1992 WL 277511
United States District Court, E.D. Pennsylvania.

Steven AUSTIN, et al., Plaintiffs,
v.
PENNSYLVANIA DEPARTMENT OF CORRECTIONS, et al., Defendants.

Civ. A. No. 90–7497. | Sept. 29, 1992.

Attorneys and Law Firms

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Opinion

MEMORANDUM

DuBOIS, District Judge.

***1** This is a civil class action for declaratory and injunctive relief brought under 42 U.S.C. § 1983, and Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 701, *et seq.* Jurisdiction is based on 28 U.S.C. §§ 1331 and 1343 of the Judicial Code.

Presently before the Court is plaintiffs' Motion for Preliminary Injunction. Plaintiffs seek a preliminary injunction enjoining defendants to establish an appropriate program for the diagnosis, treatment, and control of tuberculosis in the thirteen State Correctional Institutions that are subject to this action and State Correctional Institution (hereinafter abbreviated "SCI") Muncy. Upon consideration of plaintiffs' motion for preliminary injunction, plaintiffs' supporting brief, defendants' brief in opposition to plaintiffs' motion, after a hearing on the motion and for the reasons set forth below, plaintiffs' motion will be GRANTED.

I. BACKGROUND

A. The Parties

The named plaintiffs are inmates who are currently incarcerated at thirteen State Correctional Institutions throughout the Commonwealth of Pennsylvania. This action was filed in November 1990. On March 6, 1992 the Court certified a class pursuant to Rule 23(a) of the Federal Rules of Civil Procedure consisting of plaintiffs and all other persons who are or who may in the future be incarcerated by the Pennsylvania Department of Corrections in any facility other than SCI–Muncy and SCI–Pittsburgh.[1]

The named defendants are Joseph Lehman, Commissioner of the Pennsylvania Department of Corrections (the "DOC"), the thirteen prison superintendents of the correctional institutions subject to this action, and Robert Casey, Governor of the Commonwealth of Pennsylvania.

B. The Pennsylvania Correctional System

Over 24,000 inmates are housed at fifteen correctional institutions within the Commonwealth of Pennsylvania.[2] Management and day to day operation of correctional institutions falls within the authority of the DOC. Thirteen institutions house male inmates only. One institution, SCI–Muncy, houses only female inmates. One institution, SCI–Waynesburg, once an all female institution, no longer receives female inmates. It presently houses some female prisoners awaiting transfer to SCI–Cambridge Springs which is currently under construction. In the past, female prisoners were transferred between SCI–Muncy and SCI–Waynesburg.

Four of the correctional institutions are designated as diagnostic and classifications centers. SCI–Pittsburgh, SCI–Camp Hill and SCI–Graterford are the diagnostic and classification centers for male prisoners. SCI–Muncy is the diagnostic and classification center for female prisoners. At the diagnostic and classification centers, recently convicted prisoners and parole violators are processed and then transferred to other correctional institutions.

C. Plaintiffs' Claims

Plaintiffs' second amended complaint alleges that defendants' policies, practices, acts and omissions deprive them of their constitutional rights under the First, Fourth, Sixth, Eighth, Ninth and Fourteenth Amendments. Specifically, plaintiffs claim that defendants' policies, practices, acts and omissions have resulted in the following constitutional infractions: (1) overcrowding which rises to the level of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments; (2) excessive use of force in violation of the Fourth, Eighth and Fourteenth Amendments; (3) inadequate

medical and psychiatric services in violation of the Eighth and Fourteenth Amendments; (4) deprivation of liberty and property without due process in violation of the Fourteenth Amendment; (5) lack of access to counsel and the courts in violation of the First, Sixth, and Fourteenth Amendments; and (6) deprivation of the right to privacy and autonomy with respect to the collection and retention of medical information in violation of the First, Fourth, Ninth, and Fourteenth Amendments. Plaintiffs also claim discrimination on the basis of handicapped status in violation of Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 701, *et seq.,* as amended by the Civil Rights Restoration Act of 1987.

