IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

LaShawn Jones, *et al.*	)	Case No.
Plaintiffs,	)	
v.	)	
MARLIN GUSMAN, Sheriff, Orleans Parish, *et al.*	)	
Defendants.	)	

PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

Pursuant to Rule 23(b) of the Federal Rules of Civil Procedure, Plaintiffs move to certify a class composed of all individuals who are now or who will in the future be incarcerated in the Orleans Parish Prison ("OPP"). Plaintiffs also move to certify a subclass of individuals who are now or who will in the future be incarcerated in the OPP and who live with a serious mental illness. The proposed class and subclass seek only class-wide injunctive and corresponding declaratory relief.

Under the Federal Rules of Civil Procedure, one or more named plaintiffs may bring suit as representative parties on behalf of a class

> [O]nly if (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class.

Fed. R. Civ. P. 23(a).

Each requirement is met here. First, there are approximately 3,400 individuals incarcerated at OPP. As explained in the accompanying memorandum of law, there are approximately 2,176 individuals at the OPP who live with a serious mental illness. The classes

also include numerous future, unknown members who cannot be joined. Second, this action involves numerous common contentions that are capable of class-wide resolution. Third, because the challenged policies and practices apply with equal force to all class members, the claims of the named Plaintiffs are typical of the class. Finally, the named Plaintiffs will fairly and adequately represent the interests of the class. The named Plaintiffs have a personal interest in the subject matter of the lawsuit, and Plaintiffs' counsel is experienced in class action civil rights litigation and is prepared to pursue the case vigorously on behalf of the class.

Because the putative class satisfies every element of Rule 23(a), and because the Defendants have acted and refuse to act on grounds generally applicable to the class as a whole, class certification is proper under Rule 23(b)(2).

For the reasons stated above and explained in the memorandum of law accompanying this filing, the Plaintiffs request that this motion for class certification be granted.

RESPECTFULLY SUBMITTED, this the2nd day of April 2012.

/s/ Katie M. Schwartzmann
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Certificate of Service

I hereby certify that a true and correct copy of the foregoing document was filed electronically, and will be personally served on the Defendants along with a copy of the Complaint, this 2nd day of April 2012.

_s/ Katie M. Schwartzmann

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PLAINTIFFS' MEMORANDUM OF LAW IN SUPPORT OF MOTION FOR CLASS CERTIFICATION

I. Introduction

This challenge to the brutal, inhumane and unconstitutional conditions of confinement at the Orleans Parish Prison presents a classic case for class certification. The proposed Plaintiff class consists of all individuals who are now or who will in the future be imprisoned in the Orleans Parish Prison ("OPP"). A proposed subclass consists of individuals who now or in the future will be imprisoned in OPP and who live with a serious mental health illness

This case is ideally suited to proceed as a class under Federal Rule of Civil Procedure 23(b)(2) because (a) every single member of the class and subclass has the same legal theory as to why their Eighth or Fourteenth Amendment rights are being violated; (b) every single member of the class and subclass will utilize precisely the same evidence in support of his cause of action; and (c) every single member of the class and subclass seeks precisely the same relief. In other words, the named Plaintiffs and the putative classes share all legal claims, all factual questions are common to the named Plaintiffs and the putative classes, and the named

Plaintiffs and the class all seek the same relief. It is difficult to conceptualize a class that is more cohesive than this one. To some extent the Plaintiffs will rely on different, individual incidents of brutal violence and specific instances where the Defendants have forced individuals with serious mental health needs to languish without necessary medical care. These incidents demonstrate the Defendants' wholesale, systemic deliberate indifference to Plaintiffs' serious medical needs and failure to protect the Plaintiffs from reasonably foreseeable harm.

The Plaintiff class seeks permanent injunctive relief, as well as corresponding declaratory relief. The Plaintiffs do not seek any form of individualized relief. Indeed, the only relief sought by the Plaintiff classes is a wholesale reform of the Defendants' unconstitutional policies and practices. It would be literally impossible to join every individual who now or who in the future will be imprisoned in OPP in a single suit, and the named Plaintiffs will more than adequately represent the interests of the class. By granting Plaintiffs' motion for class certification, the Court will help resolve this suit with speed, consistency and fairness to all parties.

II. Standards for Class Certification

A class should be certified under F.R.C.P. 23(a) when (1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class. Plaintiffs seeking class certification must establish all of the elements of Rule 23(a), as well as at least one element of Rule 23(b). See *M.D. v. Perry*, No. 11-40789, __ F.3d __, 2012 WL 974878 (5th Cir. March 23, 2012); *Bolin v. Sears, Roebuck & Co.*, 231 F.3d 970, 975 (5th Cir. 2000). Courts considering the issue of class certification must "look beyond the pleadings to understand the claims, defenses, relevant facts, and applicable substantive law in order to make a

meaningful determination of the certification issues." *M.D.,* 2012 WL 974878 at *3 *(internal citations omitted).*

Class certification is routinely granted in cases related to prison and jail conditions. *See e.g., Martin v. Hadix*, 527 U.S. 343 (1999); *Lewis v. Casey*, 518 U.S. 343 (1996); *Castillo v. Cameron County*, 238 F.3d 339 (5th Cir. 2001); *Gates v. Cook*, 234 F.3d 221 (5th Cir. 2000). Even since the Supreme Court heightened the standards for interpreting compliance with FRCP 23, in *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (2011), courts have recognized that class certification is a necessary device to address unlawful policies and practices in cases concerning jails and prisons. See *Logory v. County of Susquehanna*, 277 F.R.D. 135 (M.D. Penn. 2011) (certifying a class of prisoners seeking declaratory and injunctive relief as well as compensatory damages against a county that subjected the plaintiff class to unconstitutional polices, practices and procedures at the local jail); *Bumgarner v. N.C. Dep't of Corr.*, 276 F.R.D. 452 (E.D.N.C. 2011) (certifying a class of prisoners with disabilities who were subject to the Department of Corrections' discriminatory policies and procedures). Indeed, the class action device was specifically developed to improve the ability of courts to resolve suits involving the criminal justice system. HERBERT B. NEWBERG, 485 NEWBERG ON CLASS ACTIONS § 25.18 (2d ed. 1985).

Courts across the country have found that when a putative class seeks common—as opposed to individualized— injunctive and declaratory relief and there exists common contentions that are capable of class-wide resolution, the *Wal-Mart* decision is no bar to class certification. *Compare Morrow v. Washington*, 277 F.R.D. 172 (E.D. Tex. 2011) (approving a class of people seeking injunctive and declaratory relief who were subjected to discriminatory and improper traffic stops); *Ortega-Melendres v. Arpaio*, __ F. Supp. 2d. __, No. CV-07-2513-PHX-GMS, 2011 WL 6740711 (D. Ariz. Dec. 23, 2011) (approving class of individuals harmed

by alleged racial profiling in Arizona's Maricopa County seeking declaratory judgment and injunction); *Abadia-Peixoto v. U.S. Dept. of Homeland Sec.*, No. C 11-4001 RS, 2011 WL 6749089 (N.D. Cal. Dec. 23, 2011) (approving class of current and future detainees with proceedings in San Francisco's immigration courts seeking injunctive relief); *and Logory v. County of Susquehanna*, 277 F.R.D. 135 (M.D. Pa. 2011) (approving class of detainees who challenged unconstitutional jail policy); *with M.D. v. Perry*, No. 11-40789, __ F.3d __, 2012 WL 974878 (5th Cir. March 23, 2012) (vacating class certification order where class sought individualized injunctive relief) *and Jamie S. v. Milwaukee Pub. Schs.,* 668 F.3d 481 (7th Cir. 2012) (same)

A. Numerosity

Rule 23(a)(1) of the Fed. R. Civ. P. has two components: the number of class members and the practicability of joining them individually in the case. For the purpose of satisfying the first component, the "plaintiff[s] must ordinarily demonstrate some evidence or reasonable estimate of the number of purported class members." *See James v. City of Dallas*, 254 F.3d 551, 570 (5th Cir. 2001) (internal quotations and citations omitted). "[A] sufficiently large number of potential claimants alone may indicate that the numerosity requirement is met." *Mullen v. Treasure Chest Casino,* No. CIV. A. 96-0052, 1997 WL 539917 at *2 (E.D. La. Aug. 29, 1997), *aff'd,* 186 F.3d 620 (5th Cir. 1999). The "plaintiff[s] must ordinarily demonstrate some evidence or reasonable estimate of the number of purported class members." *See James v. City of Dallas*, 254 F.3d 551, 570 (5th Cir. 2001) (internal quotations and citations omitted). Courts in the Fifth Circuit have not required evidence of exact class size or identity of class members to satisfy the numerosity requirement, and there is no set number above or below which a class is considered

to have or have not satisfied the numerosity requirement. *See Mullen v. Treasure Chest Casino*, 186 F.3d 620 (5th Cir. 1999).

In addition to considering the number of people in a proposed class, courts also look at the impracticability of joining all the plaintiffs. The federal rule merely requires a determination that the class is so numerous as to make joinder of all members impracticable. *See Mullen v. Treasure Chest Casino,* No. CIV. A. 96-0052, 1997 WL 539917 at *2 (E.D. La. Aug. 29, 1997) (stating "a sufficiently large number of potential claimants alone may indicate that the numerosity requirement is met."), *aff'd* 186 F.3d 620 (5th Cir. 1999). In *Jack v. American Linen Supply Co.*, 498 F.2d 122, 124 (5th Cir. 1974), where the proposed class included "unnamed, unknown future" members, the Court noted that "joinder of unknown individuals is certainly impracticable" and weighs in favor of certification. *See also Pederson v. La. St. Univ.*, 213 F.3d 858, 868 n.11 (5th Cir. 2000) (inclusion of future class members relevant to whether joinder is impracticable). Courts have frequently found that, regardless of the current size of the class, in cases involving prisons and jails, the numerosity requirement is satisfied because joining future members is impracticable. *See Andre H. v. Ambach*, 104 F.R.D. 606, 611 (S.D.N.Y. 1985) ("The fact that the [detention center] population . . . is constantly revolving establishes sufficient numerosity to make joinder of the class members impracticable."); *Skinner v. Uphoff*, 209 F.R.D. 484, 488 (D. Wyo. 2002) ("The proposed class potentially includes over 700 inmates currently confined . . .and any persons who will be confined . . . in the future. . . . As members *in futuro*, they are necessarily unidentifiable, and therefore joinder is clearly impracticable."); *Holland v. Steele*, 92 F.R.D. 58, 63 (N.D. Ga. 1981) (accord).

The Plaintiff class in this case consists of the approximately 3,400 individuals who are now incarcerated at OPP, plus the unknowable number of individuals who will be incarcerated

there in the future. The proposed subclasses also contain an unknowable number of individuals who will be detained at OPP. Because OPP is a jail rather than a long term prison facility, many people cycle through there, spending only days or weeks at a time; over 34,000 people are booked through OPP intake annually. This number is extremely high, and joinder of all such individuals would be impossible.

