

No. 10-945

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In The  
**Supreme Court of the United States**

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ALBERT W. FLORENCE,

*Petitioner,*

v.

BOARD OF CHOSEN FREEHOLDERS  
OF THE COUNTY OF BURLINGTON, et al.,

*Respondents.*

—◆—  
**On Writ Of Certiorari To The  
United States Court Of Appeals  
For The Third Circuit**

—◆—  
**BRIEF AMICI CURIAE OF MEDICAL SOCIETY OF  
NEW JERSEY, THE CENTER FOR PRISONER  
HEALTH AND HUMAN RIGHTS, AND MEDICAL  
EXPERTS IN SUPPORT OF PETITIONER**

—◆—  
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(i)

**QUESTION PRESENTED FOR REVIEW**

Whether the Fourth Amendment permits a jail to conduct a suspicionless strip search of every individual arrested for any minor offense no matter what the circumstances.

**TABLE OF CONTENTS**

	<i>Page</i>
<b>QUESTION PRESENTED FOR REVIEW .....</b>	<b>i</b>
<b>TABLE OF CONTENTS .....</b>	<b>ii</b>
<b>TABLE OF AUTHORITIES .....</b>	<b>iv</b>
<b>INTEREST OF <i>AMICI CURIAE</i> .....</b>	<b>1</b>
<b>ARGUMENT .....</b>	<b>3</b>
<b>I. PURPORTED MEDICAL OR PUBLIC HEALTH “EXPERTISE” OF PRISON OR JAIL ADMINISTRATORS MUST BE AFFORDED NO JUDICIAL DEFERENCE.....</b>	<b>3</b>
<b>II. STRIP SEARCHES AT INTAKE ARE A COUNTERPRODUCTIVE AND POOR STRATEGY FOR SURVEILLANCE, SCREENING, INTERVENTION AND PREVENTION OF MRSA.....</b>	<b>5</b>
<b>    A. Checking New Inmates For MRSA Is A Bogus Justification For The Blanket Strip Search Policy Because Current Strip Search Methods Are Ineffective At Detecting MRSA .....</b>	<b>6</b>

(iii)

1. <i>A Bona Fide, Effective MRSA Screening Should Include A Medical History and An Assessment of Risk Factors by Trained Personnel.....</i>	7
a. <i>A Bona Fide Skin Exam Takes Into Account Medical History And Risk Factors.....</i>	8
b. <i>A Bona Fide Skin Exam Would Be Conducted By Trained Personnel.....</i>	12
2. <i>A Good Faith Effort Screening for MRSA Should Include Ensuring The New Inmate Ample Opportunity To Maintain Good Hygiene And To Receive Information About Preventing The Disease.....</i>	15
<b>B. Strip Searches Fail To Address, and Detract From The Root Causes Of, MRSA Epidemics In Correctional Facilities .....</b>	<b>17</b>
<b>CONCLUSION .....</b>	<b>22</b>
Appendix A: List of <i>Amici</i> Doctors .....	1a

**TABLE OF AUTHORITIES**

*Page*

**CASES**

*Bell v. Wolfish*,  
441 U.S. 520 (1979)..... 3, 4

*Estelle v. Gamble*,  
429 U.S. 97 (1976)..... 4

*Jones v. North Carolina Prisoners' Labor Union*,  
433 U.S. 119 (1977)..... 3, 4, 5

*Procunier v. Martinez*,  
416 U.S. 396 (1974)..... 3

*Wolff v. McDonnell*,  
418 U.S. 539 (1974)..... 3, 4

**MEDICAL PUBLICATIONS**

Aiello, *et al.*,  
*Methicillin-resistant Staphylococcus aureus among  
U.S. prisoners and military personnel: Review and  
recommendations for future studies*, 6 THE LANCET  
INFECTIOUS DISEASES, 335 (2006) ..... 17, 19

Baillargeon, *et al.*,  
*Methicillin-Resistant Staphylococcus Aureus  
Infection In The Texas Prison System*, 38 CLINICAL  
INFECTIOUS DISEASES 92 (2004) ..... 20

Campbell, *et al.*,  
*Risk Factors For Community-Associated Methicillin-Resistant Staphylococcus Aureus Infections In An Outbreak Of Disease Among Military Trainees In San Diego, California, In 2002*, 42 J. CLINICAL MICROBIOLOGY 4050 (2004) .....20

Center for Disease Control and Prevention,  
*Methicillin – Resistant Staphylococcus in aureus Infections in Correctional Facilities – Georgia, California, and Texas 2001 – 2003* 52 (41) MORBIDITY AND MORTALITY WEEKLY REPORT 992, 993 (2003).....8, 15, 16, 17

David, *et al.*,  
*Predominance Of Methicillin-Resistant Staphylococcus Aureus Among Pathogens Causing Skin And Soft Tissue Infections In A Large Urban Jail: Risk Factors And Recurrence Rates*, 46 J. CLINICAL MICROBIOLOGY 3222 (2010) ..... 18

Deger, *et al.*,  
*The Enduring Menace Of MRSA: Incidence, Treatment, And Prevention In A County Jail*, 15 J. CORRECT. HEALTH CARE 3, 174 (2009).....5, 21

