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Judge Lance M. Africk
U.S. District Court
Eastern District of Louisiana
500 Poydras Street, Room C405
New Orleans, LA 70130

Corrected Copy

Re: Jones v. Gusman, et al
USDC # 12-859
Public Comment

Dear Judge Africk,

Thank you for the opportunity to comment on the proposed consent decree between the Southern Poverty Law Center (SPLC), U.S. Department of Justice (DOJ), Orleans Parish Sheriff's Office (OPSO) and the City of New Orleans regarding the Orleans Parish Prison (OPP). I understand that the issue before the Court is whether the proposed consent decree is fair, adequate and reasonable.

I am writing in support of the proposed consent decree. It is my understanding that the consent decree identifies a number of significant areas to be addressed in order to bring the jail's operations into compliance with the U.S. Constitution, and that the intent is to work out many of the specific details through the drafting, adoption and implementation of new policies and procedures under the supervision of the Court and a court-appointed monitor. I believe the fact that SPLC is an integral and active party, indeed the initiator of this lawsuit, and is deeply involved in all aspects of it, provides assurance that the interests of the plaintiff class and indeed the larger community, will be vigilantly protected, along with the support and involvement of the U.S. Department of Justice.

I also understand that the question of whether the conditions in the jail fail to meet constitutional standards has been raised by the City of New Orleans as a contested matter. I find it unfortunate that the City has taken this position. I don't believe there can be any real doubt that the conditions at the jail do not meet minimal constitutional standards and that immediate and thorough-going court intervention and oversight are essential if those standards are to be met.

I am a plaintiff's civil rights attorney, in private practice in New Orleans since 1977. I have been involved with various reform efforts regarding conditions at OPP for years. I have also represented the families of a number of individuals who have died terrible deaths at the jail or

been subjected to serious mistreatment and/or denial of adequate medical care.[1] I try to pay attention to news reports and court filings about the jail, especially regarding deaths of persons in custody of the Sheriff's office. I frequently speak with other attorneys who represent plaintiffs in these cases and have some familiarity with incidents other than those with which I am direct counsel.

Throughout the years, it has become apparent that it is extremely difficult to bring about substantial, meaningful reform of policies and practices at the Orleans Parish jail through individual lawsuits, where there are no viable injunctive remedies available. I believe that not only is the consent decree warranted by the unconstitutional conditions which currently exist, but that the consent decree offers the only real opportunity available to seriously address and hopefully change, in a profound way, an institution that at this point is deeply compromised and requires a substantial overhaul in terms of policies, practices, training and personnel.

Speaking here only of the deaths, I find it disheartening and frustrating that the deaths continue to occur at the jail despite the number of lawsuits that have been filed. The deaths that I know about in any detail, are horrible. And so far, there seems to be no end to them. A brief account of some of these cases gives an idea of the kinds of incidents we have faced for years at the jail, both under the prior administration of former Sheriff Charles C. Foti and current Sheriff Marlin Gusman.[2]

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[1] *Keiwine Warren, Jr. v. Foti, et al*, No. 99-1420, USDC, E.D.La., *Wilson v. Foti, et al*, No. 02-2244, USDC, E.D.La., *Bonnette v. Hunter, et al*, No.05-1201, USDC, E.D.La., *Jones v. Hunter, et al*, No. 05-2470, USDC, E.D.La., *Miceli v. Gusman, et al*, No. 09-8078, Sec. A, USDC, (pending) E.D.La., *Nagle v. Gusman, et al*, No. 12-1910, Sec. R, USDC, E.D.La. (pending). I have also been involved in other cases regarding the jail. I was class co-counsel for plaintiffs in *Cazenave v. Foti, et al* No.00-1246, Sec. A, USDC, E.D.La., which successfully challenged illegal strip and visual body cavity searches at the jail of persons arrested on minor charges. This lawsuit resulted in changes in policy and operations at the jail, as well as payment of damages to class members, attorneys fees and costs. I am also currently co-counsel in *PLN v. Gusman, et al*, No.11-2277, Sec. A, USDC, E.D.La. which successfully challenged unconstitutional policies of the Orleans Parish Sheriff's office regarding prisoners' access to publications, resulting in changes in policy and operations at the jail and damages. Plaintiffs' application for fees and costs in that case is pending.

[2] When Sheriff Gusman took office he basically inherited the jail staff that had been in place under former Sheriff Foti for years. Sheriff Foti had been in office approximately 30 years. When Foti became Attorney General, there was a brief period when Bill Hunter, Foti's former Chief Deputy, was Acting Sheriff. When Sheriff Gusman was elected, Bill Hunter remained working at the jail. With some exceptions, there has been quite a bit of continuity of personnel, in particular in the medical and psychiatric department, as well as with top wardens and administrators, and some line deputies and supervisors, who are hold-overs from the previous administrations.