According to the federal Bureau of Justice Statistics, 64% of all individuals detained in local jails live with a mental health illness.[1] While it is certain that the rate is much higher in New Orleans,[2] assuming this conservative estimate is true, the mental health subclass would be comprised of approximately 2,176 individuals in the facility at any given time, as well as 21,760 additional individuals passing through per year.

The number of potential plaintiffs and the inclusion of future members in the class would easily satisfy the Fifth Circuit's standard for numerosity. *Cf., e.g., Jones v. Diamond*, 519 F.2d 1090, 1100, n. 18 (5th Cir. 1975) (class of 48 members), *disapproved in part on other grounds; Gardner v. Westinghouse Broad. Co*., 437 U.S. 478 (1978); *Jack v. Am. Linen Supply Co*., 498 F.2d 122, 124 (5th Cir. 1974) (class of 51 members). The inclusion of future residents renders it literally impossible to join all members of the class.

[1] Glaze, L.E. & James, D.J. (2006, September). Mental Health Problems of Prison and Jail Inmates. US Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: Washington, D.C.

[2] World Health Organization studies have found that after Katrina, the number of residents with serious mental problems rose from 6.3% to 11.3%. The percentage of the population with mild to moderate problems had risen from 9.7% to 19.9%. Similarly, in 2007, an LSU study indicated that 20% of New Orleanians were suffering from serious mental illness. *Mental Illness Tidal Wave Swamps New Orleans*, The Washington Times, August 4, 2009. Defendant Gore, Medical Director of OPP, estimates that 45% of prisoners at OPP have some form of mental illness. *New Orleans Mental Health Crisis*, The Gambit, march 13, 2012, http://www.bestofneworleans.com/gambit/new-orleans-mental-health-crisis/Content?oid=1972425, last checked April 1, 2012.

B. Commonality

In order to satisfy commonality under *Wal-Mart*, a proposed class must prove that the claims of every class member "depend upon a common contention . . . that is capable of class wide resolution," meaning that the contention is "of such a nature . . . that determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." 131 S. Ct. at 2551. ("What matters to class certification . . . is not the raising of common 'questions . . . but, rather the capacity of a classwide proceeding to generate common *answers* . . .")(citations and quotations omitted). The Plaintiffs here allege that they are all at risk of suffering brutal violence—including beatings, rapes, and assaults because of the Defendants' unconstitutional policies and practices. The mental health subclass Plaintiffs similarly allege that they are all at risk of languishing without necessary services because of the Defendants' policy and practice of exhibiting deliberate indifference to their serious mental health needs. Here, there is significant evidence that Defendants have had a longstanding policy and practice of permitting and condoning violence and of demonstrating deliberate indifference to serious mental health needs.[3]

As the Supreme Court explained in *Wal-Mart*, "for purposes of Rule 23(a)(2) [e]ven a single [common] question will do . . ." 131 S. Ct. at 2556 (citation and internal quotations omitted; alterations in original). Plaintiffs here, however, can show multiple common questions:

[3] *See* attached findings letter from the U.S. DOJ, dated September 11, 2009, Pl. Exh. 5. *See also*, state court pleadings alleging violence in the jail, Pl. Exh. 3; *see also,* data from reports in 2009 indicating that OPP had alarmingly high incidents of sexual violence, http://bjs.ojp.usdoj.gov/content/pub/pdf/svpjri0809.pdf, last checked January 18, 2012. Additionally, the problems at the facility have been widely reported in the media: http://www.nola.com/crime/index.ssf/2012/03/us_marshals_service_pulls_fede.html http://neworleanscitybusiness.com/blog/2011/11/17/opp-guards-inmate-detail-brutality-inside-jail/; http://www.nola.com/crime/index.ssf/2011/08/former_model_dean_kelly_faces.html; http://www.wwltv.com/news/crime/DA-seeks-removal-of-bail-for-ex-model-charged-in-rapes-118397829.html; http://www.nola.com/crime/index.ssf/2011/08/inmate_on_suicide_watch_kills.html.

all of the following factual and legal contentions (each of which pertains to overarching patterns and practices) are common to the class and will lead to common answers.

a. Common Contention # 1.

The Defendants have a policy and practice of failing to take reasonable measures to protect individuals from harm. The Defendants' dangerous deficient staffing practices and policies and practices related to security (including policies and practices related to contraband, classification and staff training) result in the Plaintiffs enduring brutal beatings, rapes, assaults and/or being exposed to an unacceptably high risk these injuries.

Support for Common Contention # 1.

1) The United States Department of Justice has made the following conclusions about the Defendants policies and procedures:

- "The high incidence of inmate-on-inmate violence. . .demonstrates OPP's inability to keep its inmates reasonably safe." Exh. 5 at 12;
- "The frequency and serious nature of injuries sustained by OPP inmates represent a systemic level of violence that poses a serious risk of harm to both inmates and correctional staff at the jail."*Id*. at 13;
- "We found instances where inmates with differing classification levels were assigned to ten person cells at HOD. Under this system, there is very little to safeguard against housing predatory inmates with vulnerable inmates." *Id* at 11
- "Exacerbating the staffing shortages, we found that OPP operates its facility without a staffing plan or analysis to establish the minimum number of security staff needed to safely manage OPP's population." *Id.*

2) Plaintiff and witness declarations detailing various incidents of violence resulting from the Defendants policies and practices, including:

Classification:

- "When I got out of Templeman they put me in the maximum security tier in HOD with adults. [J.J. is a juvenile.] All the cells popped open and one of the adults hit one of the kids who came over with me. Guards were not on the tiers to

protect us. I have never been so scared in my life." J.J. decl. ¶ 12. (Exhibit 2—Witness decl).

- "A deputy put me in a cell with a guy that knew the prisoner I am testifying against. He stabbed me a bunch of times. The guard knew he was my enemy, but he didn't care. I think he wanted to see one of us get hurt." Lewis dec. ¶ 3. (Exhibit 1—Plaintiff decl).
- "I was placed in the Old Parish facility because my bail was really high. Old "I Parish is where they keep the most violent offenders—yet my offense was not violent. Since my arrest I have been jumped at least three times, and other inmates have attempted to sexually assault me and threatened to kill me numerous times." Lanford dec. ¶ 2,3. (Exhibit 2—Witness decl).
- "After I was on protective custody they took me to court with general population. I ended up getting stabbed and jumped by a bunch of guys when I was on the docks waiting for court." Lewis dec. ¶ 8. (Exhibit 1—Plaintiff decl).
- "Prior to my arrest I pressed charges on someone. When I was arrested, the jail did not check for this conflict. They put me in the same building as my defendant, who put a hit on me." Sylvester ¶ 2. (Exhibit 1—Plaintiff decl).
- "Even after I was protective custody I got jumped because the guards do not protect us." J.J. decl. ¶ 11. (Exhibit 2—Witness decl).

General lack of security due to cells not closing:

- "All of the cells pop in all of the tiers and the guards leave us alone. Guys can get out and come get you any time." Journee dec. ¶ 4. (Exhibit 1—Plaintiff decl).

- "When I was recovering (after being attacked) on the medical tier at the Old Parish facility, the guards would leave our cells open, which caused me to get attacked again." Lanford dec. ¶ 9. (Exhibit 2—Witness decl).
- We're not actually on protective custody up here. The deputies are never around and all the cells pop open. No one is doing their job. They're all too busy covering up for each other." Lewis dec. ¶ 12. (Exhibit 1—Plaintiff decl).
- "All of the cells pop." Sylvester dec. ¶ 8. (Exhibit 1—Plaintiff decl).
- "All the cells pop open and the guards only come through a few times a shift." Robinson dec. ¶ 5. (Exhibit 2—Witness decl).

Knives and contraband facilitate fights:

- "I have been threatened with knives, jumped and stabbed. I also have witnessed many stabbings since I have been in OPP." Dominick dec. ¶ 2. (Exhibit 1—Plaintiff decl).
- "Another time there were two guys with knives fighting on the open tier." Gioustavia dec. ¶ 3. (Exhibit 1—Plaintiff decl).
- "There are shanks everywhere and everyone's cell pops open. "It doesn't matter which facility you are in, you are going to leave with some scars." Dominick dec. ¶ 5, 6. (Exhibit 1—Plaintiff decl).
- "Some of them held me while one of them stabbed me over and over." Journee dec. ¶ 3(Exhibit 1—Plaintiff decl).
- "There are knives everywhere." Sylvester dec. ¶ 9. (Exhibit 1—Plaintiff decl).
- "People on my tier have shanks so big, they look like kitchen knives." Journee dec. ¶ 4. (Exhibit 1—Plaintiff decl).

- "I'm afraid for my life in here. They're really stabbing people up." Robinson dec. ¶ 2. (Exhibit 2—Witness decl).
- "Altogether they stabbed me once in the neck, multiple times in the head and back. My hand was also sliced when I tried to grab the knife." Tapp dec. ¶ 3. (Exhibit 2—Witness decl).
- "This is serious. You can die in here. You can easily be killed any day. There are at least two to ten knives on every tier. If you report something, though, you'll probably get stabbed up. Animals can't live back here, much less human beings." Miorana dec. 6. (Exhibit 2—Witness decl).
- "The guy that got stabbed had to run to the window and start banging on it to get someone's attention. He was yelling 'I got stabbed? I got stabbed!' For all of these fights, the guards weren't around. Because I'm on the medical tier, though, it is the safest tier to be on. I can't imagine what goes down on the regular tiers." Sabine dec. ¶ 4, 5. (Exhibit 2—Witness decl).

Sheriff's deputies are absent:

- "These facilities are not undermanned, they are unmanned. Deputies frequently leave their posts. Guards typically work two floors during one shift, especially in Old Parish Prison." Dominick ¶ 6. (Exhibit 1—Plaintiff decl).
- "The guards keep these facilities unsafe. Guards patrol two floors at once, so my tiers have gone without supervision for long periods of time. When guards are present, they ignore us and sleep." Lanford ¶ 9. (Exhibit 2—Witness decl).

- "Guards are never around when a fight breaks out, which is often. They usually come by for count time and then leave again for hours. I don't feel like they are doing much to protect any of us." Gioustavia dec. ¶ 4. (Exhibit 1—Plaintiff decl).
- "An older, bigger guy attacked me when I first rolled in. Guards were not around when it happened. It lasted a long time." Gioustavia dec. ¶ 2(Exhibit 1—Plaintiff decl).
- "We're on our own in here." Lewis dec. ¶ 16. (Exhibit 1—Plaintiff decl).
- "Guards do nothing to prevent the violence. In fact, they often instigate it. When a severe injury results from a fight, guards fail to respond with urgency. It can take hours for a deputy to come to a tier. Consequently, I have had to apply pressure to knife wounds and called family members to contact 911 since guards refuse to help." Dominick ¶ 3. (Exhibit 1—Plaintiff decl).
- "Guards do not patrol the tiers, they do not respond to verbal complaints or grievances." Walker dec. ¶ 12. (Exhibit 1—Plaintiff decl).
- "I was bleeding all over and yelled for a deputy. No one came until the next day. When the guard did come, he did not do anything." Journee dec. ¶ 3. (Exhibit 1—Plaintiff decl).
- "During the attack, a deputy came on the floor, but he never looked into the tier. If he had, he could have seen what was happening. But the deputies don't really care what happens to us." Sylvester dec. ¶ 5. (Exhibit 1—Plaintiff decl).
- "All our safety is at risk. The guards aren't doing their jobs...." Sylvester dec. ¶ 9. (Exhibit 1—Plaintiff decl).