Elias *et al.*,  
*Community-Based Intervention To Manage An Outbreak Of MRSA Skin Infections In A County Jail*, 16 J. CORRECT. HEALTH CARE 205 (2010)..... 18

Federal Bureau of Prisons,  
*CLINICAL PRACTICE GUIDELINES: MANAGEMENT OF METHICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) INFECTIONS* (April 2011)...8, 9, 10, 11, 13, 16

Goldstein,  
*et al.*, *Impact of a Standardized Protocol to Address Methicillin-Resistant Staphylococcus aureus Skin Infections at a Large, Urban County Jail System*, 12 J. CORRECT. HEALTH CARE 3 181(2006).....20

Malcolm,  
*The Rise of Methicillin-Resistant Staphylococcus aureus in U.S. Correctional Populations*, J. CORRECT. HEALTH CARE 1 (May 13, 2011).....17,18,19

Miles,  
*Editor's Letter*, 15 J. CORRECT. HEALTH CARE 173 (2009).....18

Navy Environmental Health Center,  
GUIDELINES FOR THE MANAGEMENT OF COMMUNITY-ACQUIRED METHICILLIN – RESISTANT STAPHYLOCOCCUS AUREUS (CA-MRSA) INFECTIONS IN THE US NAVY AND MARINE CORPS (August 2005)..... 9

Stevens *et al.*,  
*Practice Guidelines for the Diagnosis and Management of Skin and Soft-Tissue Infection*, 41 Clinical Infectious Diseases 1373 (2005).....10, 13, 14

*The Most Important Standard: Receiving Screening*, National Commission on Correctional Healthcare, [www.ncchc.org/resources/spotlight/18-3.html](http://www.ncchc.org/resources/spotlight/18-3.html) (last visited June 21, 2011)..... 12

United States Department of Justice,  
NATIONAL INSTITUTE OF CORRECTIONS, PROCEEDINGS OF THE LARGE JAIL NETWORK MEETING 10 (Spring 2008)..... 11

*Webb, et al.,  
MRSA Prevention and Control in County  
Correctional Facilities*, 15 J. CORRECT. HEALTH CARE  
4, 268 (2009).....20

*Wooten et al.,  
Intervention to Reduce the Incidence of Methillicin-  
Resistant Staphylococcus aureus Skin Infections in a  
Correctional Facility in Georgia*, 25 (5) INFECTION  
CONTROL AND HOSPITAL EPIDEMIOLOGY 402  
(2004).....11, 15, 16

**OTHER MATERIALS**

Brief in Opposition for Board of Chosen Freeholders  
et al. *Florence v. Board of Chosen Freeholders*, No.  
10-945 (2011)..... 6

Brief in Opposition for Essex County Correctional  
Facility et al. in *Florence v. Board of Chosen  
Freeholders*, No. 10-945 (2011)..... 6

Petition for Writ of Certiorari, *Florence v. Board of  
Chosen Freeholders*, No. 10-945 (2011)..... 14, 16



## INTEREST OF *AMICI CURIAE*<sup>1</sup>

Founded in 1766, *amicus curiae* the *Medical Society of New Jersey* (MSNJ) is the oldest professional society in the United States. The organization and its dues-paying members are dedicated to a healthy New Jersey, working to ensure the sanctity of the physician–patient relationship. In representing all medical disciplines, MSNJ advocates for the rights of patients and physicians alike, for the delivery of the highest quality medical care. This allows response to the patients’ individual, varied needs, in an ethical and compassionate environment, in order to create a healthy Garden State and healthy citizens.

*Amicus curiae The Center for Prisoner Health and Human Rights* (CPHHR) is a collaboration of doctors, social workers and allied health staff from a variety of medical disciplines with the common mission of preserving the basic rights and needs of individuals detained in correctional systems, both in the United States and abroad. With a history of providing medical care for inmates dating back to 1986, CPHHR was formally created in 2005 to further promote quality medical care for inmates, as well as research and education about correctional healthcare. CPHHR is also committed to advocacy for prisoners in particular towards securing basic

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<sup>1</sup> No counsel of a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief and no person other than *amici curiae*, its members, or its counsel made a monetary contribution to its preparation or submission. Parties have provided written consent, on file with the Court, to the filing of briefs in support of either, or neither party.

protections such as access to care, safety and humane treatment.

*Amici* Dr. Scott Allen, Dr. Curt Beckwith, Dr. Charles Carpenter, Dr. Jennifer Clarke, Dr. Joanne Csete, Dr. Susan Cu-Uvin, Dr. Anne De Groot, Dr. Peter Friedmann, Dr. Lorie Smith Goshin, Dr. Jennifer Johnson, Dr. Michelle Lally, Dr. David Lewis, Dr. Amy Nunn, Dr. Susan Ray, Dr. Josiah Rich, Dr. David Rimland, Dr. Michael Stein, Dr. Lynn Taylor are trained medical and public health professionals with combined centuries of experience in screening, identifying, and treating infectious diseases and advancing medical scholarship on proper protocols and methods for public and correctional health care. Appendix A to this brief is a list of *amici* doctors, with institutional affiliations provided for identification purposes only.

