

C. The Jail failed in its duty to provide clean clothes, linen and living quarters.

The Hardin County Jail's "MRSA Protocol" says: "ISOLATED INMATES TO RECEIVE CLEAN UNIFORMS AND LINENS DAILY. … INMATES LIVING AREA TO BE CLEANED THOROUGHLY EACH WEEK WITH DISINFECTANT. DAILY WIPE-DOWNS OF TABLES, SINK, COMMODE."[85] The Department of Corrections' "Health Care Services Protocol" addresses the same issues: "Inmate housing areas and bathroom facilities should be regularly cleaned with a detergent disinfectant according to the manufacturer's instructions. … Correctional staff should conduct sanitation inspections of living and bathroom areas to identify visibly dirty areas. Specific attention should be focused on the cells of inmates with cognitive impairments or mental illnesses who are more likely to have poor personal hygiene." The state Corrections document also said that

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[82] *Id.* at 86-88 (Exhibit U).

[83] Lawson dep. 295, attached as Exhibit S.

[84] *Id*. at 296 (Exhibit S).

[85] Exhibit J, *supra* note 30.

"all shared laundry, including sheets, blankets and issued clothing should be collected and bagged at the bedside, washed regularly with a detergent using a hot water cycle for at least 25 minutes and then thoroughly air dried."[86]

Jailer Lawson said during his deposition that cells are cleaned after each meal by the inmates in each cell, who are given bottles with a disinfectant spray, a mop, a bucket, and other supplies, and not supervised during their cleaning work.[87] In addition, "at periodic times" that are "pretty regular," showers and bath areas are sprayed with "a special spray … to kill germs."[88] A cell where an inmate diagnosed with MRSA had last resided is cleaned immediately, and all living areas are thoroughly cleaned once a month, he said.[89] Likewise, uniforms and bed linens are cleaned "on a routine schedule."[90]

Inmate accounts, however, show that the Jail failed to provide clean clothing, linen or living space as required by the Jail's own protocol. In the survey responses from 42 infected inmates to Plaintiffs' attorneys, only one inmate reported having received a daily change of clothes, and none reported receiving a change of sheets daily. Only one reported receiving clean towels daily, and only 10 reported daily cleanings of their cells.[91]

Inmate Tina Spears said in her deposition that she did not receive a clean towel, washcloth and uniform daily as her hospital discharge instructions had called for, and was not supplied

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[86] Exhibit K, *supra* note 31, at 3-4.

[87] Lawson dep. 86-87, attached as Exhibit S.

[88] *Id.* at 188 (Exhibit S).

[89] *Id.* at 157-60 (Exhibit S).

[90] *Id*. at 80 (Exhibit S).

[91] Exhibit C, *supra* note 19.

materials to change her wound's dressing daily.[92] She also asserted that in the six and a half months she was in the Jail, her cell was cleaned and the walls sprayed down with bleach twice, not monthly.[93]

Jailer Lawson also said during his deposition that he had never heard of a recommendation that sports equipment, such as weight lifting equipment, be wiped down after every use, and he said he did not know whether inmates wipe down his jail's weight bench after using it.[94] It appears therefore that if Lawson read the Department of Corrections' "Health Care Services Protocol" sent to him in September 2004, he did not retain what it says on page 4: "Recreational equipment, such as weight benches, should routinely be wiped clean after use with a clean dry towel. Inmates should be instructed to use readily available barriers to bare skin, such as a towel or clean shirt, while using exercise equipment."[95]

D. The Jail failed to provide inmates diagnosed with MRSA with a plan for follow-up care after release, causing their families and the community to suffer.

After inmate Annete Borges was discharged from the Hardin County Detention Center on Dec. 13, 2005 -- carrying MRSA -- a relative noticed the spots on Borges's skin, for which she had taken an antibiotic while in the Jail a week before.[96] As Borges related it in her deposition, her relative was concerned because the relative's son had had eye surgery and was in vulnerable health.

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[92] Tina Spears dep. 47, attached as Exhibit U.

[93] *Id.* at 88 (Exhibit U).

[94] Lawson dep. 192-93, attached as Exhibit S.

[95] Exhibit K, *supra* note 31, at 4.

[96] Borges dep. 112, attached as Exhibit V.

The relative urged her to go to Hardin Memorial Hospital to be checked for an active MRSA infection.[97]

The relative's son soon was diagnosed himself with a MRSA infection, and in her deposition Borges indicated that the bacterial infection she acquired while in the Jail may have found its way through her to the relative's son.[98] It is significant to note that the follow-up medical attention Borges sought was at the urging of her relative and not under any follow-up plan provided her by the Hardin County Jail.

The importance of providing follow-up instruction for inmates with an infectious disease was before the U.S. District Court for the Northern District of Georgia in 2002, when it dealt with, among other things, the question of appropriate discharge planning for inmates who had tested positive for the human immunodeficiency virus (HIV). *See Foster v. Fulton County, Ga.,* 223 F.Supp 2d 1292 (N.D. Ga. 2002). The HIV-positive inmates had filed suit alleging that conditions and medical care in a jail were inadequate, and a Settlement Agreement two years earlier between the jail and the inmate had said:

> "Prior to discharge from the jail to the community, all HIV-positive inmates shall have an appropriate discharge plan. A post-discharge appointment with an appropriate HIV medical care provider in the community shall be scheduled for every HIV-positive inmate, and each inmate shall be informed upon discharge of the date, time, and location of that appointment."

Foster, 223 F.Supp. 2d at 1298.

The Court in *Foster* ordered the defendant county, two years after the agreement, to, among other things, implement a plan to put the unrealized discharge planning provision into effect. *Id.* Courts also have recognized the importance of discharge planning for mentally ill inmates. *See Brad H. v. City of New York,* 712 N.Y.S.2d 336 (N.Y. 2000).

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[97] *Id* (Exhibit V).

[98] *Id.* at 115 (Exhibit V).

With MRSA-positive inmates, as with HIV-positive inmates, the potential for both losing control of an individual's treatment and for infecting others stands as a potential by-product of inadequate medical attention once the inmate leaves the jail setting. The role of jails as incubators of MRSA has been recognized by medical researchers and inmates such as Borges believe they have provided pathways for that very thing: the spread of the disease.

Another such inmate illustrating that phenomenon is Plaintiff David Stallins. He said in his deposition in this case that two of his relatives acquired MRSA following his release from jail.[99]

V. Defendants' Conduct Has Imperiled The Health Of The Surrounding Community.

A. Defendants have grossly underestimated the extent of the MRSA problem in the Hardin County Jail.

In his deposition, Jailer Lawson understated the extent of MRSA infections in the Hardin County Jail, and he misstated the Jail's responsibility for the spread of those infections. Lawson's repeated mischaracterizations of fact suggest strongly that he and the Jail staff -- even now, some three years into this outbreak within their facility -- still have not come to terms with the depth of the problem they have on their hands. This in turn underscores the need for the Court to certify the class and assume a broad role in the ultimate answer to this public health crisis.

The Hardin County Jail's own records provided to the Plaintiffs in this litigation may not be all the records relevant to the issue -- Plaintiffs' attorneys' investigation thus far in this case leads them to believe that there are more MRSA victims of the Hardin Jail than the 80 so far identified[100] -- but the Jail records are easily sufficient to build a picture of an institutional epidemic.[101]

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[99] David Stallins dep. 46-49, attached as Exhibit X.