- "I thought it would be better on HOD 10, but guards leave us unattended just like they do at Old Parish Prison." Jenkins dec. ¶ 5. (Exhibit 1—Plaintiff decl).
- "A culture of violence exists across all facilities under Sheriff Gusman's control, due to guards failure to patrol tiers, enforce safety measures and respond efficiently to emergencies." Picou dec. ¶ 5. (Exhibit 2—Witness decl).
- "I witnessed most violent acts occurring when guards were absent from the tier for several hours at a time. When guards do make rounds, they perpetuate the violence by taunting and inciting prisoners through verbal abuse." Picou dec. ¶ 6.
- "It took awhile for the guards to respond. Then the nurses came. It took even longer for an ambulance to get there. I was just lying in my own blood." Tapp dec. ¶ 4. (Exhibit 1—Plaintiff decl).
- "Guys have almost died on the tier because the guards are never around. Sometimes it takes 30 to 45 minutes of banging on the door before the guards will respond." Miorana dec. ¶ 5. (Exhibit 2—Witness decl).
- "Fights are allowed in here. Guards let them do it, either by putting guys together they know are going to fight, or by not stopping the fights once guys get into it. But mostly it's because they're never around. You only see a guard a few times a day." Patterson dec. ¶ 6. (Exhibit 2—Witness decl).

Sheriff's deputies are complicit in the violence:

- "Guards are aware of the rampant violence on the juvenile tier of Templeman V, yet they do nothing to curb or prevent it. In fact they provoke violence by turning off the televisions, aware that they lack of stimulation leads to fights. . . I witnessed most violent acts occurring when guards were absent from the tier for

several hours at a time. When guards do make rounds, they perpetuate the violence…" Picou dec ¶ 1,2. (Exhibit 2—Witness decl).

- "When a fight or incident occurs, we are discouraged from reporting it. If someone rats to a guard, the guards will tip off the tier to who the rat is, so the guys on the tier can punish or intimidate him. Guards aren't around for the fights and the encourage violence by telling the prisoners who reports them." Dixon dec. ¶ 7, 8. (Exhibit 2—Witness decl).
- "During my time there I witnessed guards encourage violence and cheer fights on between inmates until the first blood was drawn. I had to remain constantly alert to an attack from guards or other guys on the tier. When I tried to draw attention to the situation, I was intimidated, harassed and ignored by the Sheriff's staff." Hobson dec. ¶ 2. (Exhibit 2—Witness decl).
- "The guards yelled at us and called us rats for talking to our lawyers about what is happening." J.J. dec. ¶ 10. (Exhibit 2—Witness decl).
- "The guards put me on the tier with this small young guy who was just coming on too. I watched as some bigger guys stabbed the little one a bunch of times in his neck and body. Two of them had knives. The little guy tried to fight back and was yelling loudly. Guards finally came and opened the gate to the tier, but would not come on the tier. The kid made his way out and immediately lay down. His blood was pooling all over him." Miorana dec. ¶ 3, 4. (Exhibit 2—Witness decl).

b. Common Contention # 2.

The Defendants have a policy and practice of exhibiting deliberate indifference to the Plaintiffs' serious mental health needs. The Defendants' deliberate indifference manifests in depriving individuals of necessary medication, evaluations, psychiatrist visits and other mental health inventions, of subjecting Plaintiffs seeking mental health treatment and suicide protections with degrading, humiliating and de-humanizing treatment for the purposes of punishing them—including forcing them to strip naked, holding them in large congruent cells, and locking them down for 23 hours a day.

Support for Common Contention # 2.

1) The United States Department of Justice has made the following conclusions about the Defendants policies and procedures:

- "Suicide prevention practices at OPP are grossly inadequate." Ex. 5 at 14.
- "OPP fails to properly identify inmates with mental illness through adequate intake screening and referral." *Id.* at 15.
- "We found OPP's intake and referral systems inadequate and delayed. As a result, an alarmingly high number of inmates with mental health issues, including past mental treatment; history of suicidal behavior or attempts, and/or being on psychotropic medications fail to consistently be referred to mental health service providers." *Id*. at 16.
- "Inmates who are not timely referred remain untreated and have suffered from a worsening of their symptoms, including suicidal and homicidal ideation." *Id*.
- "OPP fails to employ sufficient mental health staff to ensure that inmates receive adequate services." *Id.* at 17.

2) There have been widespread media reports about suicides and deaths in the jail.

- William Goetzee, August 2010: http://www.nola.com/opinions/index.ssf/2011/08/another_in-custody_death_at_or.html
- Tracy Barquet, August 2010: http://www.nola.com/crime/index.ssf/2011/01/inmates_deaths_raise_concerns.html
- Michael Hitzman, April 2010: http://www.nola.com/crime/index.ssf/2010/04/suicide_warning_overheard_befo.html
- Cayne Miceli, January 2009: http://www.nola.com/crime/index.ssf/2010/12/cayne_micelis_death_in_jail_re.html

- Full list of people who have died in OPP since the DOJ findings letter: http://opprc.org/OPPRC/OPP_Deaths_Timeline.html

3) Plaintiff and witness declarations detailing various incidents of violence resulting from the Defendants policies and practices, including

- "Before I was arrested, I was taking prescription medication for my bipolar disorder. I have not gotten my medication here in OPP." Jenkins dec. ¶ 3. (Exhibit 1—Plaintiff decl).
- "I suffer from several health conditions including stress and anxiety. My fiancé tried to bring my prescriptions to the jail to show the doctors what I was taking on the outside but the deputy said, 'we don't deal with that.'" Anderson dec. ¶ 2. (Exhibit 1—Plaintiff decl).
- "Recently on the medical tier, a guy who really needs some mental healthcare lunged at me and scratched me under my jaw with something sharp. It left a mark from my chin to my jaw. I know he needs help and wasn't getting any, because I helped him fill out the sick calls before the incident. He told me all the prescription medication he was on prior to coming to jail. He also told me that he wasn't getting that medication in here. As far as I know, he never received treatment. The same guy got in another fight a few weeks later. He was trying to spit on us and gouge people's eyes out. I'm not mad at him. He needs help. If medical had only responded to those sick calls, these fights never would have happened." Dixon dec. ¶ 4, 5. (Exhibit 2—Witness decl).
- "The following morning I saw the psychiatrist. …He had a really bad additude and kept telling me if I want to talk, talk to a social worker. But it's almost

impossible to get an appointment with a social worker here." Miorana dec. ¶ 2. (Exhibit 2—Witness decl).

- "I was put on suicide watch, and when I got off, the psychiatrist was hard to talk to, like I did something wrong. I needed help, but he only spent a couple of minutes with me. I put in another sick call last week to see the psychiatrist. When I saw the psychiatrist he told me to talk to a counselor. He said, 'I'm a fu**ing doctor! That's it. I prescribe medicine. If you want to talk, talk to a fu**ing counselor." Anderson dec. ¶ 7. (Exhibit 1—Plaintiff decl).
- "I put in several sick calls, but most times they are never answered. It took a really long time and lots of sick calls before I got any medicine. When I filed a grievance on not getting the medicine, they told me to file a sick call." Anderson dec. ¶ 3. (Exhibit 1—Plaintiff decl).
- "I met a lot of people with mental health issues in here. None of them are getting the help they need. It's hard to keep waking up." Anderson dec. ¶ 8. (Exhibit 1—Plaintiff decl).
- "When I first arrived, I was put in the suicide tank. I waited in my underwear with the other guys. I couldn't use the phone to call anyone. Guards wouldn't let us out to go to the bathroom." Miorana dec. ¶ 2. (Exhibit 2—Witness decl).
- "After I arrived in HOD 10 the guards made me strip down in front of several people and put me in a vest without shoes. Then the guards put me in a shower that was full of urine and semen. I asked for my shoes, but the deputies refused to give them to me. Because I did not want to sit or lay in the mess, I stood the entire night." J.J. dec. ¶ 5. (Exhibit 2—Witness decl).

- "I have struggled with depression since I have been back here, but I didn't want to say anything because I didn't want to go up to HOD 10. I even had plans to commit suicide, but was too afraid to ask for help." Dixon dec. ¶ 6. (Exhibit 2—Witness decl).
- "Early on in Templeman V I got really depressed and thought about hurting myself. Before I did, though, I reported my thoughts of suicide. I was moved to the tenth floor House of Detention for suicide watch. Since that incident, I am afraid to tell guards if I feel suicidal. I do not want to tell them if I feel like hurting myself because I do not want to be sent back to the tenth floor." J.J. dec. ¶¶ 5, 7. (Exhibit 2—Witness decl).

The Legal Framework for Contentions 1 & 2

Plaintiffs' Eighth and Fourteenth Amendment claims require proof that 1) for the protection from harm claim, that that Defendants have not taken reasonable steps to respond to a significant risk of severe injury that Plaintiffs face, and that Defendants are aware of. *See, e.g.*, *Farmer v. Brennan*, 511 U.S. 825, 834, 839 (1994); and 2) for the inadequate medical care claim, that the Defendants' have a policy and practice of manifesting deliberate indifference to Plaintiffs who live with serious medical needs. *Estelle v. Gamble, 429 U.S. 97, 103 (1976).*[4] For each claim, the Plaintiffs will prove the existence of policies and practices that threaten them with the risk of severe injury and with deprivations of necessary mental health services. Plaintiffs will prove these allegations through a significant number of individual incidents of violence and individual deprivations of mental health services. But, each individual fact situation is equally applicable to every single inmate's claim because each incident proves

[4] For the purposes of evaluating deliberate indifference, courts make no distinction between medical or mental health claims. "Mental health needs are no less serious than physical needs." *Gates v. Cook*, 376 F.3d 323,332 (5th Cir. 2004).

deliberate indifference. Thus, whether or not there are a sufficient number of individual incidents of abuse and medical neglect to constitute proof of an unconstitutional policies and practice is a question common to the class as a whole.

c. Common contention # 3

The Defendants have been and are currently aware of the unconstitutional policies and practices that are in place throughout OPP, and that function to expose prisoners to brutal violence and to deprive them of mental health services.