I mention a few of the older cases, as they illustrate a very painful, but pertinent point about the Orleans Parish jail as an institution. Many of the problems at the jail are long-standing and sometimes seem almost impervious to change. I believe that many of these problems flow from a pervasive institutional or "corporate" culture at the jail which has long resisted transparency, accountability and oversight. Part of the problem lies in the Louisiana laws and cases which have given such enormous power and discretion to Sheriffs, with very little oversight. This is not a healthy dynamic under any circumstance, but in particular in these days where citizens justifiably demand accountability and transparency of their elected officials, the lack of such in the operations of the Orleans Parish jail has, I believe, helped to create a deeply dysfunctional system.

In addition, for many years at the Orleans Parish jail, there has been a tolerance for an unacceptable level of violence, as well as a lack of professional competence, and uncaring and unresponsive attitudes towards the suffering of others, in particular in the medical and mental health areas. These attitudes and behaviors, which have also become a part of the culture of the institution, have contributed significantly to the crisis we find ourselves in today. A number of important reforms were instituted and carried out under the aegis of the lengthy federal court oversight in the *Hamilton v. Morial, et al* (originally *Hamilton v. Schiro*) case, Docket No. 69-2443, Sec. A, USDC, E.D.La. Unfortunately, after that case wound down relative to any meaningful oversight regarding prisoners' conditions, there seemed to be a resurgence of bad incidents.

The last few years in particular, when there has been no federal court oversight, have been terrible, with the near-constant reports of stabbings, sexual assaults, inadequate medical and mental health care, and deaths.

A brief account of just a few of the deaths and serious incidents which have occurred at the jail in recent years, of which I am aware, helps to illustrate these points:

* Keiwine Warren was 22 years old, the father of a young son. On July 30, 1998 he pled guilty to one count of simple possession of marijuana and was placed on probation. He tested positive on a drug test and was remanded for a probation violation on August 7, 1998. He was scheduled for court on August 13, 1998. He never made it to court. On August 10, 1998, he died an excruciating death from an untreated perforated ulcer. It took him days to die, as he begged for proper medical treatment, to no avail. He was not seen by a physician until he lay on the floor of his OPP cell, unresponsive, with no pulse and no breath sounds. He suffered irreversible brain damage and died the next day. The cause of death was peritonitis from a perforated chronic duodenal ulcer.[3]

[3] *Keiwine Warren, Jr. v. Foti, et al*, No. 99-1420, USDC, E.D.La. There have been other, more recent deaths involving individuals with ruptured ulcers at the jail. On June 14, 2008, Juan

* Shawn Duncan was 24 years old, the father of two young sons. On August 2, 2001, he was arrested for traffic-related charges, including DWI. By August 10, 2001, 8 days after his arrest, he was dead in the jail. He had obvious and ignored symptoms of withdrawal from benzodiazepines, started sweating "buckets" of water, became seriously dehydrated and delusional. He was tied down in five point restraints[4] on the 10th floor of HOD (the so-called "mental health" tier) for 42 hours. He lost 20 pounds in 8 days. Another prisoner, a tier rep, discovered him in his cell, not moving. He was pulseless and apneic with fixed pupils, still in restraints. At autopsy he was described as gaunt in appearance, with his abdomen and eyeballs sunken in. His cause of death was dehydration. He also never made it to court.[5]

* Matthew Bonnette was 34 years old, the father of a young daughter. On April 3, 2004, he was arrested for traffic-related charges, including DWI. He never made it to court alive. He was put in a cell on HOD-10 on "suicide precautions". His belt and shoelaces were taken from him. He was placed in four-point restraints. [6] The belt for five-point restraints was left in the cell with him. The cell Matthew was in was not "suicide proof" and had numerous anchor or tie-off points. Deputies were supposed to monitor him every 15 minutes and failed to do so. On April 4, 2004, Matthew hung himself using the 5-point belt. Deputies were notified of Matthew's death by another prisoner. The cause of death was "asphyxia secondary to hanging".[7]

* Mark Jones was 35 years old. He was arrested on June 28, 2004 on municipal charges of public drunkenness and simple damage to property under $500. As he was going through the booking process at the Intake and Processing Center (IPC),

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Maysonet, a 62 year old man, died while in custody of the OPSO. At autopsy he was found to have a ruptured duodenal ulcer with very early peritonitis. On August, 2004, Paul Willis, who was awaiting trial on murder charges, reportedly died of a ruptured peptic ulcer. This type of death is frequently described as a somewhat prolonged and very painful way to die if there is not appropriate medical intervention.