***2** The motion for preliminary injunction presently before the Court was filed on July 29, 1992. A three day hearing on the motion was held on September 9, 10, and 11, 1992. Plaintiffs claim that inmates face an imminent risk of being infected with tuberculosis and developing tuberculosis disease due to inadequate control and treatment measures and inadequate implementation. Plaintiffs allege in their supporting brief that in the absence of immediate injunctive relief an increase in the number of active tuberculosis cases can be expected. Finally, plaintiffs claim that without effective control and treatment measures, the risk of multi-drug resistant tuberculosis bacteria developing is imminent.

II. Tuberculosis Infection and Disease[3]

Tuberculosis (hereinafter "TB") is an infectious disease which is caused by a bacterium called the tubercle bacillus. TB is spread through the air by airborne particles called droplet nuclei which contain TB bacterium. Droplet nuclei are generated when persons with infectious TB of the lungs or larynx sneeze, cough, or speak. Unless properly ventilated, droplet nuclei remain suspended in the air where others can inhale them and become infected. TB bacterium are destroyed by sunlight and ultraviolet light.

TB can be characterized as having two stages: an infection stage and an active stage. When air is shared with a person who has developed an active case of TB, the TB bacterium in the air are breathed into the lungs where they multiply for a time until the immune system controls their growth. This is known as the infection stage. Once the immune system takes control, the bacterium normally remain dormant. A person who is only infected by TB cannot spread the disease to others, but can develop an active case of TB later in life. Persons who are infected with TB have approximately a ten percent chance of developing an active case of TB.

Active TB disease can develop in a person who is infected with TB bacterium at almost any time after infection occurs. However, suppression of the immune system increases the risk of developing an active stage of the disease. HIV infection, malnutrition, drug and alcohol abuse, among other factors, weaken the immune system and increase the risk of developing active TB disease. Symptoms associated with active TB disease include a chronic cough, fever, chills, night sweats, loss of appetite and weight loss. Persons with active TB disease are capable of spreading TB infection to others. Although active TB disease is most common in the lungs, it can also occur in other organs in the body.

III. CONTROL AND TREATMENT OF TUBERCULOSIS

At the hearing on plaintiffs' motion for preliminary injunction, plaintiffs submitted documentary and testimonial evidence in support of their allegation that the TB control policy in effect at Pennsylvania correctional facilities from 1985 to September 4, 1992 was inadequate and that implementation of that policy has not been totally effective at arresting the rise in the number of active TB cases. Based on the evidence presented at the hearing on plaintiffs' motion, the Court makes the following findings of fact.

A. Components of a Tuberculosis Control Program

***3** The essential components of an effective TB control program are surveillance, containment and assessment. (Pl. Exhibit 48, Centers for Disease Control, *Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers* (1992) at 5 (hereinafter "Control Guide"). In correctional facilities surveillance refers to the identification of TB infection and disease in prison inmates and staff through screening, diagnosis, case reporting and investigation. *Id.* Containment refers to preventing the transmission of TB through preventive therapy for persons who are infected but have not advanced to the disease stage, and isolation and treatment of diagnosed and suspected cases of active TB disease. *Id.* at 7–8. Assessment refers to activities aimed at producing information which assists in determining the effectiveness of a TB control program. *Id.* at 10.

1. Surveillance

The Mantoux tuberculin skin test is the most effective method of indicating whether a person is infected with TB. The test is performed by injecting a purified protein derivative (PPD) under the skin on the forearm. *Control Guide* at 5. The injection area is examined within 48–72 hours for signs of reaction. *Id.* An induration of ten millimeters or more is considered positive for infection with TB. *Id.* However, where the patient is infected with HIV, the PPD test may yield a false-negative result.[4] A

chest x-ray should be performed within 72 hours of a positive PPD skin test or whenever symptoms of active TB disease are diagnosed. *Id.* Where symptoms or screening indicate active TB disease, a sputum smear and culture must be examined for TB bacterium in order to confirm the diagnosis. *Control Guide* at 7.

Whenever an active case of TB disease is diagnosed additional screening must be conducted on all close contacts unless the contact has a recently documented positive PPD test. The concentric circle approach is a method which is employed to identify persons who may have been infected. *Id.* Under that approach, PPD testing is performed on those persons who have had close contact with the source case. If additional infections are revealed, the investigation is expanded until no additional infection is discovered.