Support for Common Contention # 3

As outlined extensively above, the Defendants have long been on notice of the unconstitutional conditions at Orleans Parish Prison. In addition to the U.S. Department of Justice findings letter, Plaintiffs note an extensive Prison Rape Elimination Act commission hearing in which the Defendants participated. There has been extensive coverage of the deficiencies in the media, as outlined above. In addition to all of this, upon information and belief, there have been tens of thousands of grievances and sick calls filed at OPP, including those filed by the Plaintiffs and witnesses to this action, which put Defendants on notice of the deficiencies. There also have been filed over 200 lawsuits against Defendant Gusman, in the last three years alone. Those lawsuits largely chronicle the unconstitutional practices challenged by the Plaintiff class. In addition to the pro se lawsuits filed by prisoners, Plaintiffs note that criminal defense attorneys have filed motions in state court seeking to have their clients moved, due to the conditions in the facility. Two examples are attached hereto as Plaintiff's exhibit 3. Recently, Gusman himself said that he was unable to safely house a capital defendant in OPP. http://www.nola.com/crime/index.ssf/2012/02/orleans_parish_prison_can_it_h.html.

These common contentions are more than sufficient to satisfy Rule 23(a)(2). For example, Plaintiffs' allegations that Defendants' systemic failure to put in place adequate policies and practices related dangerous deficient staffing practices and policies and practices related to security (including policies and practices related to contraband, classification and staff training), constitutes deliberate indifference to the substantial risk that the class will be subject to a serious risk of bodily harm, is common to the class as a whole. Similarly, the Plaintiffs' systemic allegations a regarding the Defendants' policies and practices of exhibiting deliberate indifference to the mental health sub-classes' serious mental health needs are also common to the sub-class. Clearly, resolving these specific allegations would "resolve an issue that is central to the validity of the each of the individuals' claims in one stroke." *Wal-Mart*, 131, S.Ct. at 2551. Thus, the common contentions listed above are more than sufficient to satisfy Rule 23(a)(2).

C. Typicality

The typicality test is "not demanding," *Lightbourn v. County of El Paso*, 118 F.3d 421, 426 (5th Cir. 1997), and is easily satisfied in this case. Typicality focuses on "whether the class representative's claims have the same essential characteristics of those of the putative class." *Stirman v. Exxon Corp.*, 280 F.3d 554, 562 (5th Cir. 2002). The test for typicality is not that the claims of the named individuals be identical to the claims of the other class members, but rather, that the class representatives must "possess the same interest and suffer the same injury" as other class members. *Gen. Tel. Co. of Sw. v. Falcon,* 457 U.S. 147, 156 (1982) (citing *E. Tex. Motor Freight Sys. v. Rodriguez,* 431 U.S. 395, 403 (1977), quoting *Schlesinger v. Reservists Comm. to Stop the War,* 418 U.S. 208, 216 (1974)).

Typicality is established because the named plaintiffs and all class members face a substantial risk of serious harm from being stabbed, beaten, raped, and denied adequate mental

health care. See Exhibit 1--Plaintiff decl. If class certification is denied, every individual imprisoned in the OPP would be forced to vindicate his or her rights in an individual lawsuit addressing the same problems challenged in this suit.

C. Adequacy of Representation

There is no question that the named Plaintiffs and Plaintiffs counsel will fairly and adequately protect the interests of the class. *See* FED. R. CIV. P. 23(a)(4); *Stirman*, 280 F.3d at 563 (holding that Rule 23(a)(4) requires consideration of "[1] the zeal and competence of the representative[s'] counsel and . . . [2] the willingness and ability of the representative[s] to take an active role in and control the litigation and to protect the interests of absentees"); *accord. Berger v. Compaq Computer Corp*., 257 F.3d 475, 479 (5th Cir. 2001); *accord. Feder v. Elec. Data Sys. Corp.*, 429 F.3d 125, 129-130 (5th Cir. 2005). First, the Plaintiff is represented by attorneys with ample experience in class actions and civil rights litigation – both in general and with respect to prisons and jails. (*See* Declaration of Sheila A. Bedi, exh. 4). Counsel are capable of pursuing the case vigorously on behalf of the class. The proposed class representatives in this case have clearly demonstrated their commitment to protect not only their rights, but also the rights of the absent class members.

D. Injunctive and Declaratory Relief

Plaintiffs also satisfy Fed. R. Civ. P. Rule 23(b)(2). Defendants' actions have been taken "on grounds generally applicable to the class, thereby making appropriate final injunctive or corresponding declaratory relief with respect to the class as a whole." FED. R. CIV. P. 23(b)(2). Courts have recognized that class actions certified under Rule 23(b)(2) are particularly important in civil rights cases where injunctive relief is sought, as in the present case. *Jones v. Diamond,* 519 F.2d 1090, 1099 (5th Cir. 1975). This is exactly the type of litigation that the Federal Rules

Advisory Committee anticipated would be certified under Rule 23(b)(2). *Id.* Defendants' refusal or failure to act equally affects rights common to all of the class members, both the representative individuals as well as the unnamed class members. Thus, Defendants are acting or refusing to act in a manner that is "generally applicable" to the entire class of persons. Therefore, final injunctive and declaratory relief is appropriate, precisely because it will resolve the challenge to Defendants' action and inactions for the class as a whole. In this case, Plaintiffs' request for class certification under Rule 23(b)(2) is necessary to ensure that any mandatory relief will extend not only to one named individual, but also to the entire class.

For all the above reasons, the Plaintiffs request that this motion for class certification be granted.

RESPECTFULLY SUBMITTED, this the2nd day of April 2012.

I/s/ Katie M. Schwartzmann
Katie M. Schwartzmann, La. Bar No. 30295
Sheila A. Bedi, Miss. Bar No. 101652 (pro hac vice application forthcoming)
The Southern Poverty Law Center
4431 Canal Street
New Orleans, Louisiana 70119
504-486-8982 (phone)
504-486-8947 (fax)

Certificate of Service

I hereby certify that a true and correct copy of the foregoing document was filed electronically. Additionally, this filing will be personally served upon the Defendants along with a copy of the Complaint, this the 2nd day of April, 2012.

_s/ Katie M. Schwartzmann

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Kent Anderson, do hereby declare:

1. I am currently incarcerated on the tenth floor of the House of Detention in Orleans Parish Prison.

2. I suffer from several health conditions including stress and anxiety. My fiancé tried to bring my prescriptions to jail to show the doctors what I was taking on the outside, but the deputy said, "we don't deal with that."

3. I put in several sick calls, but most times they are never answered. It took a really long time and lots of sick calls before I got any medicine. When I filed a grievance on not getting the medicine, they told me to file a sick call.

4. Some of the nurses on duty refuse to pass out medicine.

5. I recently came to the tenth floor of HOD from Old Parish Prison because I was getting really depressed. I told someone that I was thinking about taking pills to kill myself.

6. I was put on suicide watch and when I got off, the psychiatrist was hard to talk to, like I did something wrong. I needed help, but he only spent a couple minutes with me.

7. I put in another sick call last week to see the psychiatrist. I keep having nightmares and am really stressing. When I saw the psychiatrist he told me to talk to a counselor. He said, "I'm a fucking doctor! That's it. I prescribe medicine. If you want to talk, talk to a fucking counselor!"

8. I have met a lot people with mental health issues in here. None of them are getting the help they need. I feel all alone. Sometimes I get claustrophobic. The medicine isn't helping much and there's no one to talk to. It's hard to keep waking up.

9. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

10. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 31 day of March 2012, I declare under penalty of perjury that the foregoing is true and correct.

Kent Anderson

Sworn before me this 31 day of March 2012.

Witness

11.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Steven Dominick, do hereby declare:

1. I am currently incarcerated on a protective custody tier in the House of Detention in Orleans Parish Prison. I am on lockdown for twenty-three hours a day.

2. I have been threatened with knives, jumped, and stabbed. I have also witnessed many stabbings since I have been OPP.

3. Guards do nothing to prevent the violence. In fact, they often instigate it. When severe injury results from a fight, guards fail to respond with urgency. It can take hours for a deputy to come on the tier. Consequently, I have had to apply pressure to knife wounds and called family members to contact 9-1-1 since the guards refuse to help.

4. When I was at Old Parish Prison, they put a transgendered woman on my tier. She was living life fully as a woman and had breasts and everything. Guys were giving her a really hard time and I was worried for her. I kept telling guards they needed to move her. There was also gay, effeminate, white guy on the tier at one point. People would take him into the shower and coerce him to perform oral sex. I didn't see it, but I could hear it. It could happen because we were all alone for hours. I still struggle thinking about how I couldn't protect him.

5. I came to HOD protective custody from Old Parish Prison since I was testifying against someone in a trial. But this isn't protective custody. There are shanks everywhere and everyone's cell pops open. I have informed the jail of this breach in security, but nothing has been done to rectify it.

6. These facilities are not undermanned, they are unmanned. Deputies frequently leave their posts. Guards typically work two floors during one shift, especially in Old Parish Prison. It doesn't matter what facility you are in, you're going to be lucky to escape without some scars.

7. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

8. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 31 day of March 2012, I declare under penalty of perjury that the foregoing is true and correct.

Steven Dominick

Sworn before me this 31 day of March, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Anthony Gioustavia, do hereby declare:

1. I am a pre-trial detainee incarcerated at Old Parish Prison in Orleans Parish Prison.

2. An older, bigger guy attacked me when I first rolled in. Guards weren't around when it happened. It lasted a long time.

3. I have seen lots of other fights. One time some men grabbed this little guy when he was sleeping and started to fight him. Another time, there were two guys with knives fighting on the open tier. One of them got stabbed in the mouth and twice in the back. Other guys with knives were watching and were waiting to fight.

4. Guards are never around when fights break out, which is often. They usually come by for count time and then leave again for hours. I don't feel like they are doing much to protect any of us.

5. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

6. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

X Anthony Gioustavia
Anthony Gioustavia

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Jimmie Jenkins, do hereby declare:

1. I am a pre-trial detainee currently incarcerated on the tenth floor of the House of Detention in Orleans Parish Prison.

2. I am locked in my cell for twenty-three hours a day, but the locks pop so people can get out when the guards aren't looking.

3. Before I was arrested, I was taking prescription medication for my bipolar disorder. I have not gotten my medication here in OPP.

4. It's hard without my medicine in here and not being able to talk to a counselor or social worker. Plus, there are fights all the time. I came over to the psych tier in order to get some help after a guy stabbed me up in Old Parish Prison. I have been hit here too and seen lots of other fights. I just got punched a couple weeks ago when a guy was trying to steal my cookies.

5. I thought it would be better on HOD 10, but guards leave us unattended just like they do in Old Parish Prison and I still haven't had any mental healthcare.

6. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

7. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 31 day of March 2012, I declare under penalty of perjury that the foregoing is true and correct.

x _____
Jimmie Jenkins

Sworn before me this 31 day of March, 2012.

_____
Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Greg Journee, do hereby declare:

1. I am a pre-trial detainee currently incarcerated on the seventh floor of the House of Detention in Orleans parish Prison.

2. Before I got to HOD, I was in Old Parish Prison. There, I had to move because of threats I was getting. When the warden finally moved me he said, "you know this is a jail facility. I can't make sure that nothing happens to you."