[4]Five point restraints involves placing the individual flat on his or her back, with both arms and legs restrained and a fifth belt across the abdomen or chest area which prevents the individual from sitting up, standing or moving around.

[5]*Donniesa Wilson v. Foti, et al*, No. 02-2244, USDC, E.D.La.

[6]Four-point restraints involves restraining the arms and legs of an individual. The individual is able to sit up, stand and move around, albeit in a restrained fashion.

[7]*Bonnette v. Hunter, et al,* No.05-1201, USDC, E.D.La.

he was physically assaulted by one deputy and then violently assaulted by another deputy, without justification, causing severe head trauma, including the laceration of his vertebral artery. He was rendered unconscious, taken to Charity hospital, declared brain dead and died the next day, on June 29, 2004.The cause of death was a subarachnoid hemorrhage at the base of the brain due to blunt force injuries to the head. Mark Jones never made it to court.[8]

* Stephen Stewart did not die in the jail but what happened to him was devastating. For two years he had participated in a court-ordered Mental Health Court under the jurisdiction of Judge Calvin Johnson, Section E, Criminal District Court, Parish of Orleans. On August 2, 2006 Stephen missed a court appearance and a capias was issued to arrest and bring him before the Court. On August 15, 2006 he was arrested pursuant to the capias and taken to OPP. Instead of placing him on a mental health tier, as ordered by a physician, he was placed in general population, including with prisoners charged with violent offenses. Other prisoners, recognizing his precarious mental health status, brought his situation to the attention of the deputies. He never received appropriate treatment. He was never taken to court and the court was not notified that he was in custody. On August 31, 2006, in the midst of a delusional episode, he urinated on another prisoner's shoes. He was violently attacked and beaten by other prisoners, causing significant head and brain injury. He ended up having to have emergency surgery, which included a frontal lobectomy of his brain. [9]

* Oscar Fuselier, a 56 year old man, was arrested by NOPD on July 25, 2007, on a warrant for having missed a traffic court date in Jefferson Parish. He was physically frail and ill with emphysema and lung disease. On July 26, 2007 an individual charged with a violent offense was placed in a cell in the lockup with Mr. Fuselier. The cell was not monitored directly by deputies. Mr. Fuselier was violently assaulted by this individual, sustained serious, traumatic brain injury, went into a coma and subsequently died on August 7, 2007 of lung cancer, having never regained consciousness from the beating. Mr. Fuselier never made it to court.[10]

* Cayne Miceli, a 43 year old woman, was arrested on January 4, 2009 for municipal charges related to a disturbance she is alleged to have committed at

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[8]*Jones v. Hunter, et al* No. 05-2470, USDC, E.D.La. OPSO deputy Mark Strickland was charged and subsequently pled guilty to manslaughter for the death of Mark Jones. He was sentenced to two years imprisonment.

[9]*Stewart v. Gusman, et al,* No. 07-4132, Sec. J, USDC., E.D.La.

[10]*Fusilier v. Gusman, et al,* No. 08-3974, Sec. A, USDC, E.D.La.

Tulane Medical Center ER regarding her efforts to obtain appropriate care for an acute asthma attack. She was transferred to general population at the jail, denied appropriate care, reportedly attempted suicide, and was ordered by a jail physician to be tied down in five point restraints, flat on her back, with no accommodations or medication for her asthma. She was in a cell on HOD-10, in five point restraints, for 4 hours and 15 minutes. She complained of difficulty breathing and managed to loosen the restraints. Instead of getting medical help for her, deputies held her down to reapply the restraints. She lost consciousness and was brain dead upon arrival at the hospital on Jan 5, 2009. She was declared dead on January 6, 2009. The cause of death was bronchial asthma. She never made it to court.[11]

* Michael Hitzman was 32 years old, the father of two small children when he was taken to the Intake and Processing Center (IPC) of OPP on April 16, 2010 after having missed a court date. Michael had a serious substance abuse problem. He reported to deputies that he had recently ingested drugs. He was placed in an isolation cell which had cameras for video monitoring. No deputies were monitoring the videos and no-one physically checked on him. The cell he was in was not "suicide proof" and had numerous tie-off points. Michael hung himself in the isolation cell. His suicide was video-taped but no-one was watching it. His body was not discovered for over an hour. He had been in the jail less than four hours before he died. Cause of death: suicide.[12]

* Tracy Barquet was 25 years old, the father of a young daughter. He was booked into OPP on July 29, 2010 on drug charges. He was due to appear in court on August 6, 2010. He began experiencing an acute mental status change, became delusional and was transferred to HOD-10. He was given medication but was not being monitored or closely observed. Other prisoners report that he was behaving bizarrely and was incoherent. Court records show that he did not appear in court reportedly because he was in restraints on August 6. On August 7, 2010 he was discovered by another prisoner lying on the floor of his cell, with his body cool to the touch. His cause of death is "undetermined".