2. Containment

Isoniazid (INH) is a commonly used drug in the prevention and treatment of TB. INH drug therapy is effective in reducing the incidence of conversion from the infection stage to the active stage of TB. *Id.* at 9. Persons who are infected but have not developed the disease are placed on INH therapy for six months unless medical contraindications exist. *Id.* Individuals infected with HIV should be placed on INH for a period from nine to twelve months. Testimony of Dr. Armand Start, Hearing Transcript at 36–37 (Sept. 9, 1992) (hereinafter "Start Testimony"). Drug therapy must continue uninterrupted or relapse can occur and drug-resistant bacterium can develop. *Control Guide* at 10; Start Testimony, Hearing Transcript at 39 (Sept. 9, 1992). However, preventive drug therapy is not without risk. INH has been found to cause increased toxicity levels in the liver. Start Testimony, Hearing Transcript at 35 (Sept. 9, 1992). Persons over the age of thirty-five are particularly vulnerable to side effects from INH therapy and must be monitored by trained medical personnel. *Control Guide* at 10.

***4** Anyone who is diagnosed or has symptoms of active TB disease should be placed in isolation in a room or area under negative air pressure and ventilation to the outside. Start Testimony, Hearing Transcript at 54 (Sept. 9, 1992). Isolation rooms should be connected to a ventilation system capable of performing at least six air exchanges per hour. *Id* at 56. Treatment of active TB includes multi-drug therapy, including INH, and sputum smear and culture analysis until the patient converts to negative. *Control Guide* at 8–10.

3. Assessment

Assessment involves record-keeping and monitoring in order to track rates of infection and disease. Medical records should include among other information: the number of PPD tests administered and the date on which the tests were performed; the results of the PPD tests; medical diagnosis of PPD tests; medical diagnosis of chest x-rays, sputum smears and sputum cultures; additional treatment prescribed, if any; and the number of infections and active cases. Start Testimony, Hearing Transcript at 46, 65–66 (Sept. 9, 1992); *Control Guide* at 10. A quality assurance component is also necessary to ensure that policies and procedures are followed, and that the program is modified or corrected where necessary. Start Testimony, Hearing Transcript at 19 (Sept. 10, 1992).

B. Tuberculosis Among Inmates at Correctional Institutions

Inmates confined at correctional institutions face a higher risk of being infected with TB than the general public due to the close proximity of inmates, the high level of dust particles on which droplet nuclei can become attached and mechanically recirculated air which has not been exposed to sunlight or ultraviolet light. Start Testimony, Hearing Transcript at 25–27 (Sept. 9, 1992). Inmates are also more likely than members of the general public to be HIV-positive. Start Testimony, Hearing Transcript at 24–25 (Sept. 9, 1992).

Individuals infected with both HIV and TB are more likely to develop active TB disease. *Control Guide* at 4. They are also more likely to develop active TB disease in areas of the body other than the lungs. *Id.* Therefore, an effective TB control program is particularly important in correctional institutions.

C. Tuberculosis Among Inmates Confined At Pennsylvania Correctional Institutions

Thirty-four cases of suspected or active TB have been reported among inmates confined at Pennsylvania correctional institutions since November 1988. Hearing Transcript at 104 (Sept. 9, 1992). No multi-drug resistant strains of TB have been identified among the reported cases. Start Testimony, Hearing Transcript at 6 (Sept. 10, 1992).

D. Control and Treatment Policies at Pennsylvania Correctional Institutions

The TB control program in effect at Pennsylvania correctional institutions from 1985 to September 4, 1992 was contained in two documents: (1) *Clinical and Administrative Guidelines for the Prevention and Management of Tuberculosis,* Admin.Manual, Vol. VII,

OM–105.03 (1985); and (2) *Tuberculosis Testing and Reporting,* Administrative Manual, Vol. VII, OM–105.03 (1986). (Def. Exhibits 12 and 2, respectively).[5] The 1985 Policy directed DOC medical directors and health care administrators to follow the clinical guidelines established by the Pennsylvania Department of Health (hereinafter the "DOH"). Testimony of Dr. Judy Anderson, Clinical Director of the DOC, Hearing Transcript at 160 (Sept. 10, 1992) (hereinafter "Anderson Testimony"). The 1985 Policy set forth general procedures for screening, preventive therapy, treatment, monitoring and follow-up. (Def. Exhibit 12) The 1986 Policy updated the 1985 Policy by requiring preemployment screening, interpretation and recording of test results, inmate PPD testing upon their admission into the correctional institution and treatment in accordance with DOH guidelines. (Def. Exhibit 2)

