IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF SOUTH CAROLINA

ANDERSON DIVISION

Tony C. Boyd, Anthony E. Byrd, John T. Campbell, John R. Cartee, Mark D. Cureton, Dale S. Epps, Antonio B. Gaines, Rorey J. Johnson, Albert D. Jones, Glenn Jones, Kevin L. Keith, Joseph P. Lightsey, Timothy O. McIntosh, James A. Pearson, Alonzo C. Trotter, Loren L. Waddell, Thomas M. Whitaker, Danny E. Haught, Douglas P. Lance, Kelly M. Martin, Irwin E. McCullough, Joshua A. Mitchell, Gerald L. Roberts, Elliott J. Wimbush, and Alan W. Yates,

Plaintiffs,

vs.

The County of Greenville, Greenville County Detention Center, and Scotty Bodiford in his official capacity as Director of the Greenville County Detention Center,

Defendants

Case No._____________

COMPLAINT

JURY TRIAL DEMANDED

The Plaintiffs, complaining of the Defendants, would allege and show unto the Court the following:

JURISDICTION

1. Original subject matter jurisdiction of this action is conferred on the United States District Court for the State of South Carolina, Anderson Division, pursuant to 28 USCA § 1331 inasmuch as the matters in controversy in this case arise under the Constitution and laws of the United States and laws of South Carolina.

2. This Court has supplemental subject matter jurisdiction over the matters in controversy in this action under 42 USCA § 1983 and under 28 USCA § 1343 in that the Defendants, acting under color of South Carolina state laws, ordinances, regulations, customs and/or usages, subjected or caused to be subjected the individual Plaintiffs to the deprivation of their Constitutional rights, privileges and immunities secured by the United States Constitution under the Eighth and Fourteenth Amendments.

VENUE

3. Venue is proper in the United States District Court for the State of South Carolina, Anderson Division inasmuch as a portion of the Plaintiffs and Defendant, Scotty Bodiford, are residents and citizens of Anderson County, State of South Carolina. All of the events complained of hereinafter occurred within the County of Greenville, State of South Carolina. Also, the Plaintiffs are informed and believe that the instant case has been pre-assigned to the Honorable G. Ross Anderson, Jr. through the filing of a Petition for Immediate Discovery and an Order granting such by Judge Anderson on May 22, 2006.

4. Venue is also proper in the United States District Court for the District of South Carolina, Anderson Division, for the aforementioned reasoning regarding Judge Anderson's Order for Immediate Discovery and, inasmuch as the Defendants, the County of Greenville and the Greenville County Detention Center, are political subdivisions of the State of South Carolina conducting business within the County of Greenville, and because of Judge Anderson's previous Order for Immediate Discovery as well as the residence of a portion of the Plaintiffs and the Defendants and therefore, are subject to the jurisdiction of this Court for violations of the Plaintiffs' Constitutional and other legal rights afforded them under the laws of the United States and the State of South Carolina.

PARTIES

5. The Plaintiffs, Anthony E. Byrd, John T. Campbell, John R. Cartee, Mark D. Cureton, Dale S. Epps, Antonio B. Gaines, Rorey J. Johnson, Albert D. Jones, Glenn Jones, Kevin L. Keith, Tiberius R. Lee, Joseph P. Lightsey, Timothy O. McIntosh, James A. Pearson, Perry L. Smith, Alonzo C. Trotter, Loren L. Waddell, Thomas M. Whitaker, Tony C. Boyd, Danny E. Haught, Douglas P. Lance, Kelly M. Martin, Irwin E. McCullough, Joshua A. Mitchell, Gerald L. Roberts, Elliott J. Wimbush, and Alan W. Yates, at all times pertinent herein, were inmates at the Greenville County Detention Center.

6. The Defendant, the County of Greenville, is a political subdivision of the State of South Carolina, organized and existing under the laws of the State and in the instant case, was and is the moving force behind the customs, policies, procedures and practices procreated, implemented and utilized at the Greenville County Detention Center, through its agents, servants and employees.

7. At all times pertinent herein, Greenville County was the public employer of the Defendant, Scotty Bodiford, and other Detention Center employees, and as such is charged with the responsibility of supervising and monitoring its employees and assuring that the customs, practices, policies and procedures the County procreated and advocated be used at the Detention Center did not violate the Constitutional or other legal rights of the Plaintiffs.

8. The Defendant, the Greenville County Detention Center, is a South Carolina Governmental Class II Correctional Center, owned funded and operated by the County of Greenville, and as such, houses prison inmates who are awaiting trial and/or are serving short sentences imposed by the State of South Carolina.

9. As a Class II Correctional Center, Greenville County Detention Center, through its agents, departments and employees, including but not limited to Defendant Bodiford, is in charge

of implementing the customs, policies, procedures and practices procreated by the County as these customs, polices, procedures and practices apply to the supervision of its inmates.

10. The Defendant, Scotty Bodiford, in his official capacity as Director of the Greenville County Detention Center, is in charge of and directs and controls the customs, policies, procedures and practices implemented and utilized by the Greenville County Detention Center, through its agents, departments and employees.

11. The Defendant, Scotty Bodiford, is employed by and paid by the Defendant, Greenville County.

12. At all times material to the allegations set forth herein, the Defendants were and are acting toward the Plaintiffs under color of South Carolina state laws, ordinances, regulations, customs and/or usages, and thereby subjected or caused to be subjected the individual Plaintiffs to the deprivation of their Constitutional rights, privileges and immunities secured by the United States Constitution under the Eighth and Fourteenth Amendments and United States laws.

FACTUAL BACKGROUND

13. At all times relevant to this action, all Defendants maintained an official but unwritten policy and practice of providing no medical isolation facilities for inmates, and no adequate screening of inmates prior to admitting them to their cellblock; providing as little as possible in the way of necessary medical care to inmates; failing and refusing to provide basic sanitation for inmates; and being deliberately indifferent to, or covering up the outbreak of an infectious disease at the facility, namely MRSA infection.

14. Defendant Bodiford is responsible for this policy, and it would appear that the spread of the dangerous MRSA infection is, in part, due to cost saving measures he has instituted at the facility.

15. In July of 2005, inmates began complaining of sores on their bodies and significant pain and suffering that was associated with these necrotic flesh wounds, which were swollen and painful.

16. During this period, many inmates were complaining of such infection with a lack of any medical care to treat these inmates for their infections. The staff was deliberately indifferent to their complaints because so many were getting infected over the course of a few months time despite the numerous requests for medical treatment.

17. The authorities and medical staff Defendants knew that MRSA was spreading through the jail, but did not disclose to the Plaintiff and other inmates the severity of an MRSA infection or take any precautions to stop the spread of the disease.

18. Methicillin Resistant *Staphylococcus Aureus* (MRSA) is a chronic infection, difficult to treat because it is drug resistant. Inmates were at risk of repeated infections because the bacteria are present on virtually all surfaces at the facility. The bacteria are spread by contact. Depending on the location, the severity of the infection and the victim's immune system, MRSA can be fatal.

19. Section 44-29-10 of the Code of Laws of South Carolina, provides:

> (A) In all cases of known or suspected contagious or infectious diseases occurring within this State the attending physician must report these diseases to the county health department within twenty-four hours, stating the name and address of the patient and the nature of the disease. The county health department must report to the Department of Health and Environmental Control all such cases of infectious and contagious diseases as have been reported during the preceding month, these reports to be made upon blanks furnished by the Department of Health and Environmental Control. The Department of Health and Environmental Control must designate the diseases it considers contagious and infectious. The Department of Health and Environmental Control may also designate other diseases for mandatory reporting by physicians. Any physician who fails to comply with the provisions of this section is guilty of a misdemeanor and, upon conviction, must be fined not more than one hundred dollars or be imprisoned for a period not exceeding thirty days.