3. When I moved to HOD I was jumped by a bunch of guys right after I got on the tier. Some of them held me while another one stabbed me over and over. I was bleeding all over and yelled for a deputy. No one came until the next day. When a guard finally came, he didn't do anything. I never even received medical attention.

4. All of the cells pop in all of the tiers and guards leave us alone. People on my tier have shanks so big, they look like kitchen knives. Guys can get out and come get you any time. The guards aren't going to do anything to stop it. I don't think anyone is safe in here.

5. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

6. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 31 day of March 2012, I declare under penalty of perjury that the foregoing is true and correct.

Greg Journee

Greg Journee

Sworn before me this 31 day of March, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Richard J. Lanford, do hereby declare:

1. I am currently incarcerated in the Conchetta facility in Orleans Parish Prison. I have also been held at the House of Detention and the Old Parish facilities.

2. Since my arrest in August 2011, I have been jumped at least three times, and other inmates have attempted to sexually assault me and threatened to kill me numerous times. I have sustained multiple physical injuries as a result of these attacks, and have had to be taken to the hospital for surgery to treat broken bones and lacerations experienced as a result of getting jumped.

3. I was placed in the Old Parish facility because my bail was really high. Old Parish is where they keep the most violent offenders – yet my offense was not violent. Putting me in there with violent people exposed me to a lot of physical and emotional harm, stress, anxiety, and fear.

4. The first time I was jumped in September, my arm was twisted behind me. As a result, I can't move my arm. I am in a lot of pain but the guards say my arm is fine and won't give me medical attention to see if the ligaments in my arm are torn. When I reported this incident right away to the guards, they told me I was lying and refused to get me help or to move me away from the inmates who jumped me.

5. I was jumped again in November and had my cheekbone and jaw broken. The guards ignored me and made me wait over an hour before giving me any medical attention. I had to be taken to the hospital for surgery to have these injuries fixed.

6. Just weeks later, I was jumped in the medical tier of the Old Parish facility where I was recovering from surgery required to repair my broken cheekbone and jaw. I was jumped by a guy who thought I was a rat for complaining about getting jumped earlier.

7. Because I reported getting jumped all three times so I could get medical attention, everywhere I go men call me a rat – in my cell, on my tier, at court. I never know when I might run into someone who wants to hurt me.

8. Because of the severe violence and threats I was receiving in the Old Parish facility, I both asked and my judge ordered that I be moved to Conchetta but it took months for me to be moved. Now that I am in Conchetta, I'm on a tier with one of the men who attacked me at the Old Parish facility. I still don't feel safe.

9. The guards keep these facilities unsafe. Guards patrol two floors at once, so my tiers have gone without supervision for long periods of time. When guards are present, they ignore us and sleep. When I was recovering on the medical tier at the Old Parish facility, the guards would leave our cells open, which caused me to get attacked again.

10. I have seen violence happen constantly in the House of Detention and in the Old Parish Prison facilities. This violence includes men getting jumped, and men with knives stabbing other inmates.

11. I am being prescribed pain medication as a result of the numerous injuries I have sustained from other inmates. The nurses bring me large quantities of my pain medication at a time – usually enough to last me for one to two weeks. Having this many pills on me at once threatens my safety – other inmates know that I have large amounts of pills on me and threaten to attack me if I don't give them away.

12. I am extremely depressed as a result of the violence and conditions in this place. I am constantly looking over my shoulder, convinced someone else is going to try and get me. I feel like I have aged ten years in the six months I've spent here.

13. I know that sexual assault happens here from other inmates, and I have had inmates attempt to sexually assault me. I would rather die than have someone do that to me. Having that happen to me is my worst nightmare.

14. We are treated like animals here. The conditions are horrible – there is mildew everywhere and it is making me sick. Toilets are always broken and the food is disgusting.

15. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can get my physical injuries fixed, and to make the prison safer for me and all the other prisoners here now and in the future.

16. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 1st day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

[redacted] Richard Lanford

Sworn before me this 1st day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Leonard Lewis, hereby declare:

1. I am a pre-trial detainee currently housed on the ninth floor of the House of Detention. This is a protective custody tier. I am locked in my cell twenty-three hours a day.

2. I was transferred to HOD from Old Parish Prison about seven months ago, because I am testifying against another prisoner. But time and again jail officials keep putting me in unsafe situations with him. I have been threatened, beat up and stabbed multiple times in different buildings since my arrest. No one responds when I ask for help. No one is safe in here.

3. During the 2010 summer I was in the holding tank. A deputy put me in a cell with a guy that knew the prisoner I'm testifying against. He stabbed me up a bunch of times. The guard knew he was my enemy, but he didn't care. I think he wanted to see one of us get hurt.

4. I filed a grievance, asking that a supervisor deal with the deputy. The grievance I got back said I was placed in the holding cell by mistake.

5. I filed another grievance because that is not an acceptable mistake to make. My life is on the line. I asked in my Step Two grievance, "what if I would have got hurt real bad?"

6. The next response said that the matter was already taken care of. I filed a third grievance, saying that the other guy had a knife and if it wasn't for a female deputy who passed by, I would have been cut up.

7. Two years later, I received a response to that grievance from Sheriff Gusman himself. It should not take two years to take me seriously. No one cares about my safety or anyone else's in this place. I know because in those two years it took to get a response, I was jumped several more times.

8. After I was on protective custody, they took me to court with general population. I ended up getting stabbed and jumped by a bunch of guys when I was on the docks waiting for court.

9. I got jumped again by a couple of guys when I came back after another time in court. Someone yelled out, "I heard you were a rat." The cells were open and this guy came

into my cell and started fighting me. Some other guys came and joined in against me. Deputy Lyons knew it was going to happen. He locked the interlock so I couldn't run off the tier. I yelled for help, but it took a long time to get a deputy's attention.

10. My whole face was swollen from the fight and I think my nose was broken. A nurse just gave me an ice pack.

11. I filed another grievance on it, and Warden Louque said SOD was investigating. But I haven't heard anything from SOD since. They moved me up to another PC floor, but I still feel unsafe.

12. We're not actually in protective custody up here. The deputies are never around and all the cells pop open. No one is doing their job. They're all just busy covering up for each other.

13. On March 27, 2012 I went to court, but was brought with the guy I am testifying against. Everyone knows I'm not supposed to be in court with him. Everyone knows I'm testifying against him. They just don't care. I told someone from the Special Operations Division that I was not supposed to be with that guy, but he wouldn't do anything.

14. I was walking right behind him into court. When we were by the judge's desk he turned around and said, "stupid bitch." Then he spit in my face. I'm lucky he didn't do something worse. The DA saw what happened and asked if I was OK, but SOD didn't do a thing.

15. I filed another grievance on this when I got back to jail from court, the same day. I don't think those grievances do a thing, though, and sometimes you can't even get a form or turn it in. The mail lady hasn't been by for weeks and the last time I saw her, she said they didn't have any more copies of the forms.

16. We're on our own in here. I just pray that I make it out of here alive. People die back here. I don't want to be the next one to die, and I don't think anyone else should die back here either.

17. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

18. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the ___ day of _____ 2012, I declare under penalty of perjury that the foregoing is true and correct.

I declare under penalty of perjury that the foregoing is true and correct, this 1 day of April, 2012.

Leonard Lewis

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Euell Sylvester, do hereby declare:

1. I am currently a pre-trial detainee, incarcerated in the House of Detention in Orleans Parish Prison. I am protective custody and am supposed to be on lockdown for twenty-three hours a day.

2. Prior to my arrest, I pressed charges on someone. When I was arrested, the jail didn't check for this conflict. They put me in the same building as my defendant, who put a hit on me.

3. Because of the hit, a lot of guys came up to me one night and started giving me a hard time. Things escalated until they stripped me, restrained me and beat me in the middle of the night. Some of them had knives. They hit me with their slippers and mop buckets. The beating tore the skin off my back.

4. They sexually assaulted me including anal penetration.

5. During the attack, a deputy came on the floor, but he never looked into the tier. If he had, he would have seen what was happening. But deputies don't really care about what happens to us.

6. The next morning I did not receive any medical treatment. I never got a rape kit even after I reported what happened. I had to file something to get HIV/STD testing and it took months for them to even give me that.

7. Since the beating in Old Parish Prison, guards have put me in contact with my defendant and my attackers a few more times. It's like they want to see me get messed up.

8. I'm on protective custody now, but I still don't feel safe. All the cells pop and guys are always threatening me, both on the tier and when I go to court. They tell me they're going to beat me up. I complain to guards and ask them to move me, but they refuse.

9. Anywhere they put me, I'm not going to be safe. All of our safety is at risk. The guards aren't doing their jobs and there are knives everywhere. Plus, I think they try to set up the fights. I don't care why anyone is in this jail. We are still human beings and we do not deserve this. This violence has got to stop.

10. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

11. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 30 day of March 2012, I declare under penalty of perjury that the foregoing is true and correct.

Euell Sylvester

Euell Sylvester

Sworn before me this 30 day of March 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Mark Walker, do hereby declare:

1. I am currently incarcerated in Orleans Parish Prison on a medical tier in Old Parish Prison.

2. I am diagnosed with bipolar disorder and am legally blind.

3. Since my arrest in October 2011, I have been in the House of Detention, Orleans Parish Prison, Conchetta and the Tents. I have not been safe from harm in any of these facilities. I have been raped, beat up by guards, jumped by prisoners, had my stuff stolen, and denied access to mental healthcare. Nobody, especially those of us with a physical or mental disability, are safe here.

4. Shortly after my arrest, I was forced to perform oral sex while I was sitting on the toilet. I started making noise as loud as I could, but people in the cell got mad at me for yelling and the guards didn't check on me. I reported it to a guard afterwards, but she didn't believe me.

5. I was put on homicide/suicide watch after the assault because I told the guard if he did not protect me, I would defend myself. On suicide watch I asked for grievances to report the rape. Guards kept telling me, "We don't have any," or "It's not even worth giving you a grievance because I can't give you a pen to fill it out since you're on suicide watch." I had to ask every day for weeks until I obtained a grievance form and pen.

6. I don't think the grievances I wrote were ever turned in because people from the special investigation division didn't come see me for forty-one days after the assault. I didn't tell them everything because they interviewed me in front of other prisoners and I didn't feel comfortable.

7. It took a really long time for the jail to give me HIV testing. I still have not gotten my results back.

8. Before they moved me from HOD 10, I was jumped a couple times. In Tent One I was jumped again repeatedly and had cleaning solution sprayed in my eyes. I was moved around different tents and I kept getting jumped. Guards were never around to protect me or to break up the fights. I think they were smoking outside.

9. In December a guard told me to pack up. I obeyed, but he said that I hit him with my mat when I grabbed it to go. He got so mad that he took me and beat me up in the back part of Tent One. I was handcuffed and couldn't protect myself. He beat me so badly that a female deputy, who had been laughing at first, finally stepped in to stop him.

10. Now I'm in Old Parish. Recently a guy was harassing me in the shower. When I tried to tell jail officials about it they said to me, "do what you gotta do."