* William Goetzee, a 48 year old Commander of the U.S. Coast Guard, died on August 7, 2011. He was in federal custody at OPP, HOD-10, charged with attempting to grab a federal protective service officer's gun in order to kill himself. He was denied appropriate medical treatment while at OPP. He was supposed to be continuously watched by deputies. Deputy William Thompson abandoned his post for about 3 hours, during which time Bill Goetzee apparently swallowed toilet paper and water, resulting in his death. The cause of death:

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[11] *Miceli v. Gusman, et al*, No. 09-8078, Sec. A, USDC, E.D.La.

[12] *Cantu v. Gusman, et al*, No. 11-824, Sec. G, USDC, E.D.La.

suicide.[13]

Each of these individual deaths or incidents varies in their specific details. What they all share in common is that the deaths and the incidents were terrible, avoidable and unnecessary. Each involved a great deal of human suffering and loss. Each involved bad policies and practices, incompetent and/or deliberately indifferent staff and, in most cases, lack of accountability or discipline after the incident.

In my experience, even in those cases where an individual staff member is disciplined or prosecuted for some particularly heinous breach of duty, supervisors and those in positions of higher authority are virtually never held accountable. And while the numbers of deaths at the jail in themselves are very worrisome,[14] the types of deaths that are occurring are also of great concern. While the next death or serious injury will differ in particularities, the fact is, without court intervention and oversight, I fear we will simply continue with more of the same, i.e., terrible, avoidable and unnecessary deaths and human suffering, and no meaningful change or improvement.

And while there would be no justification for any human being to die in the manner and under the conditions of the individuals described above, it is instructive to note how many of them were in custody on relatively minor matters, how many of them are pre-trial and awaiting their court appearances, and how many of them died so quickly in the jail that they never made it to court at all. The number of individuals who died without receiving appropriate medical care and especially mental health care, is shocking. Another disturbing fact about many of these incidents is that the names of the same people who were responsible for appropriate care and supervision of these individuals who died at the jail, seem to show up over and over in subsequent cases. I am concerned that there is no real accountability or discipline of those employees who are in supervisory or leadership positions who consistently fail to adequately perform their responsibilities, often with dire, and too frequently fatal, consequences for those who are under their care and supervision.

I am glad to know that Sheriff Gusman has agreed to enter into the Consent Decree and I have to be hopeful that there can and will be real change. However, part of the changes that need to take place, in my opinion, go deeper than just the parameters of the consent decree.

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[13]*Nagle v.Gusman, et al*, No. 12-1910, USDC, E.D.La. OPSO deputy William Thompson pled guilty in state court to malfesance for abandoning his post and falsification of observation records. He was sentenced to a suspended sentence and probation. It is believed that other medical and security staff at the jail were aware that Deputy Thompson had abandoned his post, yet they failed to intervene or report him. On information and belief, none of those other individuals were disciplined

[14]Since April, 2006, there have reportedly been 40 individuals who died in the custody of the OPSO.

I would urge the Sheriff to take this opportunity, in the context of the consent decree, and with the oversight and assistance of the Court and the monitor, to closely examine the attitudes and behavior of top level personnel at the jail, especially in the medical and mental health departments, to determine whether the persons currently in these positions are capable of embracing and instituting real and meaningful reform. These positions are challenging under the best of circumstances. I am concerned that individuals who have tolerated and been a part of the problems in the system to date, oftentimes for years, are not well-suited to insure that meaningful changes will now take place, or to sustain those reforms once the federal oversight is concluded. Unless there are competent, caring individuals in leadership positions at the jail, who are committed to making profound changes from the way the jail is now being run and has been run in the past, I am concerned that the outcome of this major undertaking will ultimately not be as successful as it should be.

I also want to say that I am glad to see that the Consent Decree contemplates the hiring of a "full-time professional corrections administrator" to analyze and review OPP operations. I would hope that such a person, with appropriate credentials, experience and judgment, would be appointed to run the jail. I am also glad to see that serious attention is to be given to staffing levels, training and the conditions under which deputies are working at the jail. I know there are people who work at the jail who want to do right and who in fact do so, under very difficult circumstances. The safety and security of the people who work at the jail, in addition to those who are being held there, must be protected and a big part of that, for all concerned, is to have adequate, competent, caring and well-trained staff.

Thank you for considering these comments and for the Court's active role in this matter. I am hopeful that there will be positive and substantial improvements in this situation as soon as possible.

Sincerely,

Mary E. Howell

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