MRSA is not currently included in the South Carolina Department of Health and Environmental Control's list of reportable conditions. However, unusual clusters (usually three or more cases) **can** be reported. Defendant Detention Center did bring in a speaker, Dr. Shirley Jankelovich from the state Department of Health and Environmental Control (DHEC) to speak to senior staff about MRSA on or about September 2005. Subsequently, a general version of this talk was shown to all staff and a technical version was shown to medical staff. The GCDC did not request an investigation or any further assistance. The GCDC has not been reporting cases to the DHEC.

20. Despite the numerous requests of individual inmates for medical care because of the MRSA infections they were suffering from, to Plaintiffs' counsel's knowledge, no official of the Greenville County Detention Center or the County of Greenville requested the assistance of the Greenville County Health Department to control the outbreak of MRSA or to eliminate the conditions that encouraged the spread of the disease, and the physician on duty did not comply with Section 44-29-10 of the Code of Laws of South Carolina and report the infectious disease outbreak at the facility.

21. Defendants did not educate any of the inmate Plaintiffs about MRSA so that they could protect themselves with the limited means at their disposal.

22. After news media broke the story that this lawsuit would be filed, Defendants made some cursory efforts to clean the facility, installing soap dispensers that were then not refilled, cleaning hallways and cell blocks, and making one superficial attempt to wipe down the cells with a bleach solution directly prior to the visit by the Plaintiffs' expert, Dr. Robert Greifinger. The Defendants made the haphazard effort to clean the Detention Center because they were served copies of the Order Granting Immediate Discovery the day prior to the

Plaintiffs' expert entering the Detention Center. However, the unsanitary conditions that are a hazard to the health of the inmates and the staff of the facility and that have contributed to the outbreak of a MRSA infection remain.

23. The frequency and severity of the complaints of infection, the incidence of cellulitis, boils and abscesses should have warned Defendants to test inmates for the presence of MRSA, and take precautions against the spread of this disease. When the Plaintiffs began to survey the possibility of a lawsuit, the Defendants admitted the presence of staph in the facility and the number of such infections over the course of almost one (1) year.

24. At all times pertinent to this action, all defendants were deliberately indifferent to the Plaintiffs' serious medical needs, and to those of other inmates housed at the Detention Center.

25. At all times pertinent to this action, the Defendants were deliberately indifferent to the Plaintiffs' constitutionally protected rights to human treatment, basic sanitation, and to be free of cruel and unusual punishment while incarcerated.

26. Through the date of this complaint, Plaintiffs' counsel is aware of at least seventy-seven (77) cases of MSRA, staph infection or skin infections at the Greenville County Detention Center, and the latest inquiry of representation from an inmate from the Detention Center, was received August 14, 2006. This facility has made no effort, or insufficient effort, to clean up the unsanitary conditions and control the spread of disease and/or the harmful MRSA infection present, thereby continuing to place the inmates' health at risk with no regard for such.

FOR A FIRST CAUSE OF ACTION

27. The Plaintiffs repeat each and every allegation set forth herein above as fully as if set forth herein.

28. At all times pertinent herein, the Plaintiffs were housed at the Greenville County Detention Center as inmates under the direct control of the Defendant, Scotty Bodiford, a paid employee of the Defendant, Greenville County.

29. As inmates at the Detention Center, the Plaintiffs were and are entitled to the Constitutional protections afforded under the Eighth and Fourteenth Amendments to the United States Constitution and other United States laws which, *inter alia*, guarantee the Plaintiffs the right to be free from cruel and unusual punishment and the right to equal protection under the law.

30. Notwithstanding the guarantees afforded the Plaintiffs under these Amendments, the Defendants, acting under the color of South Carolina law, procedures and customs, from approximately July 2005 through the present, denied the Plaintiffs' rights to these Constitutional protections by failing to investigate the Plaintiffs' complaints of skin infections, various skin irritations, and staph infection at the Detention Center, thereby subjecting the Plaintiffs to repeated infections, which have resulted in severe cases of cellulitis, necrotic flesh wounds, ulcerations, swelling of surrounding tissue, skin eruptions, lesions, unsightly scarring, infections and/or tissue hardening at the sites of the wounds, all of which have caused the Plaintiffs undue and prolonged pain and suffering.

31. Further, the Defendants, acting under the color of South Carolina law, procedures and customs, denied the inmate Plaintiffs' rights to these Constitutional protections by refusing to provide

adequate medical treatment and/or delaying medical treatment, the result of which has caused the injuries sustained by the Plaintiffs to grow progressively worse.

32. During the time frame specified hereinabove, the Plaintiffs repeatedly complained to the Defendants of pain from these skin infections, repeatedly complained of the wounds covering their bodies, and repeatedly requested medical attention.

33. Notwithstanding the Plaintiffs' repeated complaints of skin infection and the pain and swelling that is noticeable therefrom and requests for medical attention, the Defendants intentionally, willfully, wantonly, maliciously and knowingly failed and refused and continue to fail and refuse to inspect the Detention Center for MRSA infection and the cause of such an outbreak and further failed and refused to provide the medical care needed by the Plaintiffs and are still subjecting the inmates to repeated skin infections, which is resulting in continual injury to prison inmates.

34. Pursuant to a Petition for Immediate Discovery filed by the Plaintiffs on May 22, 2006, an Order Granting Immediate Discovery was signed by the Honorable G. Ross Anderson, Jr. on such same date to allow "an inspection *without notice* by an independent assessor, Dr. Robert Greifinger, of the current conditions of the Center to determine what conditions, if any, are readily visible, for any administrator to knowingly observe in their daily duties that would lead to such infections" and "allowable access to the entire area of the Detention Center to assess such conditions fully and fairly to evaluate the Petitioners' claims."

35. The Plaintiffs' attorneys, along with Dr. Robert Greifinger, did inspect the Greenville County Detention Center on May 23, 2006. From this inspection, Dr. Greifinger generated an expert report on the conditions of the Detention Center, of which pertinent parts are contained in this

Complaint, including, but not limited to, each individual assessment of the inmate medical records and physical conditions, as listed below in paragraph thirty-eight (38).

36. The Plaintiffs have exhausted all of the administrative remedies available to them as inmates at the Detention Center and seek redress herein for the physical, mental and emotional damages they have sustained as a result of the Defendants' intentional and continuing denial of their constitutional rights and injury to their person.

37. Each of the Defendants, individually and in concert with the others and acting under pretense and color of State law and in their official capacity, have repeatedly denied the Plaintiffs' their rights guaranteed to them under the Eighth and Fourteenth Amendment to the United States Constitution and other United States laws.

38. As a direct and proximate result of the Defendants' intentional, malicious, willful, wanton and reckless deprivation of the Plaintiffs' Constitutional rights and privileges, the Plaintiffs have been severely and permanently damaged in each of the following particulars:

Inmate Plaintiffs:

a) Tony Boyd first received care for his skin infection following a March 16, 2006 grievance filed by his sister regarding his inability to receive care. The grievance was inexplicably denied. He was seen by a nurse on March 17, 2006 and was given antibiotics prescribed by a telephone order from the physician. He was first seen by a nurse practitioner three days later, when a culture was ordered, but not reported in the record. He had no wound care and no follow-up, although follow-up was ordered for three days after the visit. He filed a request for care for persistent skin infection on April 16, 2006 and had an antibiotic prescribed by a licensed practical nurse. He had no follow-up with a licensed health care practitioner and only one wound care encounter on April 13, 2006. His infection grew worse. Once again, on May 10, 2006 he was diagnosed and treated by a nurse. On May 24, 2006, he was given an antibiotic again. Finally, he received wound care on May 25 - 30, 2006. He received prescriptions for antibiotics on May 27 and for a different antibiotic on May 31, 2006. Mr. Boyd grieved the co-payments he was charged for this persistent infection, despite the fact that he

developed the infection through intramural transmission (he was admitted February 22, 2006 with no documented skin infections). There is no documentation that Mr. Boyd received 21 doses of his antibiotics in two months.