*Amici* respectfully submit the following brief to highlight the consensus of infectious disease and public health experts on communicable disease in correctional facilities. Among the various advocated approaches in the medical community to infectious disease epidemics in correctional facilities, casual visual inspections incidental to a security strip search is not one of them.

*Amici* urge the Court to hold that detecting skin disease or infection is not a valid justification for non-medically trained officers to strip search all arrestees upon intake to a jail. Because ordering people to strip naked and commanding them to expose their genitals and buttocks for inspection is so intrusive into personal liberty, the jails have a heavy burden providing adequate justification for this practice. The Burlington County Jail and the Essex County Correctional Facility contend that one

justification for their ‘blanket strip search’ policies is to check new inmates for signs of skin disease and infection. Their argument—as it pertains to medical or health care, rather than institutional security—deserves no deference. Furthermore, a strip search conducted by non-medical personnel for security purposes has little connection to the procedures used during a bona fide skin exam. Such searches undermine, or at best distract from, consistent policies to address the root cause of infectious disease epidemics in correctional facilities.

## ARGUMENT

### I. **PURPORTED MEDICAL OR PUBLIC HEALTH “EXPERTISE” OF PRISON OR JAIL ADMINISTRATORS MUST BE AFFORDED NO JUDICIAL DEFERENCE**

Traditionally, courts have adopted a “broad hands-off attitude” toward problems of prison administration. *See Procunier v. Martinez*, 416 U.S. 396, 404-05 (1974). However, the grant of deference is qualified by a plain view to “legitimate goals and policies” of the prison—not bogus justifications. *See Bell v. Wolfish*, 441 U.S. 520, 546 (1979) (“the legitimate goals and policies of the penal institution limits . . . retained constitutional rights”) (citing *Jones v. North Carolina Prisoners’ Labor Union*, 433 U.S. 119, 125 (1977)); *see also Wolff v. McDonnell*, 418 U.S. 539, 566 (1974) (“must balance the inmate’s interest . . . against the needs of the prison”). This Court does indeed recognize that institutional operations of correctional facilities require “difficult judgments.” *See Jones*, 433 U.S. at 128 (“necessary

and correct result of . . . deference to the informed discretion of prison administrators permits them, and not the courts, to make the difficult judgments concerning institutional operations”). At the same time, however, prisoners retain constitutional rights and administrators are not given carte blanche to arbitrarily pin the justification for impeding constitutional rights on a whim—for example, casual visual inspections for infectious diseases incidental to a security based search. *See Wolff*, 418 U.S. at 555-56 (“There is no iron curtain drawn between the Constitution and the prisons of this country.”); *see also Bell*, 441 U.S. at 545 (“convicted prisoners do not forfeit all constitutional protections by reason of their conviction and confinement in prison”); *see also id.* (explaining that pretrial detainees retain at least the same level of constitutional protection as enjoyed by convicted prisoners).

Of course, the core rationale for deference is to ensure prison administrators can accomplish their “central objective[:] . . . safeguarding *institutional security*.” *See id.* at 547 (emphasis added); *see also Jones*, 433 U.S. at 137-38 (clarifying that prison administrators deserve deference on security questions because administrators have “the most expertise in [that] field”). However, haphazard visual inspections, searches that only nominally are medically appropriate, serve absolutely no penological purpose for a correctional facility. *See Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976) (“denial of medical care may result in pain and suffering which no one suggests would serve any penological purpose”). Thus, where a prison administration employs some alternative non-security justification for violating constitutional rights, such as public health or medical necessity, this Court should only

warily extend deference. Medical determinations formulated by correctional administrators whose primary task and expertise lies in *security* matters ought to be viewed not with any deference, but a strong dose of healthy skepticism. *See Jones*, 433 U.S. at 128-32 (qualifying discretion of prison administrators due deference as that which is well informed, reasonable, and responsible).

## **II. STRIP SEARCHES AT INTAKE ARE A COUNTERPRODUCTIVE AND POOR STRATEGY FOR SURVEILLANCE, SCREENING, INTERVENTION, AND PREVENTION OF MRSA**

Skin and soft tissue infections (SSTIs) are “the inheritance of every jail and prison.” *See Deger, et al., The Enduring Menace Of MRSA: Incidence, Treatment, And Prevention In A County Jail*, 15 J. CORRECT. HEALTH CARE 3, 174, 177 (2009). Influenced by a variety of indicators, including poverty, homelessness, crowding, mental illness, lack of education, drug use, and skin and health conditions, SSTIs run rampant in correctional facilities. *See id.* National trends and local studies confirm that close to 70% of SSTIs are Methicillin-resistant *Staphylococcus aureus* (MRSA). *See id.* (“MRSA is the most common cause of SSTIs . . . consistent with national trends”). Because of MRSA, the Burlington County Jail and Essex Correctional Facility should be alert to inmate wounds but in a medical, not a security, context. Using security motivated strip searches to detect skin infections is not in line with recommended medical practices and ignores the root causes of MRSA transmission.