11. I have filed multiple sick calls for a variety of complaints. When I finally saw medical, they said that my sick calls were never put in the computer. How can I see the social worker if they do not put my sick calls in the system?

12. The guards do not patrol the tiers, they do not respond to verbal complaints or grievances. Like everyone else in here, I am constantly in fear for my well-being.

13. I believe that this lawsuit is in my best interest. I want to bring this lawsuit so that I can make the prison safer for me and all the other prisoners here now and in the future.

14. I will fairly and adequately represent the interests of all the prisoners in Orleans Parish Prison.

On this, the 30 day of March 2012, I declare under penalty of perjury that the foregoing is true and correct.

Mark Walker

Sworn before me this 30 day of March, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Ralph Anderson, declare the following is true to the best of my knowledge.

1. I am 28 years of age and competent to sign this declaration.

2. I am a prisoner at Orleans Parish Prison and expect to be here until I am transferred to Angola Correctional Facility.

3. While in Orleans Parish Prison, I was recovering from a recent surgery on both my legs from a gunshot wound. I entered Orleans Parish Prison in a wheelchair. I was not seen by any medical staff or cleared by a doctor to be removed from my wheelchair but my wheelchair was taken from me and I was given crutches. Less than a week later guards came and took my crutches, again without me seeing any medical staff. I was then placed in a 10 man holding cell in general population. The cell was already overcrowded and I was forced to sleep on the floor, even though I was not recovered from my surgery. I was unable to stand for long periods of time and I was unable to get myself off the ground in the morning. I was forced to ask for assistance from other people being housed in the cell. While I was in the 10 man cell I was very vulnerable to violence because I was unable to defend myself; this caused my belongings to be taken from me multiple times.

4. The only way Orleans Parish Prison and Sheriff Gusman responded to multiple calls and complaints from my family about my current medical condition was to place me on 23 hour lock down protective custody on the 8th floor of the House of

Detention. Sheriff Gusman assured my family and I that I would not have a cellmate during my time on the 8th floor due to my inability to protect myself and the nature of my condition. On the 14th of January, 2012 I received a cellmate. This was after my family and I had been reassured that I would not have a cellmate because of my medical condition and violence I was already subjected to. When my cellmate first arrived I did not feel safe at all. I was very vulnerable because of my medical condition with my legs and I felt that I was open to violence at any time. I filed a grievance on the 14th of January the fact that I had a cellmate and was not supposed to have one but I never received a reply.

5. The sliding front of the cell that opens and closes and allows people to enter and leave the cell are being held closed with shackles. I witnessed the Fire Marshal come onto the tier and tell guards that the shackles are a fire hazard and that they need to come down. They did not come down and are still being used to hold the cells closed.

On this, the 30 day of March 2010, I declare under penalty of perjury that the foregoing is true and correct.

By: Ralph Anderson
Ralph Anderson

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Joel Dixon, do hereby declare:

1. I am currently incarcerated in Old Parish Prison in Orleans Parish Prison.

2. During my time in the facility, I have witnessed several incidents of prisoner on prisoner violence.

3. Before I was on the medical tier, I saw one incident of sexual violence. Multiple prisoners locked another man in a cell and raped him. I couldn't see everything that was going on because I was in the adjacent cell, but I could hear everything.

4. Recently on the medical tier, a guy who really needs some mental healthcare lunged at me and scratched me under my jaw with something sharp. It left a mark from my chin to my jaw. I know he needs help and wasn't getting any, because I helped him fill out sick calls before the incident. He told me all the prescription medication he was on prior to coming to jail. He also told me that he wasn't getting that medication in here. As far as I know, he never received treatment.

5. The same guy got in another fight a few weeks later. He was trying to spit on us and gouge people's eyes out. I'm not mad at him. He needs help. Like all of us, he just needs help. If medical had only responded to those sick calls, these fights never would have happened.

6. I have struggled with depression since I've been back here, but I didn't want to say anything because I don't want to go to HOD 10. I even had plans to commit suicide, but was too afraid to ask for help.

7. When a fight or other incident occurs, we are discouraged from reporting it. If someone rats to a guard, the guards will tip off the tier as to who the rat is, so the guys on the tier can punish or intimidate him.

8. Guards aren't around for the fights and then they encourage more violence by telling the prisoners who reports them.

9. They have been painting a lot of the tiers recently, trying to make things look better. But they are merely camouflaging their inadequacies. It is going to take a lot more than paint to make us safe.

Joel Dixon

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Brent Gill, do hereby declare:

1. I am currently incarcerated in the Temporary Detention Facility in Orleans Parish Prison.

2. Before I got here, I was in the Broad Street Work Release program.

3. I had a lot of problems over there. Guards weren't giving me paychecks, they threatened me and tried to get me to fight them.

4. I started filing grievance after grievance for all of these things, but I never got a response back. One time I heard one of the guards say, "He just don't know. He keeps writing grievances, and we're just gonna keep ripping them up." I think they started retaliating against me since I kept filing grievances on them.

5. I have also seen guards throw grievances away.

6. After a while I started filling out two grievances at a time so I could give my attorneys a copy of what I was writing.

7. I don't know what else I'm supposed to do to get my money back or make sure I'm safe, since I never get a response to my grievances.

On this, the 1 day of 4th Month 2012, I declare under penalty of perjury that the foregoing is true and correct.

X Brent Gill
Brent Gill

Sworn before me this 1 day of 4th Month 2012.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Joshua Hobson, do hereby declare:

1. I was formerly incarcerated in Orleans Parish Prison from late November 2011 to the middle of December 2011.

2. During my time there I witnessed guards encourage violence and cheer fights on between inmates until the first blood was drawn. I had to remain constantly alert to an attack from guards or other guys on my tier. When I tried to draw attention to the situation, I was intimidated, harassed and ignored by the Sheriff's staff.

3. When I first arrived I was put in a holding cell in the House of Detention before my First Appearance. While I was waiting I witnessed a guard drag two bleeding inmates down the hallway. The guard threw them into the holding cell with me. One had a dime size hole in his head. After a little while, the guard came back and dragged the two men out of the cell to the elevator where he threw them in like trash and said, "serves you to niggers right."

4. In early December I was dragged out of my bed at night by several guards. They threatened to hurt me and hit me a few times in an attempt to intimidate me from publicizing the appalling conditions.

5. In addition to the violence and abusive guards, the grievance procedure is non-existent. Prisoners in OPP have absolutely no way of reporting problems. While in custody, I tried three different times to file grievances. The first time I tried to turn one into a guard, he read it in front of me and then ripped the grievance into little pieces in front of my face. The second and third times I filed a grievance, deputies took the forms, but I never received a response.

6. As a result of all of this I became hopeless. I stopped eating and couldn't sleep. These were the worst weeks of my life.

I declare under penalty of perjury that the foregoing is true and correct, this the 31 day of March, 2012.

Joshua Hobson

Sworn before me this 30 day of March, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, J.J., hereby declare:

1. I am a pre-trial detainee currently incarcerated in the House of Detention. I am locked in a cell with my cell-mate for twenty-three hours a day.

2. I was transferred to Orleans Parish Prison from the Youth Study Center four days after my arrest and spent several months in Templeman Phase V.

3. During my time in Orleans Parish Prison, I have been beaten up by tier-mates, abused by guards and neglected by medical staff. I am afraid for my life. This is no place for a juvenile.

HOD 10

4. Early on in Templeman V, I got really depressed and thought about hurting myself. Before I did, though, I reported my thoughts of suicide. In October I was moved to the tenth floor of the House of Detention for suicide watch.

5. When I arrived on HOD 10, guards made me strip down in front of several people and put me in a vest without any shoes. Then the guards put me in a shower that was full of urine and semen. I asked for my shoes, but the deputies refused to give them to me. Because I didn't want to sit or lay down in the mess, I stood in the entire night.

6. During the night I spent in HOD, I heard someone get raped. When he told the guard the next day, the guard said "you're lying." Another time I saw a guard pepper spray a prisoner.

7. Since that incident I am afraid to tell the guards if I feel suicidal. I asked to see a nurse twice for depression but no one came to see me. I do not want to tell them if I feel like hurting myself, though, because I do not want to be sent back to the tenth floor.

Templeman V

8. In Templeman V the other guys on tier harassed, threatened, beat and abused us in every way possible. They pulled shanks on us, stole our stuff and contaminated our food.

9. Guys were getting raped on the tier.

10. The guards yelled at us and called us rats for talking to our lawyers about what is happening.

11. Even after I was protective custody I got jumped because the guards do not protect us.

House of Detention

12. When I got out of Templeman, they put me on a maximum security tier in HOD with adults. All the cells popped open and one of the adults hit one of the kids who came over with me. Guards were not on the tier to protect us. I have never been so scared in my life.

13. I'm still scared when I leave my tier to go to attorney visits or court because those guys in Templeman have people all over this jail who can get me. Guards don't do much to protect me and it only takes a second to get stabbed. Only takes a second to lose your life. I am also worried about new kids coming to Templeman V. I have heard that guys are still getting jumped back there. There's nowhere safe for us.

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

X J. J.
J.J.

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Nicholas Miorana, do hereby declare:

1. Around Mardi Gras I grew extremely depressed. I asked to see a psychiatrist, but guards told me I had to go to HOD 10 to see a psychiatrist, so I said I was suicidal in order to get sent there.

2. When I arrived, I was first put in the suicide tank. I waited in my underwear with other guys. I couldn't use a phone to call anyone. Guards wouldn't let us out to go to the bathroom. The following morning I saw the psychiatrist. When he learned I was never suicidal and just wanted to talk to someone about my troubles, he became angry. He had a really bad attitude and kept telling me if I want to talk, talk to a social worker. But it's almost impossible to get an appointment with the social worker here.

3. I asked to go back to Old Parish, but guards put me on the tier with this small, young guy who was just coming on too. I watched as some bigger guys stabbed the little one a bunch of times in the neck and his body. Two of them had knives. The little guy tried to fight back and was yelling loudly. Guards finally came and opened the gate to the tier, but wouldn't come on the tier.

4. The kid made his way out and immediately lay down. His blood was pooling all around him. I came off with him because I didn't want to stay on that tier after that. It took a long time before the ambulance arrived.

5. Guys have almost died on the tier because guards are never around. Sometimes it takes 30 or 45 minutes of banging on the door before guards respond.

6. This is serious. You can die in here. You can easily be killed any day. On some tiers, inmates have shackles. There are at least two to ten knives on every tier. If you report something, though, you'll probably get stabbed up. Animals can't live back here, much less human beings.

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

/s/ Nicholas Miorana
Nicholas Miorana

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Damon Patterson, hereby declare:

1. I am a pre-trial detainee currently housed in the Tents in Orleans Parish Prison.

2. Since my arrest, I have witnessed several violent incidents including fights between inmates and beatings by guards. I try to stay out of it and stay safe. No one in safe in here, though.

3. After a few days in the House of Detention I was transferred to Tent One. I didn't have any problems there, but I saw one guy get stabbed up. He was hurt so badly that they put him in the Hole to heal up. They put guys in the Hole since you don't get visitation when you're in there. That way your family can't see how bad you're hurt.