Tony Boyd has a persistent skin infection, acquired at GCDC, that has been unresponsive to medication prescribed, inappropriately, by nurses. He was seen four times by a nurse practitioner who should have referred him to a physician because of the persistence of the infection despite multiple antibiotics. He had a culture that was never reported in the record and he missed multiple doses of antibiotics which predisposes to the development of antibiotic resistence. He did not receive wound care until the end of May 2006.

b) Anthony Byrd has had at least two admissions to GCDC. He was treated for a skin infection on September 1, 2005 with Duracef, a medication known to be ineffective for MRSA. Although it was ordered for seven days, he only got it for six days. He missed four of the 14 doses prescribed. After his readmission to the jail, prior to December 8, 2005, a nurse prescribed an antibiotic for Mr. Byrd on January 15 and again on January 20, 2006. There was no progress note for the latter order. Another nurse put him on an "antibiotic protocol" on March 6, 2006 without referring him to a physician or nurse practitioner and without providing for wound care or follow-up. He missed six of the 20 doses prescribed. On April 9, 2006, Mr. Byrd again requested care. He was started on antibiotics without being examined. It took five days to get the first dose and then four of the 14 prescribed doses were not documented. Twelve days after his request for care, there is a progress note that says "will culture" on April 21, 2006.

Anthony Byrd has a persistent skin infection, acquired at GCDC. The skin infection has been unresponsive to medication prescribed, inappropriately, by nurses. His skin culture was never reported. He did not see a physician or nurse practitioner for diagnosis or treatment. He did not receive wound care or appropriate follow-up. He was not given multiple doses of his medication.

c) John Campbell was admitted to the facility at some time prior to March 19, 2006. Although there was no note of initial treatment, there is a note dated March 24, 2006 that says his "toe" resolved on antibiotics. He requested to see a physician for his toe infection on March 25 but was not sent to see one. On March 27, 2006, when he had been on antibiotics for six days, he developed cellulitis and was sent to the emergency room of the local hospital. He had no follow-up on his return, although he was put on two antibiotics. He missed 20 of 76 doses prescribed for March 2006. He was returned to the emergency room on March 31, 2006.

On April 5, 2006, he had a boil that had to be incised and drained at orthopedics

clinic. Mr. Campbell developed further lesions in early May. He was put on other antibiotics but there is no progress note. He only received 19 of the 28 doses prescribed for him on May 5, 2006 and 15 of the 28 doses prescribed on May 19, 2006.

Mr. Campbell has persistent or recurrent skin infections that developed at GCDC. At least two times he had to be sent to the emergency room and on another occasion he was seen in orthopedics clinic at the hospital. Despite these infections, he never saw a licensed independent health care practitioner at the jail. Medication was prescribed by nurses. He had no cultures done. He had no wound care or follow-up. He was not given a high proportion of doses of his medication.

d) John Cartee began complaining of his skin infections on April 8, 2006. Although he should have been seen by a licensed independent health care practitioner, the nurse inexplicably prescribed an antihistamine and did not refer him. He asked for care again on April 13, 15, and 18. On April 18, 2006, Mr. Cartee had an elevated temperature of 99.6 degrees and an abnormally elevated heart rate of 109 beats per minute. Along with an obvious infection, he should have been seen by a physician immediately because of the risk of sepsis, a serious and potentially blood infection. Instead, the nurse ordered antibiotics for him prior to his being seen by a nurse practitioner on April 18, 2006. Eleven days after his first request for care, he was seen by the nurse practitioner who diagnosed multiple boils including his testicle (presumably she meant "scrotum" and not "testicle)." A culture was done and reported as positive for MRSA. She ordered medication on April 20, 2006 and again she ordered renewed medication on May 3, 2006 after a sick call request (but no visit), and May 16, 2006 (with no visit). She ordered medication again on May 24 and saw him for follow-up on May 25 and May 30, 2006. Mr. Cartee missed approximately 25% of his prescribed doses of antibiotics.

John Cartee had persistent skin infections acquired at GCDC. He was denied access to appropriate medical attention when he may have had sepsis. He was treated without being examined and he had an inappropriate lag to care initially.

e) Mark Cureton had multiple admissions to the GCDC. He was first prescribed antibiotics on January 3, 2006 for a skin infection. He had a positive culture for MRSA. On March 25, 2006, he had a draining wound. Nurse Practitioner Easterguard found him with a fever of 100.1 degrees and cellulitis. He was sent to the emergency room for evaluation and treatment. He received no follow-up care and missed 11 of 28 doses of his prescribed medication. The nurse practitioner was called about him on March 31, 2006, but she did not see him. He developed fever of 101.2 degrees and a headache, signs of possible sepsis, and he

was sent again to the emergency room. The note from the emergency room says that his antibiotic prescription was interrupted by the jail physician. He received no follow-up or wound care at the jail. He missed 14 of 28 prescribed doses of medication; he refused some of these doses and was not offered other. But he had a reason for the refusals, i.e., he said that the medicine caused a rash. In fact his medication was renewed, despite the drug reaction on April 19, 2006. Notwithstanding the drug reaction, he was not referred to a licensed independent practitioner. He was not seen in follow-up by the nurse practitioner until May 3, 2006. His medication was finally changed on May 11, 2006, but he did not receive nine of 28 prescribed doses of the medication. On May 17, 2006, Mr. Cureton was seen by a consultant who recommended reconstructive surgery on the finger that had been infected.

Mr. Cureton had recurrent skin infections acquired at GCDC. He was not seen in a timely manner by licensed independent practitioners at the jail. He received inadequate wound care and follow-up and missed a high proportion of medication prescribed for him. He had an allergic reaction to Bactrim and not only was not appropriately referred for care his prescription for Bactrim was renewed.

f) Dale Epps complained of skin lesions on October 23, 2005. Although he had a culture, he was not seen by a licensed independent practitioner. The culture is not reported in the medical record. A nurse prescribed antibiotics for him. He missed four of the 14 doses prescribed for him. He had no follow-up or wound care. His wife called on October 25, 2005 and Mr. Epps requested care again. He was seen by Dr. Sherman six days later, on November 1, 2005, who diagnosed folliculitis and added to the antibiotic regimen. On March 3 and 4, 2006, Mr. Epps' wife requested care for him for a new lesion. The response to the wife's March 4, 2006 request says that he was seen on March 6, 2006, but there is nothing in the record to document that he was seen or treated.

Dale Epps acquired a skin infection at GCDC, but he was not seen by a physician for a week after a nurse prescribed medication which was only given to him in part. His infection recurred. He and his wife both requested care for him, but none was given. He received no follow-up or wound care.

g) Antonio Gaines was first treated for a skin infection on August 24, 2005 with Duracef, an antibiotic known to be ineffective for MRSA. He was treated again with Duracef on September 1, 2005. He had no medical visit on these two occasions. On September 14, 2005, he was seen for a boil on his thigh by Dr. Sherman, who prescribed Augmentin, an antibiotic known to be ineffective for MRSA. By September 27, 2005, his boils were spreading and draining. He was treated with Duracef and clindamycin. He had two cultures that were positive for MRSA, on September 28 and December 25, 2005. He received courses of

antibiotics prescribed on October 17 and December 21, 2005 and January 6, February 17, March 27, and May 1, 2006. He had no follow-up, except for a March 1, 2006 visit and no wound care. He had no documented visits with a physician or nurse practitioner from September 27, 2005 through March 1, 2006 and none since March 1, 2006.