[100] Attached as Exhibit O, "Inmate Reference List of 82 Inmates Diagnosed With MRSA Infections."

[101] Defendants' production of records in this case has been spotty. For example, on July 13, 2006, Magistrate Judge Whalin entered an order instructing Defendants to provide to Plaintiffs within 30 days "the inmate files and medical files in their possession that concern persons diagnosed with methicillin-resistant Staphylococcus aureus (MRSA) while incarcerated at the Hardin County Detention Center" between Aug. 1,

That picture, viewed from a broad perspective, provides a wide-angle view of the spread of MRSA infections in the Jail since 2004 -- and it illustrates what, in effect, has been a steady drumbeat of MRSA diagnoses at least since mid-2005 among Jail inmates. Those records also show that the infections struck more widely among the Jail's population than Lawson acknowledged in his deposition.

Viewed from a narrower perspective, these records also provide snapshots of single moments in time inside the Jail. Those snapshots show, among other things, that the percentage of inmates with MRSA diagnoses in the Hardin County Detention Center at specific times was significantly greater than Lawson described in his deposition in this case. One such time was Aug. 30, 2006. On that day, *the incidence of MRSA in the Jail was four times greater than Lawson acknowledged.*

B. Defendant Lawson has drastically underestimated the scope of the MRSA problem at the Jail.

Defendant Lawson testified repeatedly in his deposition that the percentage of inmates *diagnosed* with MRSA in the Jail has remained at one percent of the Jail population or less. For example, there was this exchange between Plaintiffs' counsel and Lawson:

> **Q. Let me make sure I understand. Of the total jail population -- of all the people you've ever had in the jail, only one percent have been diagnosed with MRSA while at the jail?**
>
> **A. That's correct.**[102]

Elaborating on the same point later during the same examination, Lawson appears to assert that state statutes or regulations require the Jail to report to health authorities only a MRSA outbreak

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2004 and June 30, 2006. Defendants have continued to provide Plaintiffs with records of inmates diagnosed through January 2007. In total, Defendants have provided Plaintiffs with medical records of 79 inmates who tested positive for MRSA and whose records Defendants had not specifically requested. However, Defendants learned of other at least four other MRSA cases independently, mainly through other inmates. For example, inmate No. 3 on Exhibit N, *supra* note 51, was diagnosed on Aug. 19, 2005, but his records were not provided to Plaintiffs in Defendants' initial response in March 2006; counsel for Plaintiffs learned about him from another inmate and requested his records specifically.

[102] Lawson dep. 74, attached as Exhibit S.

reaching three percent of the Jail's population, the level at which he said an outbreak is considered "epidemic." Lawson said that the Jail filed no such reports with health authorities because the Jail's incidence of MRSA had always remained at or below one percent. In that exchange, Lawson also asserted that the Jail had not seen "an outbreak or an epidemic" of the infection. He said:

> **" … by our understanding through the Cabinet of Health and Family Services, that once you get MRSA, you establish a percentage of one percent, and we did that. If you went to three percent, then you would have to report it, because it's covered by K.S.R (sic) on that.**
>
> **" … as long as you stay at that level and it's not an epidemic until it goes to about three percent. Then it becomes an epidemic. We have never grown from the one percent.**
>
> **"… An epidemic would be if we've reached the three percent, and we've never reached that. I don't think we've had an outbreak or an epidemic. I think we've had the individual cases that's came in from the street."**[103]

During the concluding portion of his deposition on May 29, Lawson repeated his assertion that for purposes of determining whether the Jail had what would be, in his understanding of the law, a reportable outbreak of MRSA, the Jail considered all inmates who had been *diagnosed* with MRSA. The Jail, he agreed in response to a question, did the math this way: It divided the total number of people in the Jail on a particular day who had been diagnosed with MRSA infections by the total number of people in the Jail that day.[104] The infected inmates included in the first number, Lawson said, could be found "throughout the jail. They could be in isolation. They could have had MRSA but it's not draining any more and they've got a bandage on it and the doctor said put them back in living quarters."[105]

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[103] *Id.* at 124-25 (Exhibit S).

[104] *Id.* at 283 (Exhibit S).

[105] *Id*. (Exhibit S).

Back to August 30, 2006. The Jail that day held 479 inmates, according to the Hardin County Detention Center's Inmate Population Analysis for August, 2006.[106] Among those inmates in the Jail that day, according to the Jail's records provided to Plaintiffs, were at least 19 people who had been diagnosed with MRSA.[107] That group scattered throughout the facility made up *3.96 %* of the Jail's population that day -- well above the 3 percent "reportable" level for diagnosed inmates that Lawson described during his deposition.

To say that the Jail had 1 percent or less of its population with MRSA infections is to significantly minimize -- and to flatly mischaracterize -- a situation in which, in reality, at least 19 inmates throughout the Jail went to bed on Aug. 30, 2006 having been treated in the jail for MRSA infection.

Other snapshots in time would yield similar images. For example, according to the records provided by the Jail, on August 30, 2005, the same day one year earlier, there were 15 inmates sleeping, eating, showering and exercising in the jail who had been treated for MRSA infections.

Defendants' records show diagnoses of MRSA infections were confirmed among jail inmates during every single month between June 2005 and January 2007. In other words, there was a steady stream of diagnoses every month for 20 straight months -- a time period during which, in Jailer Lawson's evident assessment, the Jail was not experiencing an outbreak or reportable incidence of the disease.

Overall, more than 80 inmates have undergone such diagnosis and treatment in the past three years, according to the Jail's records made available to Plaintiffs to date.[108]

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[106] Attached as Exhibit P, "Hardin County Detention Center's Inmate Population Analysis for August, 2006."

[107] *See* Exhibit N, *supra*, note 51.

[108] Exhibit O, *supra* note 100.

It is inarguable that the occurrence of scores of cases of the same communicable disease in one jail in a 29-month period constitutes an "outbreak" in the view of national corrections and health officials. The Clinical Practice Guidelines of the Federal Bureau of Prisons defines a MRSA outbreak as "a clustering of two or more epidemiologically-related, culture-positive cases of MRSA infection."[109] The guidelines go on to say that evidence that an outbreak is caused by the same organism is found if there are "similar isolate antibiotic susceptibilities and further supported if molecular analysis … identifies a predominant MRSA strain."[110] The study of the task force in Omaha, Nebraska, *supra* note 2, in defining the word "outbreak," said: "The common definition of a MRSA epidemic is: 1) several (e.g. three or more nosocomially-acquired) cases which are epidemiologically associated by person, time or place, or 2) a substantial increase in number of cases in a facility endemic for MRSA."[111]

Clearly, Jailer Lawson has a wholly inadequate grasp of the extent of the problem in his jail. The fact that he does not understand it -- at this late date in this complicated and prolonged outbreak -- adds further urgency to the need for this Court to certify the class.

Even in its responses to this litigation, the Jail has been slow to recognize the facts of the case. In Defendants' Conference Statement filed Nov. 23, 2005, the Defendants said: "Defendants are only aware of a handful of persons that were diagnosed with MRSA while incarcerated at the Hardin County Detention Center."[112] Subsequently, after review of the Jail's own records, four months later, on March 21, 2006, Defendants produced a list of 32 inmates that the Defendants said

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[109] FEDERAL BUREAU OF PRISONS CLINICAL PRACTICE GUIDELINES, MANAGEMENT OF METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS (MRSA) INFECTIONS*, *supra* note 7, 21.