**A. Checking New Inmates For MRSA Is A Bogus Justification For The Blanket Strip Search Policy Because Current Strip Search Methods Are Ineffective At Detecting MRSA.**

The Board of Chosen Freeholders for Burlington County and the Burlington County Jail (“BCJ”) argue that one justification for a blanket strip search policy is to conduct “a visual inspection for sores and other indicia of illness.” Brief in Opposition for Board of Chosen Freeholders et al. *Florence v. Board of Chosen Freeholders*, No. 10-945, at 4 (2011) [hereinafter “BCJ Brief”]. BCJ claims that these inspections protect other inmates by preventing contact with newly arrived inmates who present symptoms of skin disease. BCJ claims that failure to screen new inmates for skin disease implicates the Eighth Amendment because the jail has an obligation to protect the health of all the detainees in its care. *See id.* at 20. The Essex County Correctional Facility (“Essex”) notes the BCJ brief’s medical justification as a reflection of its own reasons for strip-searching. Brief in Opposition for Essex County Correctional Facility et al. in *Florence v. Board of Chosen Freeholders*, at 7, No. 10-945 (2011). This medical justification cited by BCJ and Essex is disingenuous and improper.

While it is agreed that the BCJ and Essex are responsible for the health and safety of their inmates, the strip searches to which the plaintiff was subjected had none of the characteristics of a bona fide skin examination conducive to effective SSTI

identification or prevention. The rudimentary manner in which officers at BCJ and Essex conduct a visual skin inspection, as incidental to a security motivated strip search, has no medical validity that could outweigh the extreme intrusion into protected Fourth Amendment rights and personal dignity. First, an effective screening for SSTI's would include taking a medical history and questioning the inmate about his health and skin conditions and assessing his risk factors for SSTI's before and during an exam. Second, a good faith screening for SSTIs would include measures to ensure the new inmate's good hygiene, including ample opportunities to wash and to learn about preventing infections.

1. *A Bona Fide, Effective MRSA Screening Would Include A Medical History And An Assessment Of Risk Factors By Trained Personnel.*

The effective and efficient way to screen inmates for SSTIs, including MRSA, would include a medical questionnaire, an assessment of risk factors and a focused inspection and evaluation of any lesions on the skin by healthcare professionals. If BCJ and Essex were sincere in their policy of searching for SSTIs, their officers would treat a skin examination as a distinct, careful inspection independent from a security based search. In a security strip search, examination of the skin is cursory at best because the primary focus is on spotting contraband. Instead of following any of the medically recommended steps for detecting SSTIs and MRSA, BCJ and Essex's approach to supposedly

detecting SSTIs is merely incidental to their overall visual search: eyeballing naked inmates from several feet away. Neither Essex nor BCJ provide any medical support in their briefs for the validity of SSTI detection as incidental to a security search. A review of the medical literature on the topic reveals that the Jails' approach has no foundation in good medical practice because it does not take into account the inmate's medical history and risk factors and because it is not conducted by personnel trained to identify skin disease.

a. *A Bona Fide Skin Exam  
Takes Into Account Medical  
History And Risk Factors*

Numerous state and federal agencies and medical organizations have published guidelines for healthcare workers, athletic trainers and coaches, hospital workers, and correctional facility staff for detecting signs of SSTIs and MRSA. For example, in April 2011, the Federal Bureau of Prisons ("BOP") released updated medical guidelines for controlling MRSA infections.<sup>2</sup> These guidelines recommend providing skin screenings on intake that include, encouraging inmates to self-report skin problems. Federal Bureau of Prisons, CLINICAL PRACTICE GUIDELINES: MANAGEMENT OF METHICILLIN-

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<sup>2</sup> The Federal Bureau of Prisons developed its MRSA control guidelines using information from a study published by the Center for Disease Control and Prevention. See Center for Disease Control and Prevention, *Methicillin – Resistant Staphylococcus in aureus Infections in Correctional Facilities – Georgia, California, and Texas 2001 – 2003* 52 (41) MORBIDITY AND MORTALITY WEEKLY REPORT 992, 993 (2003)



RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) INFECTIONS 2 – 3 (April 2011) [hereinafter “BOP Guidelines”]. The BOP Guidelines recommend obtaining inmate medical history during skin screening which entails asking the inmate about the presence and nature of pain associated with skin lesions and recent medical history. *Id.* at 8. At no point do the BOP guidelines advocate forcibly strip-searching inmates to detect skin infections. *See id.* at 2-3.

A discussion with inmates about their medical history is crucial to properly conducting a skin inspection. The presence of MRSA in particular can more easily be assessed if it is known whether the inmate has established risk factors. Common risk factors include close contact with someone with a known infection; frequent antibiotic use; sharing personal hygiene items such as towels and soap bars with infected persons; a history of past MRSA infections; and recent hospitalizations. *Id.* at 1. The Navy Environmental Health Center also advocates that evaluations for skin lesions must start with an understanding of the person’s basic medical history through evaluation of the person’s risk factors for MRSA. Navy Environmental Health Center, GUIDELINES FOR THE MANAGEMENT OF COMMUNITY-ACQUIRED METHICILLIN – RESISTANT STAPHYLOCOCCUS AUREUS (CA-MRSA) INFECTIONS IN THE US NAVY AND MARINE CORPS 6 (August 2005). Evaluation of SSTIs should include assessment of any lesions, identification of risk factors through questioning, followed by the performance and review of laboratory cultures. *Id.*

