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Correctional Healthcare Claims Management:
The Case Studies

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Correctional healthcare claims have much in common with all malpractice claims; however, unique legal, organizational, and patient population factors can increase claim complexity and exposure. Throughout the claims process, these factors must be addressed in order to provide the best possible outcomes.

The Progression of a Claim

When a correctional insured tenders a claim, tort claim, lawsuit, or adverse event to an insurance carrier, this initiates the following:

- Prompt claim file creation/acknowledgement by the claims professional. Initial analysis of the facts with the insured; ongoing as the claim proceeds
- Thorough review of coverage, any coverage issues, identify all insured personnel
- Assignment of defense counsel to lawsuits or as otherwise warranted
- Counsel responds/answers for insured personnel within deadlines set by the Court
- Insured personnel meet with counsel; all facts reviewed; plan initial strategy
- Legal discovery -written records/documents exchanged, parties/witnesses give oral testimony, motions to the court are presented as to various issues
- Monetary claim reserves are set consistent with liability exposure and legal costs
- Claims professional, counsel, and the insured evaluate how to best resolve the claim during the investigation and discovery process, utilizing experts as required
- Claim resolution occurs either by dismissal, mediation, arbitration, a jury or bench trial, or direct negotiation between the parties.

Risk factors disproportionately impacting correctional providers include civil rights claims, inmate population issues, contractual issues, and issues with non-medical staff. Proactive claim handling and risk management can significantly mitigate and reduce these correctional healthcare provider risks.

Deliberate Indifference

Correctional healthcare providers are exposed to “Section 1983” civil rights claims, as all inmate healthcare access is governmentally-controlled. Such claims typically invoke the 8th Amendment, claiming “deliberate indifference”, or an intentional or reckless delay in or denial of care. “Deliberate indifference” requires a prisoner’s condition must be sufficiently serious,

and a practitioner's "state of mind" sufficiently culpable, to amount to deliberate indifference of the condition. Punitive damage awards, injunctive relief, and significant statutory attorney's fees may be awarded. State court Section 1983 claims may be removed to the federal court; however inmates can "sidestep" Section 1983 by pleading "deliberate indifference" in state court if imprisoned in venues sympathetic to inmate claims. Sometimes, Section 1983 claims are permitted to stand in state court.

Deliberate indifference can include repeated failure to address serious medical concerns. Such a case study involves an inmate with rectal pain and bleeding, and a diagnosis of hemorrhoids, for over eight months despite several antibiotic prescriptions. He was advised by medical personnel after 5 months that future requests would not be entertained; ten months after his first complaints he was referred out for evaluation, diagnosed, and treated for rectal cancer. Despite lack of expert support for the allegations that any delay led to decreased survivability or a need for increased care, the court was inclined to allow the allegations of deliberate indifference to proceed. Considerations including witness credibility, sympathetic venue, extraordinary litigation expense, and the court's ruling led to a high six-figure settlement. This inmate had requested punitive damages and statutory attorneys' fees.

A Section 1983 case in a dangerous State court venue involved a frequently-incarcerated heroin addict complaining of constant back pain. Eventually bedridden, he was transferred to a local hospital, diagnosed with cancer, and died soon after, having been jailed six months. The medical providers had subcontracted with a correctional staffing agency staffing the entire Jail. Jail staff made extremely vulgar slurs regarding the inmate to the nurses, and claimed he had no right to treatment; this was both alleged and also documented in a newspaper article stating nurses indicated they had resigned due to the staff's comments, and that inmates were placed at risk despite the nurses' best intentions. An "expose" cited "atrocious human rights violations" in which several inmates indicated they requested help for this inmate, but were ignored.

In another case focused on the failure to deliver proper care, the plaintiffs alleged egregious conduct of correctional staff in processing an inmate's request for care. While the family alleged the death of the inmate was from a highly treatable cancer, defense review of the blood testing solely revealed untreatable liver cancer. Nothing could have helped this inmate. This medical provider proactively identified, communicated with and prepared its witnesses. With prompt medical analysis, the provider's cooperation, and timely identification of the case for resolution, it was resolved at mediation for $200,000. Previously, exposure was estimated as exceeding $1,000,000. However, the care provider was pursued by the jail staffing provider, under its contract, for defense costs, despite direct allegations in the lawsuit as to the egregious conduct of the non-medical staff.

Notification, Identification and Communication

Prompt notification to an insurer of personnel involved and insured, under a correctional provider's policy, and their respective roles in any incident, claim or lawsuit, is crucial to promptly and accurately determine the facts, and especially critical with Section 1983 claims. Section 1983 statutes of limitations follow state personal injury statutes. Section 1983 complaints filed in federal court must be reviewed by federal magistrates to determine if they meet minimal pleading standards, with supporting facts. Generally federal complaints must be answered in 21 days, though certain circumstances may extend this period to 60 or 90 days. However, defendants have just fourteen days to object to a magistrate's recommendations, or these become final. Many jurisdictions are extremely protective of plaintiffs' rights, even when complaints are improperly plead, so Section 1983 complaints must be immediately tendered to an insurance carrier, for prompt investigation, so that proper objections to the magistrate's recommendations can be filed.

Inmates present with significantly greater substance abuse rates, untreated medical and mental conditions, and suicide risk than the general public. While the national suicide rate is 11 per 100,000, it is 16 per 100,000 in state/federal prisons and 42 per 100,000 in all other jails. Suicides remain a high correctional exposure risk. Prompt identification of potentially suicidal inmates, consistent monitoring, and detailed recordkeeping remain the most effective tools in preventing suicides and defending any resulting claims.