Antonio Gaines had persistent skin infections with MRSA. He was treated in inappropriate antibiotics without being seen by a physician or nurse practitioner. He had no wound care and no follow-up. He received nine courses of antibiotics, but still had skin infection on May 1, 2006.

h) Danny Haught complained of skin lesions on or about his right calf on April 19 and 20, 2006. He was not seen by a licensed independent practitioner, but he had a prescription for antibiotic written by the nurse practitioner. There was no clinical note. He had a positive culture for MRSA. He did not receive any follow-up or wound care. This was an infection acquired at GCDC.

i) Rory Johnson complained of a skin infection on October 14 and 20, 2005. He was seen by a nurse, but not a physician or nurse practitioner. He had a positive culture for MRSA. He only received eight of 28 doses of his prescribed medication. On February 3, 2006, he had a rash but was not seen. There is a note dated February 7, 2006 that he no longer needs medical attention.

Rory Johnson acquired a recurrent MRSA infection at GCDC. He was never seen by a licensed independent practitioner. He had no wound care and no follow-up.

j) Albert D. Jones, while patiently awaiting adjudication, was infected with MRSA on or about his underarm and foot. Albert Jones filed a request for care for a skin lesion on March 4, 2006. He was diagnosed and prescribed antibiotics by a nurse. He never saw a licensed independent practitioner. He had no wound care, no culture and no follow-up.

k) Glenn Jones filed a sick call request on January 5, 2006 for a "spider bite." He filed another request on January 6, 2006 for a lesion on his calf. He had a wound culture and was put on an antibiotic without seeing a physician or nurse practitioner. He was given six courses of antibiotics between January 6 and May 24, 2006, but only saw the nurse practitioner on April 10, May 3, and May 30, 2006. Despite five months of persistent infection, he was never referred to the physician. He received no wound care. The wound culture done in January was not reviewed by the nurse practitioner until May 30, 2006.

Glenn Jones had five months of persistent skin infections, acquired at GCDC. He had no wound care and no follow-up. His condition was diagnosed by nurses who

prescribed medication for him. He had three visits with a nurse practitioner during this period.

l) Kevin Keith developed skin lesions some time prior to March 9, 2006 when antibiotics were prescribed for him. He received six courses of antibiotics between March 9 and May 25, 2006. He had six visits with nurses who diagnosed his condition and prescribed medication, but he was never seen by a licensed independent practitioner. His wound was cultured on one occasion but the result is not in the chart. He received no wound care until May 26, 2006 where wound care notes are documented daily through June 6, 2006. Kevin Keith acquired his persistent infection at GCDC.

m) Douglas P. Lance, while awaiting adjudication, was infected with MRSA on or about his right side, chest, and leg on or about May 10, 2006. Douglas Lance developed a boil on May 10, 2006. He was diagnosed and treated by a nurse, who also ordered a culture. He was not seen by a physician or nurse practitioner during the subsequent three or four days before he was discharged. Douglas Lance acquired his infection at GCDC.

n) Joseph Lightsey was first treated with antibiotics for skin infection on August 30, 2005, without the benefit of a visit with a licensed independent practitioner. One month later, on September 30, 2005, he received a second course of antibiotics, without documentation of an examination. He had a wound culture on that date that was reported as positive for MRSA. He received a third course of antibiotics on October 30, 2005. On November 12, 2005, he complained of a skin lesion on his eyelid, but he did not get referred. His eye problem continued at least through December 14, 2005, but he did not get to see a physician or nurse practitioner.

Joseph Lightsey was diagnosed and repeatedly treated by nurses without benefit of a physician or nurse practitioner. He acquired his persistent infection at GCDC. He had no wound care and no follow-up.

o) Kelly Martin requested care for a skin lesion near her vagina on March 4, 2006. On March 14, 2006, she was seen by a nurse who found six lesions. The nurse diagnosed Ms. Martin and prescribed antibiotics. Sixteen days after she requested care, she was seen by the nurse practitioner. Ms. Martin requested the results of her culture (not documented in the record) on April 6, 11, and 13, 2006, but these test results were not shared with her. On April 24, 2006, she again requested care. Instead of getting care she received a note back that she was already being treated. On April 25, 2006, she again requested care. A nurse prescribed 14 doses of antibiotics of which she missed four. Ms. Martin had only one visit with the nurse practitioner. She had no wound care and no follow-up for

the persistent skin infection she acquired at GCDC.

p) Irwin McCullough complained of skin lesions on April 24, 2006. Without being seen, antibiotics were prescribed for him on April 30, 2006, receiving the first dose May 2, 2006. He was seen by a nurse on May 4, 2006, who followed the "protocol." Mr. McCullough's mother called the jail on May 3, 8, 11, and 25 regarding her son's skin infection but he was never seen by a nurse practitioner or physician. He had five courses of antibiotics and no wound care until daily checks were documented from May 25 - 30, 2006. On May 25, 2006, he was noted to be "non-compliant" with medication. His persistent skin infection was acquired at GCDC.

q) Timothy McIntosh first developed skin lesions on January 14, 2006 which was diagnosed and treated, inexplicably, with Benadryl, an antihistamine. He was again diagnosed and treated with antibiotics by a nurse on January 21, 2006. He had a wound culture which was reported positive for MRSA. On January 25, 2006, he was seen by the nurse practitioner who incised and drained a boil, but was not seen for follow-up until February 2, 2006 by the nurse practitioner and February 22, 2006 by a nurse. On April 18, he submitted a sick call request, but this request was not reviewed by a nurse for 33 days, on May 16, 2006, by which time he was out of custody. On April 21, 2006, he submitted a request to be seen for a boil in his armpit, but he was not seen until May 1, 2006 by the nurse practitioner. In the interim, antibiotics were prescribed for him by a nurse on April 20, 2006. Mr. McIntosh acquired his recurrent MRSA infection at GCDC.

r) Joshua Mitchell was diagnosed and treated for his skin infection on May 2, 2006. By May 7, 2006, he had developed a boil that was incised and drained in the emergency room of the local hospital. He was not seen by the nurse practitioner until May 18. He only received eight of the 16 doses of medication prescribed for him. He did not receive any wound care or timely follow-up.

s) James Pearson has no indication in his medical records that he had skin infection, although he did have a negative culture on May 25, 2006. He was seen on at least ten occasions by nursing staff for seizures and he was seen on May 2, 2006 by the nurse practitioner. Mr. Pearson had uncontrolled seizures and little, if any, attempts were made to get him on a proper course of antiseizure medication.

Dr. Robert Greifinger interviewed and examined James Pearson. At the time of his examination on May 23, 2006, Mr. Pearson had extensive pustular folliculitis of the face, consistent with long-standing MRSA infection. This rash would be obvious to a prudent layperson. In addition to his uncontrolled seizures being ignored by the medical staff, his bacterial skin infection was also ignored. The fact that he did have one wound culture demonstrates that at least one person was

aware of his infection, yet there is no documentation of the reason for the culture. The fact that the culture was negative only means that one particular sample did not grow bacteria. It does not mean that he did not have MRSA infection on his face. This persistent infection was likely acquired at GCDC.

t) Gerald L. Roberts, while serving a four month sentence for failure to pay child support, was infected with MRSA on or about his right foot, left leg, left knee, left arm, and right shoulder on or about April 9, 2006. He was diagnosed and treated with antibiotics by a nurse. On April 11, 2006, he was seen by the nurse practitioner who prescribed additional antibiotics. He did have a wound check the following day and he was seen by the physician on April 18, 2006. Mr. Roberts has yet to be taken to the emergency room even though the wounds are numerous and significant to his body. He had no culture or other wound care. This was a jail-acquired infection.

u) Alonzo Trotter developed a “spider bite” on February 7, 2006. The nurse diagnosed him and prescribed an antibiotic. The medication he received was Keflex, an antibiotic known to be ineffective against MRSA. By February 10, 2006, he developed fever and abscess, whereupon he was sent to the hospital by the nurse practitioner. This was a jail-acquired infection.