[110] *Id.*

[111] MRSA TASK FORCE OF THE GREATER OMAHA CHAPTER OF THE ASSOCIATION FOR PROFESSIONALS IN INFECTION CONTRON & EPIDEMIOLOGY, INC.,*supra* note 2, at 4.

[112] Defendants' Conference Statement, p. 2.

represented "every inmate diagnosed with MRSA while incarcerated at the Hardin County Jail from August, 2004 through December 31, 2005."[113] However, Plaintiffs now believe that, at a bare minimum, 35 were diagnosed during that time period. Plaintiffs later learned of at least three more inmates diagnosed in 2005 who were not on the Jail's list, but for whom the Jail eventually found and produced records. Those three inmates appear on Exhibit E as inmates Nos. 3, 23 and 24. Similarly, the Jail, acting on its own initiative, provided Plaintiffs with records of 79 diagnosed imates; Plaintiffs' running count of diagnoses since September, 2004 stands at 83 inmates.

In sum, through the records provided and the assertions of Defendant Lawson, the Jail has consistently understated the extent of the problem.

C. Records contradict Lawson's claim that the Jail did not have an "outbreak" and that cases instead "came in from the street."

When Jailer Lawson said in his deposition that "I don't think we've had an outbreak or an epidemic," but instead "I think we've had the individual cases that's came in from the street,"[114] the clear implication was that the principal source of MRSA infection in the Jail was something other than transmission of bacteria between inmates. Indeed, Lawson said in his deposition that he was unaware of any instance in which the Jail medical staff determined that the Jail was the source of an inmate's MRSA infection.[115] The medical files of inmates, however, strongly indicate that the vast majority of MRSA infections diagnosed in the Jail were acquired in the Jail and not brought "in from the street."

The incubation period for MRSA infections is typically described in medical literature as variable, but commonly four to 10 days passes from initial infection with MRSA to the onset of

[113] Supplemental Answer to First Set of Written Discovery by Louis B. Lawson Hardin County, p.1 and Exhibit A to that document.

[114] Lawson dep. 125, attached as Exhibit S.

[115] *Id.* at 195 (Exhibit S).

symptoms.[116] Accordingly, if an inmate has no prior record of MRSA symptoms, and then begins to exhibit such symptoms after being in the Jail 10 days or more, it is probable that she acquired the infection while incarcerated in the Jail.[117] Jail medical records show that once a culture is taken -- either of a draining sore or of matter expressed from a sore -- and submitted to Hardin Memorial Hospital's laboratory, a final lab analysis is almost always available roughly 48 hours after the taking.

Defendants have provided Plaintiffs with medical records of more than 80 inmates who have been treated for MRSA infections while in the Jail since September, 2004. In several of those cases, it was not possible to tell from the records how much time elapsed between the time the inmate entered the Jail and the date of diagnosis with MRSA infection. Of the 77 cases in which that time period could be determined, the breakdown as tabulated by Plaintiffs' counsel is as follows:

- 19 inmates, or 24.6 percent of the group for whom the time span could be determined, were diagnosed *during* their first month in the Jail.

- 58 inmates, or 75.3 percent, were diagnosed *after* their first month in the Jail.

- 32 inmates, or 41.5 percent, were diagnosed after *three months* or more in the Jail.

- Four inmates were diagnosed with MRSA after having been in the Jail for *a year* or more.

Of the 42 people who responded to Plaintiffs' questionnaire, 39 reported that they had had no MRSA-like symptoms prior to entering the Jail. Of the 40 people who answered the question of how long they were in the Jail before they began exhibiting the symptoms that ultimately resulted in a diagnosis of MRSA infection, 31 said they had been in the Jail one month or more before the onset

[116] *See*, *e.g.*, PUBLIC HEALTH AGENCY OF CANADA, MATERIAL SAFETY DATA SHEET -- INFECTIOUS SUBSTANCES, STAPHYLOCOCCUS AUREUS, Section II, at http://www.phac-aspc.gc.ca/msds-ftss/msds143e.html (last visited July 29, 2007).

[117] Opinion of Dr. John Clark, attached as Exhibit Q.

of symptoms. That represents 77.5 percent of those responding, a percentage that is virtually identical to the 75.3 percent (58 of 77) shown in Jail records to have been diagnosed after a month or more in the Jail.

Therefore, both the Jail's records and Plaintiffs' survey of inmates agree in this important respect -- they strongly indicate that a large majority of inmates experienced the onset of symptoms after more than a month in the Jail. That is a time period well beyond the common four-to-10-day incubation period for MRSA infections. And that, in turn, leads to a logical conclusion that a large majority of infected Hardin County inmates were infected while in the Hardin County Jail. As inmates in most cases rarely leave the Jail premises during their incarceration, the strong inference to be drawn is that inmate MRSA infections diagnosed in the Jail are acquired in the Jail in at least three cases out of four.

D. The Hardin County Jail failed in its community responsibility and its legal duty to recognize the MRSA outbreak and to report it to state authorities.

The Jail's duty to report infectious diseases is clearly established by a Kentucky administrative regulation. The regulation, 501 KAR 3:020 § 4(3), applies to all county jails in Kentucky that house state inmates, a group that includes the Hardin County Jail. The regulation says: "A telephonic report to the Department of Corrections shall be made of all extraordinary or unusual occurrences within twenty-four (24) hours of the occurrence, and a final written report shall be made within forty-eight (48) hours. This report shall be placed in the jail record. Extraordinary or unusual occurrences shall include, but shall not be limited to: ….. (i) Occurrence of contagious or infectious disease, or illness within the facility."

In his deposition on April 23, 2007, Jailer Lawson said that the Jail did not send reports of its MRSA cases to the state Department of Corrections[118] or the Hardin County Health Department,[119]

[118] Lawson dep. 152, attached as Exhibit S.

and it did not report the occurrence of infectious disease in monthly reports to Hardin County Fiscal Court.[120]

Plaintiffs made a request under the Kentucky Open Records Act for all reports of extraordinary or unusual occurrences filed by the Hardin County Jail with the Division of Local Facilities within the state Department of Corrections since 2004. In its response, the Division produced no records of telephonic or written reports to the Division from the Hardin jail concerning MRSA.

The most logical interpretation of the Jail's failure to follow the requirements of state regulations on the reporting of disease is that Defendants have simply been deliberately indifferent to the MRSA problem. After Lawson said during his deposition on April 23, 2007 that the Jail would report any *single occurrence* of venereal disease or tuberculosis to the Health Department,[121] he was asked if the Jail would report to the department any *other* infectious diseases:

> **A. Not unless they reached an epidemic.**
>
> **Q. Okay. And again, that's the three percent figure?**
>
> **A. Well, depends on -- depends on what it would be. You know, if it was *something that was real serious*, that would be something that would be discussed with the doctor and medical staff, and we'd look at it and see where we were on it at that -- *I can't think of any other diseases that were out there that we're not thinking of* that would be."**[122] *(Emphasis added.)*

Consider: Plaintiffs have already shown that the incidence of MRSA in the Jail at times approached four percent, well in excess of Lawson's alleged three percent reporting requirement.

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[119] *Id.* at 149-151 (Exhibit S).

[120] *Id.* at 25 (Exhibit S).

[121] *Id.* at 149-151 (Exhibit S).

[122] *Id.* at 151 (Exhibit S).

Now, Jailer Lawson is testifying that a disease would be reportable to the Health Department at *less* than the three percent standard if it is an illness the Jail considers to be "real serious."