***5** Plaintiffs are critical of the 1985/1986 TB Policy on a number of grounds. Plaintiffs claim, *inter alia,* that: (1) the policy did not require annual testing of inmates and staff; (2) medical records were inadequate; (3) important medical information was omitted from some inmate records; (4) follow-up treatment for inmates with positive PPD's was delayed in some cases; and (5) tracking and monitoring procedures were inadequate.

In May of 1991, the DOC initiated a review of the 1985/1986 TB Policy in response to concerns raised by the DOH with respect to TB control in the Pennsylvania prison system. Testimony of Joseph Lehman, Hearing Transcript at 99 (Sept. 10, 1992) (hereinafter "Lehman Testimony"). As a result of that review, current information regarding TB control and treatment procedures was disseminated to prison superintendents, health care providers and administrative staff in order to update the 1985/1986 TB Policy. Lehman Testimony, Hearing Transcript at 100–102 (Sept. 10, 1992).

In March 1992, Dr. Anderson was directed to develop by July 1, 1992, a new TB control program that incorporated the latest medical practices. Lehman Testimony, Hearing Transcript at 92 (Sept. 10, 1992). Dr. Anderson promptly convened a committee comprised of DOC health care administrators and DOH representatives in the Spring of 1992 to assist in the development of the new policy. Anderson Testimony, Hearing Transcript at 157 (Sept. 10, 1992). Drafts of the new policy were prepared by Dr. Anderson and reviewed by DOC health care administrators and representatives of the DOH. Anderson Testimony, Hearing Transcript at 161 (Sept. 10, 1992). After further review and revision, the new policy entitled *Clinical and Administrative Guidelines for the Prevention and Management of Tuberculosis* (hereinafter the "1992 TB Policy") was adopted and became effective on September 4, 1992. The 1992 TB Policy supersedes all previous TB guidelines and policies.

The 1992 TB Policy calls for: (1) TB testing of all inmates upon entry into the institution and annual testing thereafter based on the inmates' date of entry; (2) preemployment and annual testing for employees; (3) segregation of new inmates pending completion of TB screening; (4) preventive therapy for inmates with inactive TB infection and monitoring for adverse reaction to therapy; (5) isolation and treatment for inmates with active TB; (6) computerized medical record keeping for PPD test dates, results and follow-up treatment; (7) automated status reports generated on a daily and monthly basis and reporting procedures for active cases of TB; (8) annual education and training in TB prevention and control for inmates and employees and documentation of such training upon completion; (9) measures to prevent the transfer of inmates without medical clearance; (10) segregation of inmates who refuse to comply with screening and testing procedures; (11) semi-annual screening of inmates known to be infected with HIV; and (12) procedures for investigating incidents of conversion from negative to positive PPD status. (Def. Exhibit 1)

***6** The DOC is currently in the process of implementing the September 4, 1992 TB control policy. When fully implemented, the new program will address all of the issues and concerns raised by plaintiffs in their Preliminary Injunction Brief and during the hearing on the motion. Hearing Transcript at 9 (Sept. 10, 1992). According to plaintiffs' expert, Dr. Armand Start, the 1992 TB Policy is an "excellent document" that addresses all of the major elements of any TB control program. Start Testimony, Hearing Transcript at 9 (Sept. 10, 1992).

In order to insure the implementation and effectiveness of the 1992 TB Policy, the DOC plans to institute a quality assurance program. To that end, the DOC has employed the services of an independent contractor, National Capital Systems Group, to develop such a program. Specifically, the contractor has been directed to provide a system which, *inter alia,* will enable the DOC to monitor the performance of contract medical service vendors which provide health care at DOC facilities, and improve medical record keeping. Lehman Testimony, Hearing Transcript at 97, 127 (Sept. 10, 1992). The quality assurance program, when finalized, will be implemented at all corrections institutions. Lehman Testimony, Hearing Transcript at 128–29 (Sept. 10, 1992). In the interim, the DOC and the DOH have entered into a Memorandum of Understanding (Pl. Exhibit 59) dated September 9, 1992, under which the DOH will provide updated guidelines for TB prevention and control, annual training of health care staff in PPD testing and reading, and advice regarding control measures for case management and prevention of outbreaks of TB. Pursuant to the Memorandum of Understanding, the DOC will report active and suspected cases of active TB within three working days to DOH and will provide DOH with information and access to inmate records to facilitate evaluation of the policy and specific

recommendations.