On April 13, 2006, he developed signs and symptoms of kidney stones. He was in pain when he was seen and diagnosed by the nurse practitioner. Despite his pain and his diagnosis, he went five days until he was seen by the facility physician. The physician ordered him to be sent to the hospital, but he had to wait a whole day until he was sent. He suffered for six days with this pain.

v) Loren L. Waddell, while awaiting adjudication at the Detention Center, was infected with MRSA on or about the left side of his scalp noticeable by a large bump above his left ear. Loren Waddell developed boils on April 24, 2006. He was diagnosed and treated by the nurse practitioner and had one follow-up visit on April 26, 2006. He did not receive wound care or further follow-up although his prescription was renewed on May 5, 2006. He missed four of the twenty-seven prescribed doses of antibiotics. His infection was acquired at GCDC.

w) Thomas Whitaker submitted at least five requests for care for his skin infection on September 2, 5, 14, 15, and 19, 2005. He was seen on September 9, 2005 where his boil was misdiagnosed as a closed head injury. He was finally diagnosed with having a boil by a nurse after 17 days and put on Keflex, an antibiotic known to be ineffective against MRSA. One day later he was seen at the emergency room of the local hospital, treated with incision and drainage, and prescribed an appropriate antibiotic. The prescription for the appropriate

antibiotic was not picked up. Instead, he was given Duracef, another inappropriate antibiotic, prescribed October 7 and 25, 2005. He was continued on Keflex as well, with prescriptions written on September 20 and October 22, 2005. He was seen in followup approximately weekly (five visits) between September 23 and October 25, 2005. On October 25, 2005, Dr. Sherman diagnosed a new lesion which was cultured. The culture was positive for MRSA. His infection persisted, as documented by both Dr. Sherman and a nurse practitioner, through December 28, 2005.

Mr. Whittaker submitted a request for care on May 7, 2006 but was not seen by the nurse until May 16, 2006. The nurse diagnosed a skin infection and prescribed antibiotics for him. He requested care again on May 17, 18, and 23, 2006, but was not seen because he was on antibiotics. The antibiotic prescribed for him was Duracef, known to be ineffective for MRSA. During his May 2006 bought of illness, Mr. Whitaker did not see a licensed independent practitioner. He received no wound care and no follow-up.

He was on inappropriate medication for each of his episodes of persistent and recurrent skin infection. He was diagnosed by nurses to prescribed medication for him. He had inadequate attention to his wounds and no follow-up care for his infections that were acquired at GCDC.

x) Elliot Wimbush came to GCDC with a skin infection on December 22, 2005. Antibiotics were prescribed for him by the nurse practitioner on December 25, 2005, three days before she examined him. He had a wound culture that grew out MRSA on December 28, 2005. Mr. Wimbush had a wound check on January 4 and a nurse practitioner visit on January 13, 2006. On March 4, 8 and 9, 2006, Mr. Wimbush requested care for a recurrence of the infection. He was not seen for ten days until he was diagnosed by the nurse practitioner with lesions on his head and leg, although he received antibiotics as early as March 10, 2006 without being examined by a physician or nurse practitioner.

y) Alan W. Yates, was infected with MRSA on or about his right knee, right leg, face, and left hand while awaiting adjudication. Mr. Yates has yet to be taken to the emergency room even though the wounds are numerous and significant to his body. Alan Yates was given at least two courses of antibiotics by nurses beginning April 29, 2006. He had no examination or treatment by a physician or nurse practitioner. He had no wound care and no follow-up. His wound was not cultured. His infection was acquired at GCDC.

WHEREFORE, the Plaintiffs pray judgment against the Defendants for compensatory damages as provided in 42 USCA § 1983, attorneys fees and the costs of this action as authorized by 42 USCA § 1988 (b) and such other and further relief as to this Court seems just and equitable.

FOR A SECOND CAUSE OF ACTION

39. The Plaintiffs reiterate each and every allegation set forth hereinabove as fully as if repeated herein.

40. At all times pertinent herein, the Defendants herein were subject to the guarantees afforded under the Constitution of South Carolina including but not limited to right to be free from cruel and unusual punishment and the right to equal protection under the law.

41. The Defendants willfully, wantonly, reckless, maliciously and intentionally violated the Plaintiffs' rights under the South Carolina Constitution to free from cruel and unusual punishment and to equal protection under the law by failing and refusing to investigate the inmates' complaints of skin infections and the necrotic flesh wounds resulting therefrom at the Detention Center, by failing to provide adequate and/or timely medical care, and by failing to administer prescribed medication in a timely manner and by failing to provide follow-up medical care.

42. In addition, the Defendants, at all times relevant herein were subject to the rules and regulations established by the Federal Bureau of Prisons as set forth in the *Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections* (August 2005).

43. These clinical practice guidelines, among other things, provide as follows concerning Outbreak Management of MRSA, as occurred, and is occurring, at the Defendant Detention Center:

(a) Detection of two (2) or more cases of epidemiologically-related MRSA infections should prompt an immediate investigation to determine if an outbreak has occurred. § 11 *Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections* (August 2005).

(b) In the context of a large MRSA outbreak, inmate cohorting of infected skin or soft tissue cases may be considered as long as the cohorted inmates have MRSA infections with similar antibiotic susceptibilities. § 11 *Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections* (August 2005).

(c) Education efforts should target inmates, correctional workers, and health care personnel in order to contain a MRSA outbreak. § 11 *Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections* (August 2005).

(d) The most effective methods to eradicate MRSA infections from the inpatient setting have involved the active surveillance and isolation of patients with MRSA infection and/or MRSA colonization along with the use of strict contact precautions when managing these patients. Public health authorities should ordinarily be consulted to develop a specific infection control strategy due to the difficulties in managing MRSA outbreaks in the inpatient setting and the inherent risks to the patient population. § 12 *Management of Methicillin-Resistant Staphylococcus aureus (MRSA) Infections* (August 2005).

44. Notwithstanding these provisions, the Defendants willfully, wantonly, recklessly, maliciously and intentionally violated the Federal Bureau of Prisons Clinical Practice Guidelines concerning the management of MRSA infections in each of the following particulars:

(a) By failing to promptly initiate an immediate investigation of the Detention Center to determine if indeed an outbreak has occurred. The Detention Center failed in this regard and allowed an outbreak to occur, as evidence by the numerous medical records and complaints that are the subject of MRSA infections. The Detention Center staff and personnel has thereby subjected the inmates housed therein to continuous MRSA infections that have caused significant pain and suffering to each individual;

(b) By failing and refusing to place the cohorted inmates in a single location where the entire inmate general population would not be subject to the MRSA infection so as to provide for the general health and welfare of the inmate population. Such failure to segregate the infected inmates led to even more MRSA infections

throughout the Defendant Detention Center and contributed substantially to the pain and suffering of all of the inmates involved;

(c) By failing to properly educate the inmates, correctional workers, and health care personnel on how to effectively contain a MRSA outbreak, which led to an uneducated staff and population that allowed MRSA infections to persist throughout the inmate population and cause significant pain and suffering to all infected individuals;

(d) By failing to follow-up with the proper public health care authorities to develop a proper control strategy to contain the MRSA outbreak that occurred, and is occurring, at the Defendant Detention Center;

45. In addition, the Defendants, at all times relevant herein were subject to the rules and regulations established by the South Carolina legislation as set forth in the *Minimum Standards for Local Detention Facilities in South Carolina*.