A major reason why it is so important to question inmates about their health and skin is that most skin infections, at least in their early stages, do

not look very different from each other. See Stevens et al. *Practice Guidelines for the Diagnosis and Management of Skin and Soft-Tissue Infection*, 41 CLINICAL INFECTIOUS DISEASES 1373, 1378 (2005) [hereinafter “IDSA Guidelines”]. Information from the inmates, both regarding their risk factors and personal health, can help place a suspected, but unidentifiable, sore or wound into context. See *id.* A small, red lesion may appear to be a harmless insect bite. However, that same small red, lesion might be cause for further medical referral if the inmate has been involved in a known risk factor, such as unsanitary tattooing, or a recent hospitalization. As the Infectious Disease Society of America’s *Practice Guidelines for the Diagnosis and Management of Skin and Soft Tissue Infections* notes, “obtaining a careful history, including information about the patient’s immune status, the geographical locale, travel history, recent trauma or surgery, previous microbial therapy, lifestyle, hobbies, animal exposure or bites is key to developing an adequate differential diagnosis and an appropriate index of suspicion.” *Id.* Such a careful clinical assessment is important because an incorrect initial diagnosis and treatment can lead to therapy failure, or, in the case of new inmates, may result in serious infections being overlooked entirely. *Id.*

Finally, it should be noted that skin examinations of all inmates, even those conducted for bona fide medical purposes, are generally recommended when there has been an actual outbreak<sup>3</sup> of MRSA in the facility. See BOP

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<sup>3</sup> An outbreak occurs when “similar antibiotic susceptibility patterns are identified among two or more MRSA isolates from epidemiologically linked patients.” BOP Guidelines at 12.

Guidelines at 12. Even in the outbreak scenario, *en masse* strip searching has not been the recommended way to control the spread of the disease. Less intrusive measures have been successfully employed to identify cases during outbreaks, and these, unsurprisingly, have revolved around questioning the inmates themselves. A 2003 study of a MRSA outbreak at a Georgia jail, for example, successfully relied on 193 self-reported questionnaires to locate the inmates with MRSA in the facility. *See* Wooten et al., *Intervention to Reduce the Incidence of Methillicin-Resistant Staphylococcus aureus Skin Infections in a Correctional Facility in Georgia*, 25 (5) *Infection Control and Hospital Epidemiology* 402, 404 (May 2004). Meanwhile jails around the country have used practices such as conducting medical skin screens while the inmate is in underwear, steam-cleaning jail cells, and increasing the availability of hand sanitizers to combat infections, none of which are integrated into a security motivated strip search. *See* United States Department of Justice, NATIONAL INSTITUTE OF CORRECTIONS, PROCEEDINGS OF THE LARGE JAIL NETWORK MEETING 10 (Spring 2008).

There is absolutely no evidence in the BCJ and Essex opposition briefs that officials at either BCJ or Essex made any effort to learn from the plaintiff whether he had any wounds, pain, or swelling anywhere on his body. They did not ask him whether he engaged in any practices that put him at risk for MRSA, nor did they inquire from him about whether he had had any recent hospitalizations. The absence of questioning meant that if the officers did spot any abnormalities on his skin, they would have had no context with which to seriously evaluate them. The record indicates that the officers at BCJ and Essex ordered the plaintiff to strip, and then

followed with a series of commands to expose areas of his body. They did not even explain to him that they were also checking him for skin infections. The lack of questioning and explanation is a clear indication that detecting skin disease was not, in reality, a priority for the strip searches.

b. *A Bona Fide Skin Exam  
Would Be Conducted By  
Trained Personnel*

As a threshold matter, The National Commission on Correctional Health Care (“NCCHC”), which issues guidelines for healthcare screening on intake to jails, does recommend that jail officers, who are *trained*, can “check[] each entering inmate for immediate need of medical attention and ask[] about any urgent health needs.” *The Most Important Standard: Receiving Screening*, National Commission on Correctional Healthcare, [www.nchc.org/resources/spotlight/18-3.html](http://www.nchc.org/resources/spotlight/18-3.html) (last visited June 21, 2011). The ideal is for healthcare professionals to conduct the screening, but such initial screening by officers on intake is helpful to jail medical staff in identifying new inmates with possible health problems. *See id.* Officers can look for obvious potential signs of illness, follow-up with the inmate through health-related questioning, and refer inmates to proper services.

However, this recommendation in no way implies that such a check involves a full body security strip search conducted for the primary purpose of interdicting contraband. Nor does it suggest that untrained officers should be examining the inmates at all, much less for specific types of

illnesses, such as complex skin diseases. The policy at issue in this case deals specifically with *strip searching* new inmates by officers conducting a search in a security, not medical, capacity.

Proper training is crucial to detecting skin infections and other indicia of illness. Dangerous and contagious SSTIs, like MRSA, are not easily recognizable in their early stages. In particular, it is problematic to differentiate between a cellulitis that should respond to antimicrobial treatment alone and a necrotizing infection that requires operative intervention. IDSA Guidelines, *supra* at 1383. A careful, medical inspection of the skin is therefore crucial to effective containment of MRSA and other SSTIs. Trained professionals should be conducting the search because the potential for mistakenly identifying the symptoms of MRSA with another SSTI is great.