IV. CONCLUSIONS OF LAW AND DISCUSSION

When considering whether to grant a preliminary injunction, the Court is guided by the following factors: "(1) the probability of irreparable injury to the moving party in the absence of relief; (2) the possibility of harm to the nonmoving party if relief were granted; (3) the likelihood of success on the merits; and (4) the public interest." *Alessi v. Pennsylvania Department of Welfare,* 893 F.2d 1444, 1447 (3d Cir.1990) (citation omitted).

Based on the Court's findings of fact and upon application of the guidelines set forth above, the Court concludes that: (1) there is a probability of irreparable injury to plaintiff class in the absence of relief; (2) the defendants will not be harmed by preliminary injunctive relief; (3) plaintiffs have demonstrated a likelihood of success on the merits; and (4) the public will not be harmed by preliminary injunctive relief. Accordingly, plaintiffs' motion for preliminary injunctive relief will be granted.

A. Irreparable Injury

***7** In order to satisfy the irreparable injury element, "plaintiff must demonstrate potential harm which cannot be redressed by a legal or an equitable remedy following trial." *Instant Air Freight Co. v. C.F. Air Freight, Inc.,* 882 F.2d 797, 801 (3d Cir.1989). Evidence submitted by plaintiffs at the preliminary injunction hearing verified the well documented medical view that TB is a very serious disease that can be fatal in some cases. Dr. Start, plaintiffs' expert witness, testified that the TB bacterium is a hardy form of bacteria which is difficult to eradicate. Hearing Transcript at 27 (Sept. 9, 1992). He also pointed out that TB is at least three times more prevalent among inmates than the general public. Hearing Transcript at 24 (Sept. 9, 1992). Plaintiffs' evidence also established the proposition that inconsistent or interrupted treatment, or non-compliance with treatment by inmates can lead to the development of multi-drug resistant TB. Hearing Transcript at 39 (Sept. 9, 1992). Finally, plaintiffs' evidence established the importance of accurate monitoring and tracking procedures to chart TB trends and activity.

Given the increase in the number of reported cases of active TB disease between 1988 and 1992, the seriousness of active TB disease, the possibility of additional complications where the patient is infected with HIV, and the potential risk of side-effects from preventive drug therapy, the Court concludes that there is a probability of irreparable harm to plaintiff class.

B. Absence of Harm to Defendants

Defendants will not be harmed by the entry of an order directing implementation of the 1992 TB Policy. The evidence establishes that the DOC is committed to the implementation of the new policy. The implementation has already begun. Moreover, the evidence shows the DOC recognizes that the new policy will benefit inmates, prison officials and staff by providing greater protection for all persons who live and work behind prison walls.

C. Likelihood of Success on the Merits

In order to obtain injunctive relief, plaintiffs must produce evidence sufficient to demonstrate to the court that they have a likelihood of success on the merits, that is, reasonable probability of eventual success. *Instant Air Freight,* 882 F.2d at 800; *ECRI v. McGraw–Hill, Inc.,* 809 F.2d 223, 226 (3d Cir.1987). In the Third Circuit, "[i]t is not necessary that the moving party's right to a final decision after trial be wholly without doubt; rather the burden is on the party seeking relief to make a *prima facie* case showing a reasonable probability that it will prevail on the merits." *Punnett v. Carter,* 621 F.2d 578, 583 (3d Cir.1980) (citing *Oburn v. Shapp,* 521 F.2d 142, 148 (3d Cir.1970)).