* * * * * * * * * *

The facts above speak loudly: The Hardin County Detention Center has exhibited an abominable lack of regard for the inmates under its charge and the community in which it operates.

The 80-plus inmates identified by the Defendants and discussed in this Memorandum may well be only a small portion of the people who have acquired MRSA in the Hardin County Detention Center. As described in this Memorandum, the Plaintiffs identified at least four more inmates who acquired staph infections in the Hardin County Detention Center but whose names had not been supplied by Defendants -- including four not included in the original discovery response of March 21, 2006 listing 32 inmates diagnosed with MRSA while in the Hardin County Jail between August 1, 2004 and December 31, 2005. In addition, it is reasonable to assume that more inmates acquired the infection in the Jail but did not experience onset of symptoms until after their release, and therefore were not diagnosed while in the Jail. Neither Defendants nor the Plaintiffs would have any certain way of learning about such individuals.

Certification of this action as a class action is necessary in order to provide notice to and locate all such individuals, to determine the actual scope of the MRSA problem throughout the Jail and the Hardin County community, and to establish, implement and consistently enforce a single standard of conduct for the Hardin County jail. The Plaintiffs respectfully ask this Court to certify this action as a class action.

LEGAL ARGUMENT

I. **The Utility And Standard For Class Actions In General.**

The Reporter for the 1966 Amendments to the Federal Rules of Civil Procedure recognized the value of the class action mechanism in protecting "small claims held by small people -- who for one reason or another, ignorance, timidity, unfamiliarity with business or legal matters, will simply not take the affirmative step." Kaplan, *Continuing Work of the Civil Committee: 1966 Amendments of the Federal Rules of Civil Procedure*, 81 Harv.L.Rev. 356, 397-398 (1967).

In *Phillips Petroleum v. Shutts*, 472 U.S. 797 (1985), the United States Supreme Court, citing Professor Kaplan's commentary, also recognized the value of a class action to a "plaintiff so unfamiliar with the law, that he would not file suit individually, nor [even] affirmatively request inclusion in the class. . . ." 472 U.S. at 812-813. The class action is an "effective weapon for an across-the-board attack against systemic abuse." *Jones v. Diamond*, 519 F.2d 1090, 1100 (5th Cir. 1975).

At the class certification stage, the Court is required to assume that the substantive allegations of the Complaint are true. *Pecere v. Empire Blue Cross and Blue Shield,* 194 F.R.D. 66 (E.D.N.Y. 2000) (citing *Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 178 (1974)); *Davis v. Avco Corp.*, 371 F.Supp. 782, 790 (N.D. Ohio 1974)).[123] "However, a court may consider material outside the pleadings in determining the appropriateness of class certification," *Hirschfeld v. Stone*, 193 F.R.D. 175, 182 (S.D.N.Y. 2000), and Plaintiffs in this case have provided the Court far more than just the allegations of their complaint to justify class certification. Even in an uncertain case (which this is not), "any error, if there is to be one, should be committed in favor of *allowing the class action*." *Davis, supra* at 791 (emphasis added); *Kahan v. Rosentiel,* 424 F.2d 161, 169 (3d Cir.

[123] *See also In re Catfish Antitrust Litig.,* 826 F. Supp 1019 (N.D. Miss. 1993) ("the invitation to pre-try the case through the vehicle of this (class certification) motion must be respectfully declined…rather, the court's focus on a class certification motion is strictly on the requirements articulated in Rule 23").

1970), *cert. denied,* 398 U.S. 950 (1970); *Esplin v. Hirschi*, 402 F.2d 94, 101 (10th Cir. 1968), *cert. denied*, 394 U.S. 928 (1969); 7B *Wright, Miller & Kane, Federal Practice and Procedure* (1986), § 1785 at 199.

"In determining the propriety of a class action, the question is not whether the plaintiff or plaintiffs have stated a cause of action or will prevail on the merits, but whether the requirements of Rule 23 are met." *Eisen, supra* at 178 (quoting *Miller v. Mackey Int'l*, 452 F.2d 424, 427 (5th Cir. 1971)). Thus,

> a court must avoid "minitrials," and any factual determination in the Rule 23 ruling would only be for the purpose of class certification and would not be binding on the trier of fact.

Practicing Law Institute, *Recent Developments in Class Action Law,* 1590 PLI/Corp 85, 91 (March-May 2007).

"If the general outlines of the membership of the class are determinable at the outset of the litigation, a class will be deemed to exist." Wright, Miller & Kane*, Federal Practice and Procedure* (3d) Chapter 5 § 1760, 7AA FPP 1760 (2007) (footnote omitted). In the instant case, the general outlines of the membership of the class are determinable. The proposed class represents inmates, both men and women, who contracted MRSA at the Hardin County Jail sometime from one year preceding the filing of the Complaint to the present, and those who are or will be inmates of the Jail. Class members are readily identifiable, with reasonable effort, for the given time period and their names and addresses are ascertainable through Hardin County Jail records.

II. Class Action Certification Is Both Proper And Superior In The Instant Case.

"Rule 23 of the Federal Rules of Civil Procedure outlines a two-step process for determining whether class certification is appropriate." *Thomas v. Baca*, 231 F.R.D. 397, 399 (C.D. Cal. 2005). First, all four of the prerequisites set forth in Rule 23(a) must be satisfied. *Id.* Second, with the Rule

23(a) prerequisites satisfied, "the party seeking class certification must also demonstrate that the action falls within one of the three kinds of actions permitted under Rule 23(b)." *Id.*

A. Plaintiffs have met the class action prerequisites enumerated in Rule 23(a).

In order to justify class certification, the Federal Rules of Civil Procedure Rule 23(a) require Plaintiffs to show that they meet each of the following four prerequisites:

> One or more members of a class action may sue or be sued as representative parties on behalf of all only if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed.R.Civ.P 23(a). "These four requirements are often referred to as numerosity, commonality, typicality, and adequacy." *Thomas*, *supra* at 399.

1. The class is so numerous that joinder of all members is impracticable.

When class size reaches substantial proportions, the impracticability requirement is usually satisfied by the numbers alone. *In re American Medical Systems, Inc.,* 75 F.3d 1069, 1079 (6th Cir. 1996). Moreover, the number of class members who actually come forward is not determinative of the numerosity issue. *Bremiller v. Cleveland Psychiatric Inst.,* 195 F.R.D. 1, 20 (N.D. Ohio 2000). “Satisfaction of the numerosity requirement does not require that joinder is impossible, but only that plaintiff will suffer a strong litigational hardship or inconvenience if joinder is required.” *Boggs v. Divested Atomic Corp.,* 141 F.R.D. 58, 63 (S.D. Ohio 1991).

Classes have ranged in size from just 4 members, as in *Swanson v. American Consumer Industries, Inc.*, 415 F.2d 1326, 1333 (7th Cir. 1969), to the 23 plaintiffs in *Basile v. Merrill Lynch, Pierce, Fenner & Smith, Inc.,* 105 F.R.D. 506, 507 (S.D. Ohio 1985), to the 1.6 million plaintiffs in *Dukes v. WalMart Stores, Inc.*, No. C01-2252 (N.D. Cal. 6/22/04). Generally speaking, however, courts have presumed that numerosity exists with proposed classes consisting of at least 40

members. *Allen, supra* at 406; *Consolidated Rail Corp. v. Town of Hyde Park*, 47 F.3d 473, 483 (2d Cir. 1993); *Cox v. American Cast Iron Pipe Co.*, 784 F.2d 1546, 1553 (11th Cir.), *cert. denied*, 479 U.S. 883 (1986).