Training in the different treatment options for various SSTIs would include studying the potential implications of skin lesions of various sizes and presentations. *See e.g.* BOP Guidelines, *supra* at 8. For example, patients with skin lesions smaller than 5cm, without accompanying cellulitis and no systemic signs and systems, should receive only conservative treatment, such as warm soaks and compresses. *Id.* Those with larger lesions should receive oral antibiotics, but if these lesions are accompanied by cellulitis, they should receive further assessment along with the antibiotics. *Id.* Meanwhile, inmates whose lesions are accompanied by systemic signs and symptoms should be hospitalized. *Id.* There is no evidence either in the record or in the BCJ or Essex briefs that indicate the officers involved had any such training in SSTI identification or treatment.

Trained personnel would also be expected to understand that there is a great deal of overlap in the clinical presentation of different skin infections and “in the initial phases, distinguishing between a cellulitis that should respond to antimicrobial treatment alone and a necrotizing infection that requires operative intervention may be difficult.” IDSA Guidelines, *supra* at 1383. Again, a combination of knowledge about the disease and how it presents, alongside an understanding of the medical history and risk factors of the patient, is necessary to proper inspection for MRSA and other SSTIs. “Recognizing the physical examination findings and understanding the anatomical relationships of skin and soft tissues are also crucial for establishing the correct diagnosis,” and so the need for a serious, medical approach to skin exams conducted by medically trained personnel is particularly required given the danger of missing the signs of severe infection. *Id.* at 1378. The overlap in presentation between different SSTIs, especially between deadly and innocuous ones, is an area where a bona fide skin inspection policy would be essential.

Officers involved in a good faith effort to detect disease would have been able to identify different types of skin lesions, and would have used that training in a thorough exam of the skin upon intake. In this case, however, there is no documentation that officers seriously inspected the skin, or looked for and evaluated signs of infection. In fact, at Essex, two officers visually inspected five naked men at one time. Petition for Writ of Certiorari, *Florence v. Board of Chosen Freeholders*, No. 10-945, at 7 (2011) [hereinafter “Cert. Petition”]. Glancing over five men at once is not a realistic method of professionally detecting skin disease. Rather, it is further evidence

that the Jails' were not effectively using security strip searching to catch disease and that the medical justification for strip searching is merely an unfounded, post-hoc rationalization that makes little medical sense.

2. *A Good Faith Effort Screening For SSTI's Would Include Ensuring The New Inmate Ample Opportunity To Maintain Good Hygiene And To Receive Information About Preventing The Disease*

It is mainstream, scientific and medical fact that poor hygiene exacerbates SSTI and MRSA wounds and increases transmission risk to other people. Describing outbreaks of MRSA in Texas, California, and Georgia jails, the Center for Disease Control and Prevention ("CDC") cited barriers to inmate hygiene as contributing factor to its spread in the jail. *See* Center for Disease Control and Prevention, *Methicillin – Resistant Staphylococcus aureus Infections in Correctional Facilities – Georgia, California, and Texas 2001 – 2003* 52 (41) *Morbidity and Mortality Weekly Report* 992, 993 (2003) [hereinafter CDC 2003 study]. In particular, limited access to anti-bacterial soap and clean laundry increased the risk of MRSA's spread. *Id.* Personal hygiene was also identified as a serious cause of MRSA transmission in a published study on efforts by the Georgia Division of Public Health to reduce the incidence of MRSA. *See* Wooten, *supra* at 407. In that study, investigators found it problematic that inmates were provided only one bar of soap, and

credited a policy change allowing soap dispensers in the shower facilities with decreasing MRSA transmission. *See id.* at 405-06.

The fact that bodily filth is causally linked to SSTI spread is why such authorities as the Bureau of Prisons, the Center for Disease Control and Prevention, the U.S. Navy, and various state and local public health agencies emphasize the urgent need to educate inmates about hygiene and to provide inmates with access to clean towels, anti-bacterial soaps, and immediate help for wound care. In the Los Angeles County jail system (the largest in the country), the L.A. County Department of Health Services recommended “enhanced administrative infection-control measures” near the health clinic “to ensure frequent showering and appropriate personal hygiene for inmates.” CDC 2003 Study, *supra* at 994. Meanwhile, the BOP explains that “[r]egular handwashing should be emphasized as the most important intervention for preventing a MRSA outbreak.” BOP Guidelines, *supra* at 9.

It follows that if BCJ and Essex were actively trying to prevent a MRSA outbreak, they would have made at least a minimal effort to provide inmates with access to hygiene. The opposite is true. Not only did BCJ and Essex fail to take affirmative steps to provide such resources for the plaintiff, but the record reflects that they actually withheld his access to shower facilities for six full days following his arrest. The plaintiff had to wait, day in and day out, in his cell without the opportunity to shower, wash his clothes, or even to brush his teeth. *See Cert. Petition, supra* at 5 - 6. In light of these facts, BCJ and Essex’s use of MRSA prevention as a justification for strip searching the plaintiff and other inmates is misguided.