4. It's not just inmate on inmate violence in there. I've seen guards beating on people in Tent One. They take guys into the back area by their office. They tell everyone to get away from the gate and then they beat the guys up. It happened a lot, usually during the night shift. The guys that have been beaten up by guards were mostly young and almost always were handcuffed for the beating.

5. Later on, I was transferred to Tent Six where I am now. Tent Five and Six are worse than the other tents. They are a cesspool for violence and corruption. Since I have been in Tent Six I've seen fights and stabbings.

6. Fights are allowed in here. Guards let them do it, either by putting guys together they know are going to fight, or by not stopping the fights once guys get into it. But mostly it's because they're never around. You only see a guards a few times a day.

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

Damon Patterson

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Jelpi Picou, an individual of the age of majority, do hereby state:

1. That I was incarcerated in Orleans Parish Prison for one year and was released on or around July 15, 2011.

2. During this period, I witnessed systemic prisoner on prisoner violence as well as abuse and neglect by the guards in several Orleans Parish Prison facilities.

3. For instance, I was held temporarily in the Templeman V facility directly across from the juvenile tier. There were no visual obstructions between the tiers, and guards often encouraged us to watch the juveniles beat each other for entertainment.

4. Guards are aware of the rampant violence on the juvenile tier of Templeman V, yet, they do nothing to curb or prevent it. In fact, they provoke violence by turning off the televisions, aware that the lack of stimulation leads to fights.

5. Prisoner on prisoner violence is not contained to the juvenile tier of Templeman V. A culture of violence exists across all facilities under Sheriff Gusman's control, due to the guards' failure to patrol tiers, enforce safety measures and respond efficiently to emergencies.

6. I witnessed most violent acts occurring when guards were absent from the tier for several hours at a time. When guards do make rounds, they perpetuate the violence by taunting and inciting prisoners through verbal abuse. The resulting experience of humiliation and emasculation among the prisoners leads to increased instances of aggression.

7. On the rare occasion that guards are present for a physical altercation, they wait either for its conclusion or until prisoners to draw blood before responding to scene.

8. On top of the hostile and unsafe environment, OPP lacks an established grievance system. If you file a grievance about someone on your tier, the guard tells them within in minutes which puts you at risk. If you file a grievance against a guard, they usually rip it up and throw it away. Consequently, you feel cut off from any type of order. You are totally on your own.

9. Due to the pervasive violence across facilities coupled with the lack of available institutional remedies, juveniles suffering physical and sexual abuse in Templeman V will not benefit from transferring to an adult facility. Prisoners and guards alike identify the weakest targets to attack, thus putting juveniles at a heightened risk in facilities outside of Templeman V.

I declare under penalty of perjury that the foregoing is true and correct, this the 18th day of January, 2012.

Jelpi Picou

Sworn before me this 18th day of January, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Paul Robinson, do hereby declare:

1. I am currently incarcerated on the tenth floor of the House of Detention in Orleans Parish Prison.

2. I am afraid for my life in here. They're really stabbing people up. I have heard guards beat on people, I have seen guys get in fights, and guys have attacked me too.

3. When I was in Old Parish Prison my cellmate pushed me, and I fell and hit my face on the toilet. My face was swollen. My nose was also busted and bleeding. I didn't tell the guards I got in a fight, but they moved me anyway. I never did get medical attention for my face, though. There's no help in this place.

4. Now I'm on the tenth floor and I'm afraid to come off of it because people are waiting to get me back in Old Parish Prison. People are out to get you all over this jail and guards don't stop it. Guards encourage it. The tenth floor isn't even safe. I just checked off my tier because I was afraid for my life. I've never done that before because it makes you look weak.

5. All the cells pop open up here and guards only come through a few times a shift. I think I would only be safe on PC. We're all in a house of danger back here.

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

X Paul Robinson
Paul Robinson

Sworn before me this 1 day of April, 2012.

Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Ben Sabine, do hereby declare:

1. I am currently incarcerated in Old Parish Prison in Orleans Parish Prison, waiting for a bed to open up in a rehab program.

2. I'm on the medical tier right now because I was on crutches when I was arrested. I had just gotten a tumor taken out of my leg.

3. A little while ago, one of the guys I was cool with gave some of my pills away. I got upset with him and then he put his shoes on to fight. While we were fighting in the back away from the guards, two other guys came up behind me and hit me on the head and face over and over like they were boxing. I was seeing stars by the end. When it was over, my eyes were swollen and black and I had to get stitches at LSU for a cut under my eye.

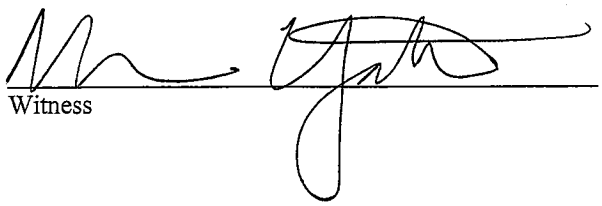
4. Another time a guy on the tier stabbed someone up when he thought someone stole his stuff. The guy that got stabbed had to run to the window and start banging on it to get someone's attention. He was yelling, "I got stabbed! I got stabbed!"

5. For all of these fights, guards weren't around. Because I'm on a medical tier, though, it is the safest tier to be on. I can't imagine what goes down on the regular tiers.

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

Ben Sabine

Sworn before me this 1 day of April, 2012.



Witness

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

DECLARATION

STATE OF LOUISIANA)
PARISH OF ORLEANS)

I, Jray Tapp, do hereby declare:

1. I was incarcerated in Old Parish Prison in February and March of 2012.

2. The weeks I spent in OPP were the worst weeks of my life. Immediately after booking I was put on the tenth floor. I spent some time in the suicide tank and then was released to a cell with a ton of other people in it. I didn't have a bed or a mat, so I asked a guard if I could have a mat. He sent another inmate in with one. I went to grab it, but he stabbed me in the back in the neck. I passed out and when I came to, there were two guys kicking and stomping me. I tried to fight back, but they just kept hitting me. They stabbed me again, and I passed out a second time. They stole my shoes when I was blacked out.

3. Altogether, they stabbed me once in the neck, multiple times in the head and the back. My hand was also sliced when I tried to grab the knife. I also had two black eyes and my face was all swollen up.

4. It took a while for guards to respond. Then the nurses came. It took even longer for an ambulance to get there. The whole time I was just lying in my own blood. I was in shock. I was shaking. There was blood oozing everywhere and I couldn't breathe. Then I started coughing up blood and stuff.

5. Guards were yelling at me to shut up. They said I wasn't even hurt that bad. I told them I couldn't move my head, so one of them grabbed my neck and yanked it around to prove that I could.

6. When I got to the hospital, they gave me fluids and cleaned out my wounds. A few hours later they brought me to jail and put me back on the tenth floor, but a different tier. One of the guys in my cell needed a colostomy bag. Since he didn't have one, he was just making a mess all over himself and the cell. I didn't have a mat or a bed and I slept on the floor for a few nights.

7. They moved me to the Tents after a few more days. But some big guy came up and told me I took his rack. He put his shoes on for a fight. Then he slammed me on the ground a couple of times and hit me too. My face puffed back up and he bruised my elbow. The worst part was that my stab wounds opened back up.

8. I'm really lucky to have made it out of there alive, but I'm worried about everyone still in OPP. I'm not the only person this has happened to and I know that it will continue to happen unless some action is taken.

On this, the 1 day of April 2012, I declare under penalty of perjury that the foregoing is true and correct.

Jray Tapp

Sworn before me this 1 day of April, 2012.

Witness

STATE OF LOUISIANA	PARISH OF ORLEANS STATE OF LOUISIANA
v.	
CEDRIC BERRYHILL	No. 504-025 Section G Hon. Julian A. Parker, Presiding
FILED: _____	_____ DEPUTY CLERK OF COURT

MOTION TO ORDER ORLEANS PARISH SHERIFF TO PROTECT AND SAFEGUARD CEDRICK BERRYHILL

COMES NOW, CEDRICK BERRYHILL by counsel, and moves this Court pursuant to the 8th Amendment to the United States Constitution, and Article 1, Section 20 of the Louisiana Constitution to provide relief from cruel and inhumane treatment in the Orleans Parish Prison Templeman Phase V Facility. In support of his motion, Mr. Berryhill states as follows:

> The United States Supreme Court has not waivered in its holding that the Eighth Amendment prohibiting the imposition of cruel and unusual punishment is, *inter alia*, intended to protect and safeguard a prison inmate from an environment where degeneration is probable and self-improvement unlikely because the conditions existing inflict needless suffering, whether physical or mental. Ramos v. Lamm, 639 F.3d 559 (1980 10th Cir); Battle v. Anderson, 564 F.2d 388 (1977 10th Circ), *relying on* Estelle v. Gample, 429 U.S. 97 (1976); Gregg v. Georgia, 428 U.S. 153. (1976)

1. Cedrick Berryhill moves this court to order protective action while Cedrick is in the custody of the Orleans Parish Sheriff.

2. While incarcerated at the Templeman Phase V facility, Mr. Berryhill has been the subject of multiple assaults.

3. Almost immediately upon his transfer from the Youth Study Center to the custody of the Orleans Parish Sheriff, Mr. Berryhill was assaulted by other inmates, many of whom were subsequently charged with battery.

4. After the attack, Mr. Berryhill was placed in protective custody where he has been ever since.

5. However, protective custody has proved to be even more violent for Mr. Berryhill than general population.

6. On February 25th, Juvenile Regional Services was informed that Mr. Berryhill had been "gang raped" by 4-5 men and that he was taken to the hospital. Because Cedrick has limited

capacity to communicate with his counsel and a general reluctance to report abuse given his particular vulnerability, this account was neither confirmed nor denied.

7. On March 18th, 2011, Mr. Berryhill's attorneys were informed by the Assistant District Attorney that Mr. Berryhill had, again, been raped.

8. Multiple individuals have confirmed that Mr. Berryhill is being abused, although he is housed in protective custody.

9. Additionally, shortly after the original attack, Mr. Berryhill attempted suicide and was allegedly placed on suicide watch. He was on suicide watch when the next series of attacks occurred.

10. The Eighth Amendment protects individuals from cruel and unusual punishment. Article 1, Section 20 of the Louisiana state constitution provides for the right to humane treatment.

11. The Prison Reform Act of 1995, Section 738 provides that":

> No incarcerated or state prisoner, whether before trial, during trial or on appeal, or after final conviction, who is housed in any jail, prison, correctional facility, juvenile institution, temporary holding center, or detention facility within the state shall have a standard of living above that required by the constitutions of the United States and the state of Louisiana, as ordered or interpreted by the appropriate courts of last resort, or by the standards set by the American Correctional Association.

12. One of the commitments of the American Correctional Association (ACA) is to eliminate and prevent prison rape. To that end the organization has proposed standards and practices to be incorporated into the *4th edition Performance Based Standards for Adult Local Detention Facilities.* [1]

13. The standards set by the ACA, the United States constitution as interpreted by the courts and Article 1, Section 20 of the Louisiana state constitution are being violated as demonstrated by the continuing abuse of Cedrick Berryhill.