Furthermore, it is not required that a class representative state the exact number of class members or identify each class member, as "a judge may consider reasonable inferences drawn from facts before him at that stage of the proceedings. . . ." *Senter v. General Motors Corp.*, 532 F.2d 511 (6th Cir. 1975); *Kifafi v. Hilton Hotels Retirement Plan*, 189 F.R.D. 174, 176 (D.D.C. 1999); *Pigford v. Glickman*, 182 F.R.D. 341, 347 (D.D.C. 1998); *Glover v. Johnson*, 85 F.R.D. 1 (E.D. Mich. 1977). Given the presently known facts, the membership of both proposed classes *significantly* exceeds 40. Defendants have already identified more than 80 persons who were diagnosed with MRSA while incarcerated at the Jail, and more -- perhaps significantly more -- likely exist. In addition, Plaintiffs seek certification of a class of persons incarcerated now or in the future at the Jail, a facility with a daily inmate population of over 400 souls. Once this case is certified as a class action and potential claimants receive notice, a substantial number of new MRSA claimants are likely to come forward. In *Dean v. Coughlin*, the proposed class consisted of 500 inmates of a correctional facility. 107 F.R.D. 331, 332. The *Dean* court observed that

> in this case, as in many civil rights cases, the members of the class are 'incapable of specific enumeration.' The **fluid composition of a prison population is particularly well-suited for class status**, **because**, although the identity of the individuals involved may change, **the nature of the wrong and the basic parameters of the group affected remain constant.**

Id. (emphasis added). As in *Hirschfeld*, "[t]he fluid nature of the class further supports th[e] Court's finding that joinder is impracticable." *Hirschfeld*, *supra* at 182. As aforementioned, class members are sufficiently definite for class certification. Unquestionably, Plaintiffs have satisfied the numerosity requirement of Rule 23(a)(1).

2. There are questions of both law and fact common to the class.

Rule 23(a)(2) requires that questions of law or fact common to the class be present, and that the resolution of common questions affect all or a substantial number of the class members. *Califano v. Yamasaki,* 442 U.S. 682, 701 (1979); *In re American Med. Systems*, *supra* at 1080. Further, peripheral or secondary individual member questions do not destroy class certification. "The mere fact that questions peculiar to each individual member of the class remain after the common questions of the defendant's liability have been resolved does not dictate the conclusion that a class action is impermissible." *Sterling v. Veisicol Chem. Corp.*, 855 F.2d 1188, 1197 (6th Cir. 1988). "It is to be expected that there will be some factual differences between individual plaintiffs; moreover, the commonality requirement may be met if the common questions go to liability despite individual differences in damages." *Bremiller*, *supra* at 20.

In addition, it is not necessary that every issue of law or fact be common to each class member, only that "a single aspect or feature of the claim is common to all proposed class members." *Bynum v. District of Columbia,* 214 F.R.D. 27, 33 (D.D.C. 2003) (citations omitted). A common question has been defined as "one which arises from a 'nucleus of operative facts,' regardless of whether 'the underlying facts fluctuate over a class period and vary as to individual claimants.'" *Meyer v. Citizens & Southern Nat'l Bank*, 106 F.R.D. 356, 360 (M.D. Ga 1985) (citations omitted).

Although only a *single* aspect or feature of the claim must be common to all proposed class members, there are multiple features of the immediate claim that is shared by all proposed class members. There is overwhelming overlap in the questions of both law and fact presented in this case. The common questions raised by Plaintiffs' claims include, but are not limited to: (a) whether the Jail failed to properly screen, isolate, educate, or treat its inmates in violation of the very policies

the Jail had adopted to protect inmates from MRSA; (b) whether the MRSA problem at the Jail was caused or contributed to by overcrowding, understaffing, underfunding, or a lack of training, education or supervision of the Jail's employees; (c) whether the Jail has experienced incidence of MRSA sufficient to warrant reporting to state correctional and local and state public health authorities; (d) whether the Jail has experienced a MRSA "outbreak" sufficient to warrant an outbreak investigation to determine the source of the MRSA infection and means of transmission; (e) whether the MRSA problem at the Jail reached "epidemic" proportions warranting quarantine of the facility; (f) whether injunctive relief is necessary to protect current and future inmates at the Jail, and the Hardin County community; and (g) whether Defendants are liable for the actual damages sustained by infected inmates.

"[C]ommonality is satisfied where [a] . . . lawsuit challenges a system-wide practice or policy that affects all of the putative class members." *Armstrong v. Davis*, 275 F.3d 849, 868 (9th Cir. 2001). More generally, Plaintiffs believe that most, if not all, of the abuses identified in their Complaint are the result of Defendants' deliberate indifference to their constitutional right to be protected from a known and obvious hazard to their health. All Plaintiffs share the essential circumstance of being in the custody and care of the Hardin County Jail and being subjected to the deliberate indifference of Defendants. Thus, Plaintiffs allege both "system-wide practice or policy that affects all of the putative class members" and constitutional violations, "thus raising questions of law common to all class members." *Armstrong*, *supra* at 868. The commonality prong is undoubtedly satisfied.

3. The class representatives' claims are typical of the claims of the classes.

Rule 23(a)(3) requires that "claims or defenses of the representative parties are typical of the claims or defenses of the class." Fed.R.Civ.P 23(a). "Typicality 'requires that the claims of the class

representatives be typical of those of the class, and is satisfied when each class member's claim arises from the same course of events, and each class member makes similar legal arguments to prove the defendant's liability.'" *Robinson v. Metro-North Commuter R.R.*, 267 F.3d 147 (2d Cir. 2001) (quoting *Marisol A. by Forbes v. Giuliani,* 126 F.3d 372, 376 (2d Cir. 1997)). The Sixth Circuit has explained that a "necessary consequence of the typicality requirement is that the representative's interests will be aligned with those of the represented group, and in pursuing his own claims, the named plaintiff will also advance the interests of the class members." *In re American Medical Systems*, *supra* at 1082.

> A plaintiff's claim is typical if it arises from the same event or ***practice or course of conduct*** that gives rise to the claims of other class members and his or her claims are based on the same legal theory. . . The typicality requirement may be satisfied even if there are factual distinctions between the claims of the named plaintiffs and those of other class members.

De La Fuente v. Stokely-Van Camp, Inc., 713 F.2d 225, 232 (7th Cir. 1983) (emphasis added). *See also Senter v. General Motors Corp.*, *supra* at 525, n. 31 (6th Cir. 1976) ("To be typical, a representative's claim need not always involve the same facts or law, provided there is a common element of fact or law.")

"The test generally is whether other members have the same or similar injury, whether the action is based on conduct which is not unique to the named plaintiffs, and whether other class members have been injured by the same course of conduct." *Thomas*, *supra* at 400 (citation omitted). Plaintiffs suffered the same injury from systemic conduct of Defendants, conduct that was not unique to the named plaintiffs and accordingly, other class members have been injured by the same course of conduct. Even if Defendants' claim that MRSA infections vary (amongst those infected) too greatly to be deemed the "same" injury, typicality is still met. "Where an action challenges a policy or practice, the named plaintiffs suffering one specific injury from the practice

can represent a class suffering other injuries, so long as all the injuries are shown to result from the practice." *Thomas*, *supra* at 401 (quoting *General Tel. Co. of Southwest v. Falcon*, 457 U.S. 147, 157-59 (1982)). Both policies and practices are being challenged in the instant action and will be shown to cause Plaintiffs' injuries.