**B. Strip Searches Fail To Address, And Distract From The Root Causes Of, MRSA Epidemics In Correctional Facilities**

Prisons, like hospitals and health facilities before them, are a critical site for public health interventions seeking to stem the tide of community acquired MRSA (“CA-MRSA”). While the 1970’s and 1980’s saw an emergence of resistance of methicillin among *S. aureus* infections in hospitals, and even in the community, in persons who had a recent health care procedure or contact with someone who had a health care-associated risk factor, it was not until the 1990’s and 2000’s that CA-MRSA outbreaks became associated with correctional facilities. See Malcolm, *The Rise of Methicillin-Resistant Staphylococcus aureus in U.S. Correctional Populations*, J. CORRECT. HEALTH CARE 1, 2 (May 13, 2011).

Every year, 10 million people are processed in correctional facilities throughout America, a number that has grown 300% since 1980. See Aiello, *et al.*, *Methicillin-resistant Staphylococcus aureus among U.S. prisoners and military personnel: Review and recommendations for future studies*, 6 THE LANCET INFECTIOUS DISEASES, 335, 335-41 (2006). In the past decade, the CDC noted a high prevalence and noted increase of MRSA infection in correctional populations. See Malcolm, *supra* at 2 (citing Centers for Disease Control and Prevention, *MRSA infections in correctional facilities—Georgia, California and Texas, 2001-2003*, 52 MORBIDITY AND MORTALITY WEEKLY REPORT 992, 992 (2003)). Jails, in particular,

are a “critical point of access for care.” See Miles, *Editor’s Letter*, 15 J. CORRECT. HEALTH CARE 173, 173 (2009) (“mental and physical health conditions seen in jails are a reflection of the populations at highest health risk in the community . . . . We need to make the most of this opportunity . . . to foster and support partnerships between jails, public health, and community-based care and service providers . . . . Prevention activities and primary health care in jails benefit not only the incarcerated but also the community at large”).

Conditions of correctional facilities are responsible for epidemics of CA-MRSA in jails. Visual body cavity searches hopelessly aim to address only a symptom of the crisis, rather than the root cause. Time spent in correctional facilities is the largest contributor to spread of CA-MRSA, not infusion of the disease from the community. See Malcolm, *supra* at 6 (“studies . . . found a positive association between length of exposure to prison and likelihood of MRSA colonization”); see also David, *et al.*, *Predominance Of Methicillin-Resistant Staphylococcus Aureus Among Pathogens Causing Skin And Soft Tissue Infections In A Large Urban Jail: Risk Factors And Recurrence Rates*, 46 J. CLINICAL MICROBIOLOGY 3222, 3222-26 (2010) (inmates with *S. aureus* had longer incarceration times than the general incarcerated population). Thus, the “key event is not so much the introduction of MRSA into a facility;” but rather, the transmission and expansion of circulating strains in the facility. See Elias *et al.*, *Community-Based Intervention To Manage An Outbreak Of MRSA Skin Infections In A County Jail*, 16 J. CORRECT. HEALTH CARE 205 (2010) (focus needs to be on prevention of transmission due to the low probability of preventing introduction of

MRSA in an endemic situation).

Unless public health interventions against CA-MRSA in correctional facilities are comprehensive and sustained, the epidemic across our nation's prisons will continue to spread. To date, haphazard implementation of preventive measures in correctional facilities has produced "mixed results." See Malcolm, *supra* at 9 ("Data suggest that targeted interventions can decrease the risk of acquiring skin infections in a correctional setting . . . . Interventions implemented in the Texas and some of the Georgia facilities may have failed because the interventions were not sustained"). Promotion of irrelevant strip searches is an unfortunate detour from the growing threats of MRSA to communities, particularly when jails "represent a model of the transmission dynamics" that may be "useful in preventing transmission . . . also among people in other closed and crowded living conditions." See Aiello, *supra* at 338 (study of MRSA in correctional facilities "would provide a better understanding . . . and ultimately control within these specialized settings").

Moreover, no strip search can even begin to respond to the confluence of risk factors perpetually present within correctional facilities and among inmates for transmission of CA-MRSA. Studies have shown that incarceration itself is a leading risk factor for MRSA. See Malcolm, *supra* at 9 (citing Aiello, *supra* at 338) (risk factors included prison occupation, gender, comorbidities, and other demographic conditions); see also Malcolm, *supra* at 9 (risk factors include young age, ethnicity, homelessness, and drug use). Furthermore, many risk factors are associated with correctional facilities as well. See *id.* (living or working in crowded conditions, immunosuppression, exposure to

environmental and behavioral factors) (citing Baillargeon, *et al.*, *Methicillin-Resistant Staphylococcus Aureus Infection In The Texas Prison System*, 38 CLINICAL INFECTIOUS DISEASES 92, 92–95 (2004)).