46. These minimum standards, among other things, provided as follows:

(a) "All portions of existing buildings, both interior and exterior, are maintained in such manner that structural, strength, stability, and sanitation, indoor air quality, and safety of life and property are free from fire and other hazards. Repairs and upkeep are provided to ensure public safety, health, and general welfare." § 2029 of the *Minimum Standards for Local Detention Facilities in South Carolina.*

(b) "Each facility shall develop and implement written standard operating procedures, which are approved by the responsible physician or medical authority for the following: (in pertinent part)

……………………………………………………………………

(1) Non-emergency medical services

(2) Emergency medical and dental services

……………………………………………………………………"

§ 2054 of the *Minimum Standards for Local Detention Facilities in South Carolina.*

(c) "The facility shall have written policies which ensure adequate medical attention for those inmates requesting it. § 2055 of the *Minimum Standards for Local Detention Facilities in South Carolina.*

(d) "Each facility shall provide twenty-four (24) hour emergency medical and dental care availability, as outlined in a written plan which includes arrangement for: ....

(1) Use of one (1) or more designated hospital emergency rooms or other appropriate health facilities ...."

47. Notwithstanding these provisions, the Defendants willfully, wantonly, recklessly, maliciously and intentionally violated the minimum standards governing detention center in each of the following particulars:

(a) By failing and refusing to maintain the interior of the Detention Center in such a manner that it is free from infection and disease thereby subjecting the inmates housed to continuous MRSA infections that caused significant pain and suffering to each individual;

(b) By failing and refusing to provide minimum upkeep to the interior of the Detention Center so as to provide for the general health and welfare of the inmate population;

(c) By failing to provide the inmates with access to medical care when requested;

(d) By failing to administer medication as prescribed by medical providers;

(e) By failing to provide adequate follow-up medical care when it had been prescribed by medical personnel at the Greenville Memorial Hospital.

48. As a direct and proximate result of the Defendants willful, wanton, reckless, malicious and intentional failure to adhere to the aforementioned minimum standards and the Defendants willful, wanton, reckless, malicious and intentional denial of the Plaintiff's rights guaranteed under the Constitution of the State of South Carolina, the Plaintiffs have been severely and permanently damaged in each of the following particulars:

Inmate Plaintiffs:

a) Tony Boyd first received care for his skin infection following a March 16, 2006 grievance filed by his sister regarding his inability to receive care. The grievance was inexplicably denied. He was seen by a nurse on March 17, 2006 and was given antibiotics prescribed by a telephone order from the physician. He was first seen by a nurse practitioner three days later, when a culture was ordered, but not reported in the record. He had no wound care and no follow-up, although follow-up was ordered for three days after the visit. He filed a request for care for persistent skin infection on April 16, 2006 and had an antibiotic prescribed by a licensed practical nurse. He had no follow-up with a licensed health care practitioner and only one wound care encounter on April 13, 2006. His infection grew worse. Once again, on May 10, 2006 he was diagnosed and treated by a nurse. On May 24, 2006, he was given an antibiotic again. Finally, he received wound care on May 25 - 30, 2006. He received prescriptions for antibiotics on May 27 and for a different antibiotic on May 31, 2006. Mr. Boyd grieved the co-payments he was charged for this persistent infection, despite the fact that he developed the infection through intramural transmission (he was admitted February 22, 2006 with no documented skin infections). There is no documentation that Mr. Boyd received 21 doses of his antibiotics in two months.

Tony Boyd has a persistent skin infection, acquired at GCDC, that has been unresponsive to medication prescribed, inappropriately, by nurses. He was seen four times by a nurse practitioner who should have referred him to a physician because of the persistence of the infection despite multiple antibiotics. He had a culture that was never reported in the record and he missed multiple doses of antibiotics which predisposes to the development of antibiotic resistence. He did not receive wound care until the end of May 2006.

b) Anthony Byrd has had at least two admissions to GCDC. He was treated for a skin infection on September 1, 2005 with Duracef, a medication known to be ineffective for MRSA. Although it was ordered for seven days, he only got it for six days. He missed four of the 14 doses prescribed. After his readmission to the

jail, prior to December 8, 2005, a nurse prescribed an antibiotic for Mr. Byrd on January 15 and again on January 20, 2006. There was no progress note for the latter order. Another nurse put him on an "antibiotic protocol" on March 6, 2006 without referring him to a physician or nurse practitioner and without providing for wound care or follow-up. He missed six of the 20 doses prescribed. On April 9, 2006, Mr. Byrd again requested care. He was started on antibiotics without being examined. It took five days to get the first dose and then four of the 14 prescribed doses were not documented. Twelve days after his request for care, there is a progress note that says "will culture" on April 21, 2006.

Anthony Byrd has a persistent skin infection, acquired at GCDC. The skin infection has been unresponsive to medication prescribed, inappropriately, by nurses. His skin culture was never reported. He did not see a physician or nurse practitioner for diagnosis or treatment. He did not receive wound care or appropriate follow-up. He was not given multiple doses of his medication.

c) John Campbell was admitted to the facility at some time prior to March 19, 2006. Although there was no note of initial treatment, there is a note dated March 24, 2006 that says his "toe" resolved on antibiotics. He requested to see a physician for his toe infection on March 25 but was not sent to see one. On March 27, 2006, when he had been on antibiotics for six days, he developed cellulitis and was sent to the emergency room of the local hospital. He had no follow-up on his return, although he was put on two antibiotics. He missed 20 of 76 doses prescribed for March 2006. He was returned to the emergency room on March 31, 2006.

On April 5, 2006, he had a boil that had to be incised and drained at orthopedics clinic. Mr. Campbell developed further lesions in early May. He was put on other antibiotics but there is no progress note. He only received 19 of the 28 doses prescribed for him on May 5, 2006 and 15 of the 28 doses prescribed on May 19, 2006.

Mr. Campbell has persistent or recurrent skin infections that developed at GCDC. At least two times he had to be sent to the emergency room and on another occasion he was seen in orthopedics clinic at the hospital. Despite these infections, he never saw a licensed independent health care practitioner at the jail. Medication was prescribed by nurses. He had no cultures done. He had no wound care or follow-up. He was not given a high proportion of doses of his medication.

d) John Cartee began complaining of his skin infections on April 8, 2006. Although he should have been seen by a licensed independent health care practitioner, the nurse inexplicably prescribed an antihistamine and did not refer

him. He asked for care again on April 13, 15, and 18. On April 18, 2006, Mr. Cartee had an elevated temperature of 99.6 degrees and an abnormally elevated heart rate of 109 beats per minute. Along with an obvious infection, he should have been seen by a physician immediately because of the risk of sepsis, a serious and potentially blood infection. Instead, the nurse ordered antibiotics for him prior to his being seen by a nurse practitioner on April 18, 2006. Eleven days after his first request for care, he was seen by the nurse practitioner who diagnosed multiple boils including his testicle (presumably she meant "scrotum" and not "testicle)." A culture was done and reported as positive for MRSA. She ordered medication on April 20, 2006 and again she ordered renewed medication on May 3, 2006 after a sick call request (but no visit), and May 16, 2006 (with no visit). She ordered medication again on May 24 and saw him for follow-up on May 25 and May 30, 2006. Mr. Cartee missed approximately 25% of his prescribed doses of antibiotics.