Both typicality and commonality serve as

> guideposts for determining whether under the particular circumstances maintenance of a class action is economical and whether the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence.

General Tel. Co., *supra* at 157, n.13. Interests of the class members will be "fairly and adequately protected in their absence." *Id.* The named Plaintiffs' claims all arose from the same operative facts that bind them to all class members and the injuries asserted by Plaintiffs resulted from the same policies and practices being challenged. Named Plaintiffs and class members share a common interest in eliminating the unconstitutional conditions and practices they endured (as a group) at Hardin County Jail, along with receiving damages for injuries suffered. The typicality requirement is met.

4. Plaintiffs will adequately represent the class through qualified counsel.

In *Senter v. General Motors Corp., supra*, the Court articulated two criteria for determining adequacy of representation: "1) the representative must have common interests with unnamed members of the class, and 2) it must appear that the representatives will vigorously prosecute the interests of the class through qualified counsel." 532 F.2d at 525. There can be no doubt that the adequacy prong is satisfied. Class representatives have interests which are identical to the members of the class. In addition, the representatives eagerly seek relief for their injuries. Named Plaintiffs seek no special consideration or relief through this suit. There is no potential conflict between the class representatives and the unnamed members of the class.

Moreover, Plaintiffs are represented by counsel who has substantial experience in prison abuse litigation. Gregory Belzley is an expert in the Fourth, Eighth and Fourteenth Amendment rights of inmates and pretrial detainees, and in civil rights class actions against jails. He has been actively engaged in civil rights jail litigation for almost 20 years, was lead counsel for plaintiffs in three prior jail class actions,[124] and is lead counsel for plaintiffs in six other pending cases brought as class actions against Kentucky jails, four of which (including this case) involve MRSA.[125] The pleadings, conduct of pretrial discovery, and other pretrial memoranda further demonstrate counsel's competence and diligence. Counsel has repeatedly demonstrated his intent and wherewithal to undertake litigation of this magnitude, and to vigorously prosecute this action before this Court.

B. Plaintiffs have met the requirements for an action to be maintained as a class action under Rule 23(b).

In order for a class action to be maintainable, the putative class also must satisfy one of the three subsections of Rule 23(b):

> (1) [T]he prosecution of separate actions by or against individual members of the class would create a risk of
>
> (A) inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class, or
>
> (B) adjudications with respect to individual members of the class which would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests; or

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[124] *Eddleman, et al. v. Jefferson County, et al.*, No. 3:91-CV-144-J (W.D. Ky.); *Wilson, et al. v. Franklin County, et al.*, No. 97-35 (E.D. Ky.); *Foreman, et al. v. State of Connecticut, et al.*, No. 3:01-CV-0061 (D.C. Conn.).

[125] *Turner, et al. v. Hopkins County, et al.,* No. 4:03-CV-00003-M (W.D. Ky.); *Miracle, et al. v. Bullitt County, et al.*, No. 05-00130-C (W.D. Ky.); *Chapman, et al. v. Hardin County, et al.*, No. 3:05-CV-00433-S (W.D. Ky.); *Napier, et al. v. Laurel County, et al.*, No. 6:06-CV-00368-DCR (E.D. Ky.); *Taber, et al. v. McCracken County, et al.,* No. 5:06-CV-00144-R (W.D. Ky.); and *Mumphrey, et al. v. Shelby County, et al.,* No. 3:06-CV-00070-KKC (E.D. Ky.).

(2) [T]he party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole; or

(3) [T]he court finds that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy. . . .

Fed.R.Civ.P. 23(b). Given the facts and legal issues of the instant case, class certification can be satisfied through more than one of the subsections of Rule 23(b).

1. With the Rule 23(a) prerequisites satisfied, certification under Rule 23(b)(1) is appropriate to avoid inconsistent adjudications and to protect the rights of members of a class by ensured representation through the vehicle of a class action.

Rule 23(b)(1)(A) states that class certification is proper if separate actions "would create a risk of inconsistent or varying adjudications with respect to individual members of the class which would establish incompatible standards of conduct for the party opposing the class." Fed.R.Civ.P. 23(b)(1)(A). "The phrase 'incompatible standards of conduct' is deemed to refer to the situation in which different results in separate actions would impair the opposing party's ability to pursue a uniform continuing course of conduct." Wright & Miller, *Federal Practice & Procedure:* Civil 2d § 1773, 7AA FPP 1773 (2007) (citations omitted). "[S]ubdivision 23(b)(1)(A) is applicable when practical necessity forces the opposing party to act in the same manner toward the individual class members and thereby makes inconsistent adjudication in separate actions unworkable or intolerable." *Id.* It is clear from the circumstances of this case that the interests of all parties would be served by having common issues resolved as a class action, rather than in separate actions that could produce varying results that would only confuse the issue further and delay effective remedy.

2. With the Rule 23(a) prerequisites satisfied, certification under Rule 23(b)(2) is appropriate because Defendants have acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole.

In addition to monetary relief, Plaintiffs seek declaratory and injunctive relief requiring Defendants to adopt, observe, respect and implement the recognized policies and applicable state and federal regulations necessary to protect their inmates and the Hardin County community from MRSA. In *Hendrix v. Faulkner*, a case involving conditions of confinement at the Indiana State Prison, the court stated that "[a] class action is particularly well-suited to this civil rights case alleging that certain conditions, practices, and procedures of defendants violate constitutional guarantees. Courts have unhesitatingly certified classes when confronted with similar problems involving prisoners." 525 F.Supp. 435, 443 (N.D. Ind. 1981), *aff'd in part, vacated in part*, 715 F.2d 269 (7th Cir. 1983), *cert. denied*, 468 U.S. 1217 (1984) (citations omitted).

Certification under Rule 23(b)(2) is warranted where the “defendant has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive and corresponding declaratory relief with respect to the class.” Fed.R.Civ.P. 23(b). Such is the case here. "The Defendants have acted on grounds generally applicable to the class." *Thomas*, *supra* at 403. Under this rule, “injunctive relief embraces all forms of judicial orders, whether they be mandatory or prohibitory.” Wright, Miller & Kane, *Federal Practice and Procedure:* Civil 2d § 1775, 7AA FPP 1775 (2007). Moreover, the “corresponding declaratory relief” language of Rule 23(b)(2) refers “to any remedy that ‘as a practical matter…affords injunctive relief or serves as a basis for later injunctive relief.” *Id.* at 462.

> As the Second Circuit has stated '. . . it is well established that civil rights actions are the paradigmatic 23(b)(2) class suits, for they seek classwide structural relief that would clearly redound equally to the benefit of each class member.'

Dean, *supra* at 335 (quoting *Marcera v. Chinlund*, 595 F.2d 1231, 1240 (2d Cir. 1979), *vacated on other grounds sub nom. Lombard v. Marcera*, 442 U.S. 915 (1979).

For all these reasons, federal courts frequently certify Rule 23(b)(2) class actions to consider declaratory and injunctive relief in cases like this one that involve claims arising from "conditions of confinement." *See, e.g.*, *Langley v. Coughlin*, 715 F.Supp. 522 (S.D.N.Y. 1989). Indeed, the Hardin County Jail's systemic failure to protect inmates in its custody and care make this case particularly appropriate for injunctive relief.