Specific risk factors for CA-MRSA in correctional facilities have been analyzed in peer-reviewed scientific settings. For example, being in a room with another person carrying a MRSA skin infection can increase “substantially” the risk of MRSA transmission. *See Webb, et al.*, *MRSA Prevention and Control in County Correctional Facilities*, 15 J. CORRECT. HEALTH CARE 4 268, 273 (2009) citing Campbell, *et al.*, *Risk Factors For Community-Associated Methicillin-Resistant Staphylococcus Aureus Infections In An Outbreak Of Disease Among Military Trainees In San Diego, California, In 2002*, 42 J. CLINICAL MICROBIOLOGY 4050, 4050–53 (2004).

Inadequate medical care and lack of standardized treatment protocols are another root cause of CA-MRSA transmission in correctional facilities. *See Webb, supra* at 273 (describing an outbreak in Georgia where antimicrobials were improperly prescribed in 26% of cases and no proper treatment protocols were in place before the outbreak). The value and necessity of standardized treatment protocols “cannot be overstated.” *Id.* In a study of San Diego County jail systems comparing infection rates seen prior and subsequent to execution of a standardized treatment protocols, standardized procedures created a marked decrease in MRSA infections. *See Goldstein, et al.*, *Impact of a Standardized Protocol to Address Methicillin-Resistant Staphylococcus aureus Skin Infections at a Large, Urban County Jail System*, 12 J. CORRECT.

HEALTH CARE 3 181, 183 (2006).

Tackling MRSA in correctional facilities requires a deep dive into prevention of root causes, rather than hopelessly ineffective casual strip searches. As proven by repeated studies, prevention must encompass a plethora of interventions—including, but not limited to, “daily showering, washing hands frequently, covering all wounds with clean dry dressings, and avoiding sharing towels, clothing and razors.” *See Deger, supra* at 177 (study of a Washington jail emphasizing the importance of liberally dispensing antibacterial soaps, inmate education regarding picking at furuncles and wounds, frequent hand washing, proper disposal of wound dressings, bleach-washing cells after inmate isolation, and flu vaccinations to prevent lethal necrotizing CA-MRSA pneumonia from following influenza). Only “persistent attention to sanitation” can “keep [the] menace of MRSA at a minimum.” *See id.* at 178.

Neither Burlington County Jail nor the Essex County Correctional Facility provide any explanation or support as to how those facilities look for MRSA and other SSTIs during routine strip searches. The idea that checking for skin disease can be seriously accomplished during a security strip search is utterly simplistic. The Jails have offered no evidence of their expertise in this area, and therefore deserve no deference. Moreover, the actual strip search practices at both facilities show that detecting disease was an incidental objective at best. Officers made no effort to assess the plaintiff’s SSTI or MRSA risk factors, to gather any medical history, or to ensure his access to hygiene in the days following the search. This slipshod approach to skin inspection is

not medically effective and, therefore, does not justify the extreme privacy intrusion of examining a person's naked body against his or her will.

### **CONCLUSION**

The decision of the court of appeals should be reversed.

Respectfully Submitted,

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**Appendix A**  
**List of Amici Doctors**

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Clinical Associate Professor of Medicine, Brown University

**Dr. Curt Beckwith**

Assistant Professor of Medicine, Division of Infectious Diseases, Brown University

**Dr. Charles Carpenter**

Professor of Medicine, Brown University  
Director of Lifespan/Tufts/Brown Center for AIDS Research

**Dr. Jennifer Clarke**

Director of Health Disparities Research, The Center for Primary Care and Prevention, Memorial Hospital of Rhode Island  
Associate Professor of Medicine and OB/GYN, Brown University

**Dr. Joanne Csete**

Associate Clinical Professor, Columbia University School of Public Health

**Dr. Susan Cu-Uvin**

Professor of Obstetrics & Gynecology and Medicine, Brown University  
Director, Global Health Initiative, Brown University

**Dr. Anne De Groot**

Founding Editor of Infectious Diseases in Corrections Report (IDCR)  
Professor, University of Rhode Island



**Dr. Peter Friedmann**

Professor of Medicine & Community Health, Brown University

Director, Research Section, Division of General Internal Medicine, Rhode Island Hospital

Director, Center on Systems, Outcomes & Quality in Chronic Disease & Rehabilitation, Providence VA Medical Center

**Dr. Lorie Smith Goshin**

Associate Research Scientist, Columbia School of Nursing

**Dr. Jennifer Johnson**

Assistant Professor (Research), Brown Department of Psychiatry and Human Behavior  
Center for Prisoner Health and Human Rights

**Dr. Michelle Lally**

Division of Infectious Diseases, Lifespan  
Associate Professor of Medicine, Brown University

**Dr. David Lewis**

Professor Emeritus of Community Health, Brown University

**Dr. Amy Nunn**

Assistant Professor of Medicine (Research), Division of Infectious Diseases, Brown University

**Dr. Susan Ray**

Associate Professor of Medicine (Infectious Diseases), Emory University  
Hospital Epidemiologist, Grady Health System

**Dr. Josiah Rich**

Professor of Medicine and Community Health, Brown  
University

**Dr. David Rimland**

Professor of Medicine (Infectious Diseases), Emory  
University

**Dr. Michael Stein**

Director of General Internal Medicine Research  
Group, Brown University  
Professor of Medicine & Community Health, Brown  
University

**Dr. Lynn Taylor**

Assistant Professor of Medicine, Brown University