In one case study, a correctional nurse screened a county jail detainee and recommended psychiatric seclusion. A psychologist instituted suicide precautions including 15-minute checks. A deputy allowed the inmate to leave his cell, unattended, for a lengthy phone call. He hung himself with the phone cord and died at a local hospital. Mental health records could not be located. Deliberate indifference and failure to properly train the guards and failure to maintain proper medical records were alleged. However, aiding this provider's defense, the jail maintained a "lock and track" system showing who the inmate was with, at any given moment, and for what purpose. Documentation provided by the "lock and track" system overcame Plaintiff counsel's claims regarding loss or destruction of the mental health records. It was also proven that the county, not the correctional provider, had the duty to train its correctional officers with respect to inmate monitoring.

This case study, and the liver cancer case discussed above, highlight problems created when jail staff are unaware or neglectful of their responsibilities, or worse, deliberately impede the ability to provide care. Perhaps a more direct case study involves a female detainee, arrested for drunk and disorderly conduct, screened at intake by a correctional nurse. Due to her drunken state, contrary responses and combativeness, the nurse recommended she be stripped and placed on suicide watch. An off-site physician placed an order based on this recommendation. However, the plaintiff alleged she was forcibly strip searched in front of male officers. A videotape of a very combative strip search, with no medical employees present, documented this. This detainee

was then re-interviewed by another nurse, denied suicidal ideation, was allowed to dress, taken off all precautions, and released after posting bond. A court ruling on this provider's motion to dismiss agreed suicide precautions were appropriate. However, under the agreement with the county and the healthcare provider, prison staff training was to have been provided; the court ruled that this provider had not properly trained jail staff as to implementing suicide precautions. Due to the court's specific ruling on this issue, and attendant publicity surrounding the case, the provider settled for a mid five-figure amount.

Such examples show how claims can result from ineffective communications between jail staff and medical providers, and lack of clarity as to the non-medical staff's role. Clear and unambiguous definition of the specific roles and responsibilities of medical and non-medical correctional staff, in contracts between medical providers and the facilities they service, coupled with periodic training and inservices, not only help mitigate claims which arise, but can prevent the circumstances which cause them, resulting in better delivery of medical services. Contracts should specifically state a medical provider's services, and clarify all services will be provided in compliance with accreditation agencies, such as the ACA and NCCHC, and within all applicable state or federal guidelines. Non-medical staff's involvement in providing security, carrying out medical orders issued, promptly notifying medical staff of any inmate believed to require immediate medical attention, and all other duties should be included. Protocol for maintaining secure medical records, separate from inmate confinement records, should be included, in accordance with applicable regulations.

Contractors

Most providers deliver correctional healthcare by contract with governmental entities or correctional staffing vendors. Such contracts should be specific as to liabilities assumed by the healthcare provider, and by the entity or vendor. Medical providers are frequently tendered lawsuits by correctional entities and vendors pursuant to indemnification provisions in these contracts. In the cited liver cancer case study, independent claims were brought against the jail staff. Nonetheless, the medical provider owed the staffing entity its defense costs as the contractual liability portion of their agreement at issue was written broadly enough to encompass these costs. Additionally, this medical provider had no insurance coverage for these costs.

In another case study where an inmate filed Section 1983 allegations as to all parties, a more favorable outcome resulted. The inmate claimed medical staff allowed his anxiety medications to lapse, causing major panic attacks and a full-blown mental breakdown. However, he had at the same time been placed in segregation by a prison employee, which contributed to the delay in receiving his medications. The contract between the state and the medical provider specifically limited the provider's liability to that arising solely from care and treatment, or lack thereof, on the part of its employees. This provider had also obtained coverage, for its contracted facilities, through its insurance carrier, solely for the medical actions of its employees. The state was provided a limited defense, per both the contract and the insurance coverage. By promptly

reporting of the state's tender to this provider's insurer, and with the defense afforded to the state, conflicts between medical and prison staff were minimized. Through timely investigation and an aggressive defense, a federal magistrate recommended the medical providers be dismissed from the prisoner's lawsuit, which subsequently occurred.

Managing Claims

In conclusion, correctional healthcare providers face unique risks due to the circumstances under which they provide their services, their unique patient populations, reliance on nonmedical staff, and their relationships with jails, prisons, and correctional staffing providers However, many steps can be taken to mitigate claims which arise, or prevent claims altogether. These steps can include:

- Prompt identification of all personnel involved in any significant incident, claim or lawsuit, and identification of personnel covered by the provider's insurer
- Prompt notification to an insurer of any claim, lawsuit, or significant incident
- Designation of dedicated personnel to facilitate communications between correctional staff, medical personnel, the insurance carrier, and defense counsel
- Prompt, thorough and well-documented intake evaluations of all inmates and detainees
- Mechanisms to ensure chronic, non-resolving medical complaints are escalated
- Detailed facility contracts clarifying the specific roles of medical and non-medical staff, in conjunction with continuing education
- Carefully-drafted indemnification agreements with any contracted parties

While all healthcare providers risk claims and lawsuits, and correctional healthcare providers face additional, unique risk factors, knowledge of claims and legal processes, coupled with effective policies, procedures and contracts, can help mitigate and avoid clams and lawsuits, and ensure the delivery of consistent, high quality correctional healthcare.