3. With the Rule 23(a) prerequisites satisfied, certification under Rule 23(b)(3) as to class claims for compensatory damages is appropriate because questions of law or fact common to the class predominate over questions affecting individual members and a class action is the superior method for resolving the class of claims.

"Recovery of damages is available under [Rule] 23(b)(3)." *Thomas*, *supra* at 399. Rule 23(b)(3) has two primary requirements: (1) common issues must predominate over individual issues, and (2) class treatment must be superior to other methods of adjudication. Fed.R.Civ.P. 23(b)(3). Stated differently, Rule 23(b)(3) has both a predominance requirement and a superiority requirement. Rule 23(b)(3) parallels Rule 23(a)(2) in that both subdivisions require that common issues exist, but Rule 23(b)(3)'s predominance test goes further by ensuring that the common issues predominate over individual issues. *In re American Medical Systems*, *supra* at 1084. "In order to 'predominate,' common issues must constitute a significant part of the individual cases." *Jenkins v. Raymark Industries*, 782 F.2d 468, 472 (5th Cir. 1986). "The Rule 23(b)(3) predominance inquiry tests whether proposed classes are sufficiently cohesive to warrant adjudication by representation." *Thomas*, *supra* at 402 (quoting *Amchem Products, Inc. v. Windsor*, 521 U.S. 591, 623 (1997)). "[T]he determination rests not on whether individualized damages determinations will be necessary but on 'legal or factual questions that qualify each class member's case as a genuine controversy.'" *Id.*

The *Thomas* court characterized this requirement as "a heightened commonality inquiry: do the common legal and factual questions appear more significant than the individualized legal and factual questions?" *Thomas*, *supra* at 402. This Court should answer, "Yes."

a. Defendants' common course of conduct, where conduct involves possibility of systemic violations of inmates rights and systemic gross negligence, has overriding significance to any individual factual or legal issues.

The overarching commonality among all class claims trumps any factual differences among class members' individual claims. As previously noted in Plaintiffs' discussion regarding commonality pursuant to Rule 23(a)(2), common issues of law and fact pervade this case and there will likely be very little factual variation in the legal issues that determine the Defendants' liability. If the cases were to be tried individually, all class members would be offering essentially identical proof in support of their claims. The common issues in this action that link Plaintiffs and all members of the classes unquestionably predominate over any questions affecting only individual class members. Given the number and extent of the common issues in this case, a class action certified under Rule 23(b)(3) is clearly superior to any other method and will advance the efficient and fair adjudication of this controversy.

In *Langley, supra,* the court said:

> Plaintiffs' "failure to treat" claims raise a number of common legal and factual issues. To the extent that plaintiffs seek to recover based on a "systemic failure to treat" claim, each must demonstrate such "systemic" failures in the manner in which mental health care was provided at Bedford Hills during the relevant period and the Court must determine whether such failures did indeed occur and whether, as a matter of law, they were of such a dimension as to constitute potential violations of the constitutional rights of those inmates on whom they impacted. **These broad historical issues plainly require common factual presentations.** Furthermore, to the extent that an individual claimant contends that specific medical decisions of the defendants that affected her were so egregiously improper as to reflect deliberate indifference, she will necessarily seek to

> demonstrate **an extended pattern of such erroneous decisions** — whether concerning her or other class members — as a means of showing that the alleged errors constituted not merely simple negligence but rather deliberate indifference. (Citations omitted). Such an effort to prove the defendants' indifference will necessarily require each class member to rely on the same body of evidence for the purpose of persuading the court that when the responsible authorities erred, it occurred for reasons other than honest error. This too adds a large body of common issues of both fact and law to the "failure to treat" case, thus further enhancing the appropriateness of class treatment.

Id. at 560 (emphasis added).

Likewise, class-action treatment is appropriate in the immediate action, since common questions represent a majority of the components of this action and thus, can be resolved for all members in a single adjudication, rather than on an individual basis. In the Sixth Circuit, class actions are a favored procedural tool:

> The procedural device of a Rule 23(b)(3) class action was designed not solely as a means for assuring legal assistance in the vindication of small claims, but rather to achieve the economies of time, effort and expense.

Sterling, *supra* at 1196-97.

b. Class action is the superior method of adjudication.

Subdivision (b)(3) of Rule 23 lists four factors that the court should consider to determine whether class-action treatment would be the superior method of adjudication:

> (A) the interest of members of the class in individually controlling the prosecution or defense of separate actions;
>
> (B) the extent and nature of any litigation concerning the controversy already commenced by or against members of the class;
>
> (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; [and]

(D) the difficulties likely to be encountered in the management of a class action.

Fed.R.Civ.P. 23(b)(3). An examination into each of these factors will indicate that class-action treatment is the superior method.

(1) It is unrealistic to expect Plaintiffs to resort to individual litigation and there is no ongoing pertinent litigation.

Although each MRSA class member has sustained a significant injury, their ignorance of their rights, the costs of pursuing the matter individually, and the fact that each member of the class has acquired an infectious disease that may make them fearful of public scrutiny significantly impairs the ability of individual claimants to come forward and proceed on a case-by-case basis. Further, the injuries and claims of the putative class members are virtually identical.

Under similar situations, courts enthusiastically certify class actions where the cost of individual adjudication, personal and economic, may discourage plaintiffs from pursuing their claims. *Scholes v. Stone, McGuire & Benjamin*, 143 F.R.D. 181, 185 (N.D. Ill. 1992); *Wehner v. Syntex Corp.,* 117 F.R.D. 641, 645 (N.D. Cal. 1987). In the instant case, litigation will truly be reduced by class certification because its highly unlikely that class members will exclude themselves under Rule 23(c)(2). As stated previously, Plaintiffs are eager to pursue their claims against the Defendants. Further, there are no potential conflicts or complications from ongoing litigation that would interfere with the interests of other plaintiffs. "Additionally, because of the transitory nature of the class members, class certification will avoid any mootness issues that could otherwise arise if an individual's claims became moot." *Hirschfeld*, *supra* at 184.

(2) It is desirable to concentrate similar actions in one forum and class action certification will not result in significant management difficulties or unduly burdensome litigation.

"Certainly any difficulties in handling this suit as a class action are far surpassed by the difficulties, in terms of judicial economy of administration, which would be involved in litigating

these claims as individual actions." *DuPont Glore Forgan v. AT&T,* 69 F.R.D. 481, 489 (S.D.N.Y. 1975). Indeed, certification will permit the Court, through the use of a class trial, to resolve the predominant common issues. Individual trials, as opposed to class trials, will require courts to hear the same evidence regarding Defendants' practices and procedures. Individual trials will require the parties to incur substantial expense in re-litigating issues. Class certification will promote economy, expediency, and efficiency. Individual trials will promote delay, increase the costs of the litigation and inundate the Court with unnecessary individual claims. It is in the best interest of all parties, including the Court to certify this class.

The class descriptions are sufficiently definite to be administratively feasible in the identification of class members. There will be limited management difficulties in identifying class membership. Certification of this action is therefore consistent with both the spirit and letter of Rule 23.