John Cartee had persistent skin infections acquired at GCDC. He was denied access to appropriate medical attention when he may have had sepsis. He was treated without being examined and he had an inappropriate lag to care initially.

e) Mark Cureton had multiple admissions to the GCDC. He was first prescribed antibiotics on January 3, 2006 for a skin infection. He had a positive culture for MRSA. On March 25, 2006, he had a draining wound. Nurse Practitioner Easterguard found him with a fever of 100.1 degrees and cellulitis. He was sent to the emergency room for evaluation and treatment. He received no follow-up care and missed 11 of 28 doses of his prescribed medication. The nurse practitioner was called about him on March 31, 2006, but she did not see him. He developed fever of 101.2 degrees and a headache, signs of possible sepsis, and he was sent again to the emergency room. The note from the emergency room says that his antibiotic prescription was interrupted by the jail physician. He received no follow-up or wound care at the jail. He missed 14 of 28 prescribed doses of medication; he refused some of these doses and was not offered other. But he had a reason for the refusals, i.e., he said that the medicine caused a rash. In fact his medication was renewed, despite the drug reaction on April 19, 2006. Notwithstanding the drug reaction, he was not referred to a licensed independent practitioner. He was not seen in follow-up by the nurse practitioner until May 3, 2006. His medication was finally changed on May 11, 2006, but he did not receive nine of 28 prescribed doses of the medication. On May 17, 2006, Mr. Cureton was seen by a consultant who recommended reconstructive surgery on the finger that had been infected.

Mr. Cureton had recurrent skin infections acquired at GCDC. He was not seen in a timely manner by licensed independent practitioners at the jail. He received inadequate wound care and follow-up and missed a high proportion of medication

prescribed for him. He had an allergic reaction to Bactrim and not only was not appropriately referred for care his prescription for Bactrim was renewed.

f) Dale Epps complained of skin lesions on October 23, 2005. Although he had a culture, he was not seen by a licensed independent practitioner. The culture is not reported in the medical record. A nurse prescribed antibiotics for him. He missed four of the 14 doses prescribed for him. He had no follow-up or wound care. His wife called on October 25, 2005 and Mr. Epps requested care again. He was seen by Dr. Sherman six days later, on November 1, 2005, who diagnosed folliculitis and added to the antibiotic regimen. On March 3 and 4, 2006, Mr. Epps' wife requested care for him for a new lesion. The response to the wife's March 4, 2006 request says that he was seen on March 6, 2006, but there is nothing in the record to document that he was seen or treated.

Dale Epps acquired a skin infection at GCDC, but he was not seen by a physician for a week after a nurse prescribed medication which was only given to him in part. His infection recurred. He and his wife both requested care for him, but none was given. He received no follow-up or wound care.

g) Antonio Gaines was first treated for a skin infection on August 24, 2005 with Duracef, an antibiotic known to be ineffective for MRSA. He was treated again with Duracef on September 1, 2005. He had no medical visit on these two occasions. On September 14, 2005, he was seen for a boil on his thigh by Dr. Sherman, who prescribed Augmentin, an antibiotic known to be ineffective for MRSA. By September 27, 2005, his boils were spreading and draining. He was treated with Duracef and clindamycin. He had two cultures that were positive for MRSA, on September 28 and December 25, 2005. He received courses of antibiotics prescribed on October 17 and December 21, 2005 and January 6, February 17, March 27, and May 1, 2006. He had no follow-up, except for a March 1, 2006 visit and no wound care. He had no documented visits with a physician or nurse practitioner from September 27, 2005 through March 1, 2006 and none since March 1, 2006.

Antonio Gaines had persistent skin infections with MRSA. He was treated in inappropriate antibiotics without being seen by a physician or nurse practitioner. He had no wound care and no follow-up. He received nine courses of antibiotics, but still had skin infection on May 1, 2006.

h) Danny Haught complained of skin lesions on or about his right calf on April 19 and 20, 2006. He was not seen by a licensed independent practitioner, but he had a prescription for antibiotic written by the nurse practitioner. There was no clinical note. He had a positive culture for MRSA. He did not receive any follow-up or wound care. This was an infection acquired at GCDC.

i) Rory Johnson complained of a skin infection on October 14 and 20, 2005. He was seen by a nurse, but not a physician or nurse practitioner. He had a positive culture for MRSA. He only received eight of 28 doses of his prescribed medication. On February 3, 2006, he had a rash but was not seen. There is a note dated February 7, 2006 that he no longer needs medical attention.

Rory Johnson acquired a recurrent MRSA infection at GCDC. He was never seen by a licensed independent practitioner. He had no wound care and no follow-up.

j) Albert D. Jones, while patiently awaiting adjudication, was infected with MRSA on or about his underarm and foot. Albert Jones filed a request for care for a skin lesion on March 4, 2006. He was diagnosed and prescribed antibiotics by a nurse. He never saw a licensed independent practitioner. He had no wound care, no culture and no follow-up.

k) Glenn Jones filed a sick call request on January 5, 2006 for a "spider bite." He filed another request on January 6, 2006 for a lesion on his calf. He had a wound culture and was put on an antibiotic without seeing a physician or nurse practitioner. He was given six courses of antibiotics between January 6 and May 24, 2006, but only saw the nurse practitioner on April 10, May 3, and May 30, 2006. Despite five months of persistent infection, he was never referred to the physician. He received no wound care. The wound culture done in January was not reviewed by the nurse practitioner until May 30, 2006.

Glenn Jones had five months of persistent skin infections, acquired at GCDC. He had no wound care and no follow-up. His condition was diagnosed by nurses who prescribed medication for him. He had three visits with a nurse practitioner during this period.

l) Kevin Keith developed skin lesions some time prior to March 9, 2006 when antibiotics were prescribed for him. He received six courses of antibiotics between March 9 and May 25, 2006. He had six visits with nurses who diagnosed his condition and prescribed medication, but he was never seen by a licensed independent practitioner. His wound was cultured on one occasion but the result is not in the chart. He received no wound care until May 26, 2006 where wound care notes are documented daily through June 6, 2006. Kevin Keith acquired his persistent infection at GCDC.

m) Douglas P. Lance, while awaiting adjudication, was infected with MRSA on or about his right side, chest, and leg on or about May 10, 2006. Douglas Lance developed a boil on May 10, 2006. He was diagnosed and treated by a nurse, who also ordered a culture. He was not seen by a physician or nurse

practitioner during the subsequent three or four days before he was discharged. Douglas Lance acquired his infection at GCDC.

n) Joseph Lightsey was first treated with antibiotics for skin infection on August 30, 2005, without the benefit of a visit with a licensed independent practitioner. One month later, on September 30, 2005, he received a second course of antibiotics, without documentation of an examination. He had a wound culture on that date that was reported as positive for MRSA. He received a third course of antibiotics on October 30, 2005. On November 12, 2005, he complained of a skin lesion on his eyelid, but he did not get referred. His eye problem continued at least through December 14, 2005, but he did not get to see a physician or nurse practitioner.