Plaintiffs' request for preliminary injunctive relief is based upon their allegation that inmates threatened with TB infection and disease are provided a constitutionally deficient level of medical care. In order to succeed on the merits, plaintiffs are required to demonstrate deliberate indifference to the serious medical needs of inmates on the part of prison officials. *Wilson v. Seiter,* 111 S.Ct. 2321, 2324 (1991); *Estelle v. Gamble,* 429 U.S. 97 (1976). Prison officials are deliberately indifferent when they know or should have known of a sufficiently serious danger to inmates and fail to respond reasonably to the danger. *Young v. Quinlan,* 960 F.2d 351, 360–61, 360 n. 22 (3d Cir.1992). Negligent or inadvertent failure to provide adequate medical care is not enough. *DeShaney v. Winnebago County Department of Social Services,* 489 U.S. 189 (1989).

***8** In considering whether to grant or deny preliminary injunctive relief, the Court is not required to determine whether defendants' past or present response to the need for TB control and treatment amounts to deliberate indifference, and no such finding has been made. The question of whether defendants' TB control and treatment policies pass constitutional muster is an issue to be resolved at trial.

The Court finds that, when implemented, the 1992 TB Policy will adequately address the need for TB treatment and control in the State correctional system. The Court

further finds that DOC has begun the task of implementing the new policy. However, under the facts presented, plaintiffs have demonstrated that until the new policy is implemented, there is a likelihood of success on the merits.

D. Absence of Harm to the Public

There is no evidence that any harm would befall the general public by the granting of preliminary injunctive relief. To the contrary, the public will benefit from more effective TB screening and control measures in the State correctional system. The risk of infected inmates progressing to the active stage and spreading the disease to the general public upon their release from prison will be reduced by tighter screening and more effective treatment. Furthermore, the risk of infection spreading among prison employees, their families and friends will be decreased.

IV. CONCLUSION

Plaintiffs have produced sufficient evidence to convince the Court that preliminary injunctive relief is warranted. An appropriate order will be issued requiring defendants to implement the Clinical and Administrative Guidelines for the Prevention and Management of Tuberculosis dated September 4, 1992.

ORDER

AND NOW, to wit, this 29th day of September, 1992, upon consideration of Plaintiffs' Motion for Preliminary Injunction and Brief In Support of the Motion (Document No. 75), Defendants' Brief In Opposition to Plaintiffs' Motion For Preliminary Injunction (Document No. 78), and after a hearing on the Motion held by this Court on September 9, 10 & 11, 1992, IT IS ORDERED that, plaintiffs' Motion for Preliminary Injunction is GRANTED.

IT IS FURTHER ORDERED that, the defendants, their employees, medical contractors, agents and all other persons acting in concert with them are preliminarily enjoined to implement defendants' Clinical and Administrative Guidelines for the Prevention and Management of Tuberculosis, dated September 4, 1992, at every State Correctional Institution subject to this action.

IT IS FURTHER ORDERED that the injunctive relief granted by this Order shall be extended to SCI–Muncy.

Parallel Citations

3 NDLR P 158

Footnotes

1 SCI–Pittsburgh is involved in an ongoing case, *Tillery v. Owens,* 719 F.Supp. 1256 (W.D.Pa.1989), *aff'd* 907 F.2d 418 (3d Cir.1990). SCI–Muncy is covered by the Consent Decree in *Imprisoned Citizens Union v. Shapp,* 451 F.Supp. 893 (E.D.Pa.1978).

2 Seven additional institutions are currently under construction. Testimony of Joseph Lehman, Hearing Transcript at 88 (Sept. 10, 1992).

3 The sources of the facts set forth in this part of the Memorandum are, *inter alia,* Centers for Disease Control, *Control of Tuberculosis in Correctional Facilities: A Guide for Health Care Workers* (1992); Testimony of Dr. Armand Start, Hearing Transcript (Sept. 9 & 10, 1992); and Testimony of Dr. Ronald Rahman, Hearing Transcript (Sept. 11, 1992).

4 A false-negative result may also result where the PPD test is given shortly after infection occurs due to a latency period of six to eight weeks between the time of exposure to the time a PPD test will result in a positive reaction. Testimony of Dr. Armand Start, Hearing Transcript at 12 (Sept. 9, 1992).

5 According to Dr. Judy Anderson, the Department of Health Tuberculosis Guidelines were revised in 1988 and again in 1991. Testimony of Dr. Judy Anderson, Hearing Transcript at 160 (Sept. 10, 1992).