C. Class actions are commonly certified to address patterns and practices involving prisons or jails.

The instances and circumstances in which federal courts have certified inattention-to-medical-needs class actions are too numerous to list here, but for a sample, see *Rouse v. Plantier*, 182 F.3d 192 (3d Cir. 1999); *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982); *Coleman v. Wilson*, 912 F.Supp. 1282 (D. Cal. 1995); *Inmates of Occoquan v. Barry*, 717 F.Supp. 854 (D.D.C. 1989) (involving claims of inattention to inmates with, among other things, urinary problems, dizziness, Hodgkin's disease, diabetes, vision problems, dental problems and mental health issues); *De Gidio v. Pung*, 704 F.Supp. 922 (D. Minn. 1989); *Feliciano v. Barcelo*, 672 F. Supp. 591 (D.P.R. 1986); *Dean v. Coughlin*, 107 F.R.D. 331 (D.N.Y. 1985); *Martino v. Carey*, 563 F.Supp. 984 (D. Or. 1983) (involving claims of inattention to medical needs including but not limited to epilepsy, delusions and other mental health conditions); *Lightfoot v. Walker*, 486 F.Supp. 504, 506 (D. Ill. 1980) (involving

a comprehensive assault on all aspects of the prison's health care system and its inattention to the full panoply of inmate medical needs); *Owens-El v. Robinson*, 442 F.Supp. 1368 (D. Pa. 1978); and *Palmigiano v. Garrahy*, 443 F.Supp. 956, 966 (D.R.I. 1977).

Likewise, the number of federal courts that have certified failure-to-protect class actions is comparably numerous. See, e.g., *LaMarca v. Turner*, 995 F.2d 1526 (11th Cir. 1993) (failure to protect from inmate assaults); *Hoptowit v. Ray*, 682 F.2d 1237 (9th Cir. 1982); *Jones v. Diamond*, 636 F.2d 1364 (5th Cir. 1981), *overruled on other grounds by*, *Int'l Woodworkers of America, AFL-CIO v. Champion Intern. Corp.*, 790 F.2d 1174 (5th Cir. 1986); *Skinner v. Uphoff*, 234 F. Supp. 2d 1208 (D. Wyo. 2002); *Austin v. Hopper*, 15 F. Supp. 2d 1210 (D. Ala. 1998) (involving allegations that the defendants' policies, customs and practices placed inmates at the risk of unprovoked assault, bodily injury and death at the hands of other inmates); *Caroline C. By and Through Carter v. Johnson*, 174 F.R.D. 452 (D. Neb. 1996); *Inmates of Occoquan v. Barry*, 717 F. Supp. 854 (D.D.C. 1989); *Fisher v. Koehler*, 692 F.Supp. 1519 (D.N.Y. 1988); *Feliciano v. Barcelo*, 672 F.Supp. 591 (D.P.R. 1986); *Martino v. Carey*, 563 F.Supp. 984 (D. Or. 1983) (assaults by other inmates); *Doe v. Lally*, 467 F.Supp. 1339, 1346 (D. Md. 1979); and *Palmigiano v. Garrahy*, 443 F.Supp. 956, 966 (D.R.I. 1977).

In addition, a court can simultaneously certify a 23(b)(2) class with a 23(b)(3) class. Practicing Law Institute, *supra* at 107. The Southern District of New York has stated that

> [n]othing in the language of Rule 23 precludes certification of both an injunctive and a damages class in the same action. In fact, where injunctive relief and damages are both important components of the relief requested, courts have regularly certified an injunctive class under Rule 23(b)(2) and a damages class under Rule 23(b)(3) in the same action.

Id. (quoting *In re Nasdaq Market-Makers Antitrust Litig.*, 169 F.R.D. 493, 515 (S.D.N.Y. 1996)). Such is the case here--both injunctive relief and damages are important components of the relief

requested. Alternatively, if the Court believes there are separate issues concerning damages amongst the class,

> the common issue of liability [could be] adjudicated on a class basis. Rule 23 provides the courts with enough flexibility and room for judicial innovation so that the question of damages can be determined through individual trials on that issue pursuant to "equitable procedures" devised by the court.

Wright, Miller & Kane*, Federal Practice and Procedure* Chapter 5, § 1784, 7AA Fed. Prac. & Proc. Civ.3d § 1784 (2007) (footnotes omitted).

D. A federal district court has already certified a class action in a comparable MRSA case.

In *Inmates of Bucks County Correctional Facility v. County of Bucks*[126], Plaintiffs alleged Eighth and Fourteenth Amendment violations around the "conditions of confinement" at the Bucks County Correctional Facility (the "Bucks County jail"). *Bucks County*, 2004 WL 2958427, 4 (E.D. Pa. 2004). Amongst other allegations, Plaintiffs claimed that as of June 2004, 95 inmates had been isolated for MRSA infection. *Id.* Plaintiffs also alleged that all inmates were "threatened and effected by the disease due to the unsanitary conditions within the facility" and alleged Eighth and Fourteenth Amendment violations "based on systemic deficiencies in sanitation and basic medical and health care needs." *Id*.

The *Bucks County* court held that the numerosity requirement was "clearly" met -- considering that Plaintiffs alleged that the size of the class exceeded 650 members and that the fluidity of class made joinder impracticable. *Id.* at 3. Further, the court concluded that "common questions exist[ed] as to the conditions and as to whether the Defendants' conduct violate[d] the

[126] Attached as Exhibit R. Not reported in F. Supp. 2d. This is the only case presently known to counsel where a MRSA class has been certified. No published case provides such analogous relevance and precedential value.

constitutional rights of Plaintiffs." *Id.* at 4. Typicality and adequacy were likewise determined to be satisfied by the court. It stated that

> [i]n the case at bar, Plaintiffs aver that the Defendants have instituted a policy and practice of both action and inaction which deprives Plaintiffs of humane treatment in violation of their Constitutional rights and is thus appropriate for a class action suit.

Bucks County, *supra* at 5. Ultimately, the court concluded that the Plaintiffs' claims met the requirements of a class action pursuant to Rule 23(a) and (b)(2). *Id.*

Bucks County shares many commonalities with the instant case. Both cases allege federal constitutional violations involving inmates of a correctional facility with similar population sizes, where MRSA was colonizing, causing inmates to suffer preventable injuries because of (and without the remediation of) the Defendants' conduct and practices. Systemic deficiencies in both sanitation and isolation procedures were common allegations, as well as inattention to medical needs. Thus, Plaintiffs are not asking this Court to write on a clean slate.

CONCLUSION

The persons victimized by the continuing abuses at the Hardin County Jail must be identified, contacted, permitted to come forward to assert their claims, and awarded damages in instances in which their treatment violated their constitutional rights. One thing is certain -- absent certification of a class action, the legitimate claims of unnamed class members will never be discovered and will likely be forever barred. The record indicates that there are many more claims like Plaintiffs' that have yet to be asserted. A comprehensive remedy, finality, and economy not only for the Court, but for all parties require that this case be certified a class action for injunctive and declaratory relief and recovery of damages. In addition, certification is required in order to afford potential class members the protection of numerosity and ensured representation. In the instant case, "a class action is the procedural vehicle of choice." *Hendrix*, *supra* at 443.

Federal courts have certified class actions in circumstances similar to those presented in this case. The Defendants bear direct responsibility for their continued and systemic conditions and practices, actions and inactions, which give rise to the present suit. The conditions of confinement at Hardin County Jail affect not only named Plaintiffs and proposed class members, but has general application to Hardin County jail inmates, past, present, and future, and the Hardin County community beyond the jail walls.

FOR THESE REASONS, Plaintiffs respectfully request that their motion for class certification be granted.

Respectfully submitted,

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CERTIFICATE OF SERVICE

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