Joseph Lightsey was diagnosed and repeatedly treated by nurses without benefit of a physician or nurse practitioner. He acquired his persistent infection at GCDC. He had no wound care and no follow-up.

o) Kelly Martin requested care for a skin lesion near her vagina on March 4, 2006. On March 14, 2006, she was seen by a nurse who found six lesions. The nurse diagnosed Ms. Martin and prescribed antibiotics. Sixteen days after she requested care, she was seen by the nurse practitioner. Ms. Martin requested the results of her culture (not documented in the record) on April 6, 11, and 13, 2006, but these test results were not shared with her. On April 24, 2006, she again requested care. Instead of getting care she received a note back that she was already being treated. On April 25, 2006, she again requested care. A nurse prescribed 14 doses of antibiotics of which she missed four. Ms. Martin had only one visit with the nurse practitioner. She had no wound care and no follow-up for the persistent skin infection she acquired at GCDC.

p) Irwin McCullough complained of skin lesions on April 24, 2006. Without being seen, antibiotics were prescribed for him on April 30, 2006, receiving the first dose May 2, 2006. He was seen by a nurse on May 4, 2006, who followed the “protocol.” Mr. McCullough’s mother called the jail on May 3, 8, 11, and 25 regarding her son’s skin infection but he was never seen by a nurse practitioner or physician. He had five courses of antibiotics and no wound care until daily checks were documented from May 25 - 30, 2006. On May 25, 2006, he was noted to be “non-compliant” with medication. His persistent skin infection was acquired at GCDC.

q) Timothy McIntosh first developed skin lesions on January 14, 2006 which was diagnosed and treated, inexplicably, with Benadryl, an antihistamine. He was again diagnosed and treated with antibiotics by a nurse on January 21, 2006. He had a wound culture which was reported positive for MRSA. On January 25,

2006, he was seen by the nurse practitioner who incised and drained a boil, but was not seen for follow-up until February 2, 2006 by the nurse practitioner and February 22, 2006 by a nurse. On April 18, he submitted a sick call request, but this request was not reviewed by a nurse for 33 days, on May 16, 2006, by which time he was out of custody. On April 21, 2006, he submitted a request to be seen for a boil in his armpit, but he was not seen until May 1, 2006 by the nurse practitioner. In the interim, antibiotics were prescribed for him by a nurse on April 20, 2006. Mr. McIntosh acquired his recurrent MRSA infection at GCDC.

r) Joshua Mitchell was diagnosed and treated for his skin infection on May 2, 2006. By May 7, 2006, he had developed a boil that was incised and drained in the emergency room of the local hospital. He was not seen by the nurse practitioner until May 18. He only received eight of the 16 doses of medication prescribed for him. He did not receive any wound care or timely follow-up.

s) James Pearson has no indication in his medical records that he had skin infection, although he did have a negative culture on May 25, 2006. He was seen on at least ten occasions by nursing staff for seizures and he was seen on May 2, 2006 by the nurse practitioner. Mr. Pearson had uncontrolled seizures and little, if any, attempts were made to get him on a proper course of antiseizure medication.

Dr. Robert Greifinger interviewed and examined James Pearson. At the time of his examination on May 23, 2006, Mr. Pearson had extensive pustular folliculitis of the face, consistent with long-standing MRSA infection. This rash would be obvious to a prudent layperson. In addition to his uncontrolled seizures being ignored by the medical staff, his bacterial skin infection was also ignored. The fact that he did have one wound culture demonstrates that at least one person was aware of his infection, yet there is no documentation of the reason for the culture. The fact that the culture was negative only means that one particular sample did not grow bacteria. It does not mean that he did not have MRSA infection on his face. This persistent infection was likely acquired at GCDC.

t) Gerald L. Roberts, while serving a four month sentence for failure to pay child support, was infected with MRSA on or about his right foot, left leg, left knee, left arm, and right shoulder on or about April 9, 2006. He was diagnosed and treated with antibiotics by a nurse. On April 11, 2006, he was seen by the nurse practitioner who prescribed additional antibiotics. He did have a wound check the following day and he was seen by the physician on April 18, 2006. Mr. Roberts has yet to be taken to the emergency room even though the wounds are numerous and significant to his body. He had no culture or other wound care. This was a jail-acquired infection.

u) Alonzo Trotter developed a "spider bite" on February 7, 2006. The nurse diagnosed him and prescribed an antibiotic. The medication he received was Keflex, an antibiotic known to be ineffective against MRSA. By February 10, 2006, he developed fever and abscess, whereupon he was sent to the hospital by the nurse practitioner. This was a jail-acquired infection.

On April 13, 2006, he developed signs and symptoms of kidney stones. He was in pain when he was seen and diagnosed by the nurse practitioner. Despite his pain and his diagnosis, he went five days until he was seen by the facility physician. The physician ordered him to be sent to the hospital, but he had to wait a whole day until he was sent. He suffered for six days with this pain.

v) Loren L. Waddell, while awaiting adjudication at the Detention Center, was infected with MRSA on or about the left side of his scalp noticeable by a large bump above his left ear. Loren Waddell developed boils on April 24, 2006. He was diagnosed and treated by the nurse practitioner and had one follow-up visit on April 26, 2006. He did not receive wound care or further follow-up although his prescription was renewed on May 5, 2006. He missed four of the twenty-seven prescribed doses of antibiotics. His infection was acquired at GCDC.

w) Thomas Whitaker submitted at least five requests for care for his skin infection on September 2, 5, 14, 15, and 19, 2005. He was seen on September 9, 2005 where his boil was misdiagnosed as a closed head injury. He was finally diagnosed with having a boil by a nurse after 17 days and put on Keflex, an antibiotic known to be ineffective against MRSA. One day later he was seen at the emergency room of the local hospital, treated with incision and drainage, and prescribed an appropriate antibiotic. The prescription for the appropriate antibiotic was not picked up. Instead, he was given Duracef, another inappropriate antibiotic, prescribed October 7 and 25, 2005. He was continued on Keflex as well, with prescriptions written on September 20 and October 22, 2005. He was seen in followup approximately weekly (five visits) between September 23 and October 25, 2005. On October 25, 2005, Dr. Sherman diagnosed a new lesion which was cultured. The culture was positive for MRSA. His infection persisted, as documented by both Dr. Sherman and a nurse practitioner, through December 28, 2005.

Mr. Whitaker submitted a request for care on May 7, 2006 but was not seen by the nurse until May 16, 2006. The nurse diagnosed a skin infection and prescribed antibiotics for him. He requested care again on May 17, 18, and 23, 2006, but was not seen because he was on antibiotics. The antibiotic prescribed for him was Duracef, known to be ineffective for MRSA. During his May 2006 bought of illness, Mr. Whitaker did not see a licensed independent practitioner. He received

no wound care and no follow-up.

He was on inappropriate medication for each of his episodes of persistent and recurrent skin infection. He was diagnosed by nurses to prescribed medication for him. He had inadequate attention to his wounds and no follow-up care for his infections that were acquired at GCDC.

x) Elliot Wimbush came to GCDC with a skin infection on December 22, 2005. Antibiotics were prescribed for him by the nurse practitioner on December 25, 2005, three days before she examined him. He had a wound culture that grew out MRSA on December 28, 2005. Mr. Wimbush had a wound check on January 4 and a nurse practitioner visit on January 13, 2006. On March 4, 8 and 9, 2006, Mr. Wimbush requested care for a recurrence of the infection. He was not seen for ten days until he was diagnosed by the nurse practitioner with lesions on his head and leg, although he received antibiotics as early as March 10, 2006 without being examined by a physician or nurse practitioner.

y) Alan W. Yates, was infected with MRSA on or about his right knee, right leg, face, and left hand while awaiting adjudication. Mr. Yates has yet to be taken to the emergency room even though the wounds are numerous and significant to his body. Alan Yates was given at least two courses of antibiotics by nurses beginning April 29, 2006. He had no examination or treatment by a physician or nurse practitioner. He had no wound care and no follow-up. His wound was not cultured. His infection was acquired at GCDC.

WHEREFORE, the Plaintiffs pray judgment against the Defendants for compensatory damages for the physical, mental and emotional injuries they each individually have sustained and for such further relief as to this Court seems just and equitable.

[signature block on following page]

Respectively submitted,

Tom W. Dunaway, III (ID# 639)
DUNAWAY & ASSOCIATES
514 South McDuffie Street
Post Office Box 1965
Anderson, South Carolina 29622
(864) 224-1144 (telephone)
(864) 224-2083 (facsimile)

Attorney for Plaintiffs

Anderson, South Carolina.

August 22, 2006