14. Measures must be taken to prevent further abuse of Cedrick and harm to him. Given the current conditions of his environment, Cedrick is being held in an environment which threatens his physical and mental well being degeneration is not only probable, but certainly occurring.

CONCLUSION

WHEREFORE, for the foregoing reasons, the defense urges that the Court order the Orleans Parish Sheriff to take protective action regarding Cedrick Berryhill including, adding

[1] Proposed Prison Rape Elimination (PREA) Standards and Practices. American Correctional Association. July 2008 www.aca.org

additional security to where he is being held, or transferring custody of Cedrick Berryhill to the Youth Study Center.

Respectfully submitted,

L. Scott Sherman
La. Bar No. 30722
Counsel for the Accused
Orleans Public Defenders
2601 Tulane Ave., 7th Floor
New Orleans, LA 70119

CERTIFICATE OF SERVICE

I hereby certify that I have caused a copy of the foregoing pleading to be served upon the Office of the District Attorney by hand on the day of filing.

standards/pdfs/Proposed_ACA_PREA_Standards_Revisions_and_Enhancements_July_7_2008[1].pdf, last visited March 21, 2011.

STATE OF LOUISIANA

v.

CEDRICK BERRYHILL

FILED: _____

PARISH OF ORLEANS
STATE OF LOUISIANA

No. 504025
Section G
Hon. Julian A. Parker, Presiding

_____
DEPUTY CLERK OF COURT

ORDER TO SHOW CAUSE

IT IS HEREBY ORDERED that the State of Louisiana show cause why the Defendant's Motion should not be granted on the _____ day of _____, 201__, at _____.

SIGNED this ___ day of _____, 201__.

_____
DISTRICT COURT JUDGE,

Please serve:

L. Scott Sherman
Orleans Public Defenders
2601 Tulane Ave., 7th Fl.
New Orleans, LA 70119

George Hesni
Assistant District Attorney
619 S. White St.
New Orleans, LA 70119

STATE OF LOUISIANA v. CEDRICK BERRYHILL	PARISH OF ORLEANS STATE OF LOUISIANA No. 504025 Section G Hon. Julian A. Parker, Presiding

FILED: _____ _____ DEPUTY CLERK OF COURT

ORDER

IT IS HEREBY ORDERED that the Defendant's motion be GRANTED.

_____

_____

_____

_____

_____

SIGNED this ___ day of _____, 2011.

_____
DISTRICT COURT JUDGE,

Please serve:

L. Scott Sherman
Orleans Public Defenders
2601 Tulane Ave., 7th Fl.
New Orleans, LA 70119

George Hesni
Assistant District Attorney
619 S. White St.
New Orleans, LA 70119

Tuesday, January 17, 2012 Text Size

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DOCKET MASTER

Case: 504025 D O C K E T M A S T E R Date: 01/17/2012
Section: J/G Time: 15:45:41
Class: 2

ORLEANS PARISH CRIMINAL DISTRICT COURT

DF#	DEFENDANT(S):	CNTS	CHARGE(S):		
1	BERRYHILL, CEDRICK				
		5	RS 14 (27)30.1 ATT 2ND DEGREE MURDER	BOND:	5,000,000.00
		1	RS 14 (27)64 ATT ARMED ROBBERY	BOND:	1,000,000.00
		3	RS 14 30.1 2ND DEGREE MURDER	BOND:	3,000,000.00
		5	RS 14. 60 AGGRAVATED BURGLARY	BOND:	5,000,000.00
		2	RS 14 42 AGG RAPE	BOND:	2,000,000.00
		3	RS 14 44.1 SECOND DEGREE KIDNAPPING	BOND:	3,000,000.00

DATE	PROCEEDINGS	
02/28/2011		TROSCLAIR
	FILED INDICTMENT - TRUE BILL NO CAPIAS ISSUED BOND SET $19,000,000.00 MAGISTRATE PAPERWORK FILED (NONE) ********** ********** ***ALLOTTED. ARRAIGNMENT SET FOR 03/02/2011. PDOJL	
03/02/2011		GEORGEM
	>DEFENDANT, CEDRICK BERRYHILL DID NOT APPEAR. COUNSEL SCOTT SHERMAN APPEARED ON BEHALF OF THE DEFENDANT. >TRANSFERRED TO SECTION "G" TO FOLLOW CASE(S) 503-073 "G" >CONTINUED WITHOUT DATE. NOTE: THE DEFENDANT IS A JUV TRIED AS AN ADULT, MAY NEED TO BE HANDWRITTEN ONTO THE JAIL LIST.	
03/04/2011		BAGNELISEA
	CASE RECEIVED. CASE SET FOR STATUS HEARING 4/11/11.	
03/23/2011		BUTSCHERM
	>AS TO DEFENDANT, CEDRICK BERRYHILL: FILING(S) IN OPEN COURT ATTORNEY, SCOTT SHERMAN, PRESENT AND FILED: -MOTION TO ORLEANS PARISH SHERIFF TO PROTECT AND SAFEGUARD CEDRICK BERRYHILL; GRANTED. DEFENSE TO PROVIDE COURT WITH AN ORDER TO SUBMIT TO ORLEANS PARISH SHRIFF.	
03/24/2011		BUTSCHERM
	>DEFENSE COUNSEL SCOTT SHERMAN APPEARED WITHOUT DEFENDANT, CEDRICK BERRYHILL, FOR FILING(S) IN OPEN COURT DEFENSE FILED: >-ORDER TO ORLEANS PARISH SHERIFF, GRANTED. COURT ORDERED THE ORLEANS PARISH CRIMINAL SHERIFF TO COMPLY WITH THE ORDER IN THIS MATTER.**********	
04/11/2011		BUTSCHERM

About Docket Master Inmate Query Civil Division Resources Back to Top

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IN THE ORLEANS PARISH CRIMINAL DISTRICT COURT

STATE OF LOUISIANA

STATE OF LOUISIANA,	Docket Number	508-438
v.	Section	I
RICHARD LANFORD		

FILED:_____

_____
DEPUTY CLERK OF COURT

ORDER

IT IS HEREBY ORDERED that the Motion is GRANTED and the Orleans Parish Criminal Sheriff's Office, Sheriff Marlin Gusman, and their authorized representatives are hereby ordered to move the defendant out of OPP.

FURHTER, It is the recommendation of this Court that Mr. Lanford be housed in Conchetta.

DATED this 6 day of December, 2011.

Karen K Herman
Honorable Karen Herman
Criminal District Court, Section I

IN THE ORLEANS PARISH CRIMINAL DISTRICT COURT

STATE OF LOUISIANA

STATE OF LOUISIANA,	Docket Number	508-438
v.	Section	I
RICHARD LANFORD		

FILED: _____ _____
DEPUTY CLERK OF COURT

MOTION TO MOVE DEFENDANT INTO PROTECTIVE CUSTODY

The Defendant, through undersigned counsel, respectfully requests this Honorable Court to order the Orleans Parish Criminal Sheriff's Office to move the defendant out of OPP. On November 18, and December 1 the accused appeared in open court in Section I and Section A respectively. On both dates the accused had injuries and bruising to his face. It is clear that the defendant is not being adequately protected in OPP and needs to be moved immediately.

CONCLUSION

WHEREFORE, for the above stated reasons, and any other reason that may occur to this Honorable Court, the Defendant respectfully requests this Honorable Court to order the Orleans Parish Criminal Sheriff's Office to move the defendant out of OPP.

Respectfully Submitted

Joe Thorp
Bar No. 33256
Orleans Public Defenders
2601 Tulane Avenue, Suite 700
504-821-8101

IN THE ORLEANS PARISH CRIMINAL DISTRICT COURT

STATE OF LOUISIANA

STATE OF LOUISIANA,	Docket Number	508-438
v.	Section	I
RICHARD LANFORD		

FILED: _____ _____
DEPUTY CLERK OF COURT

ORDER

IT IS HEREBY ORDERED that the Motion is GRANTED and the Orleans Parish Criminal Sheriff's Office, Sheriff Marlin Gusman, and their authorized representatives are hereby ordered to move the defendant out of OPP.

FURHTER, It is the recommendation of this Court that Mr. Lanford be housed in Conchetta.

DATED this ___ day of _____, 2011.

_____
Honorable Karen Herman
Criminal District Court, Section I

IN THE ORLEANS PARISH CRIMINAL DISTRICT COURT

STATE OF LOUISIANA

STATE OF LOUISIANA,	Docket Number	509-129 509-616
v.		
RICHARD LANFORD	Section	H

FILED: _____ _____
DEPUTY CLERK OF COURT

MOTION TO MOVE DEFENDANT INTO CONCHETTA

The Defendant, through undersigned counsel, respectfully requests this Honorable Court to order the Orleans Parish Criminal Sheriff's Office to move the defendant to Conchetta. On November 18, and December 1 the accused appeared in open court in Section I and Section A respectively. On both dates the accused had injuries and bruising to his face. Mr. Lanford had to be taken to the hospital because of those injuries.

Despite being recently moved from OPP to HOD, Mr. Lanford is still receiving threats. Mr. Lanford was previously housed in Conchetta and received far fewer threats and attacks while inside that facility. Conchetta traditionally houses non-violent and/or older inmates and it is far less likely that Mr. Lanford will be attacked or assaulted in Conchetta. Therefore, Mr. Lanford respectfully requests this Court to Order the Orleans Parish Sheriff to move Mr. Lanford to the Conchetta facility.

CONCLUSION

WHEREFORE, for the above stated reasons and any other reason that may occur to this Honorable Court, the Defendant respectfully requests this Honorable Court to order the Orleans Parish Criminal Sheriff's Office to move the defendant to Conchetta.

Respectfully Submitted

Joe Thorp
Bar No. 33256
Orleans Public Defenders
2601 Tulane Avenue, Suite 700
504-821-8101

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF LOUISIANA

LaShawn Jones, *et al.*	)	
Plaintiffs,	)	Case No.
v.	)	
MARLIN GUSMAN, Sheriff, Orleans Parish, et al.	)	
Defendants.	)	

DECLARATION OF SHEILA A. BEDI

I, Sheila A. Bedi, counsel for the Plaintiffs in the above captioned case, state that the following is true and correct to the best of my knowledge:

1. I am an attorney and the deputy legal director at the Southern Poverty Law Center. I submit this declaration in support of the Plaintiffs' motion for class certification.

2. For over ten years, my practice has focused on civil rights, special education, and open government litigation in federal court. During my first two years of practice, I developed a prisoners' rights litigation project at the Georgetown University Law Center. My work in that project included constitutional litigation on behalf an inmate with HIV/AIDS. *Smith v. Carpenter*, 316 F.3d 178 (2d Cir. 2003). I also monitored conditions at the District of Columbia Jail to ensure the District's compliance with the final order in *Inmates of D.C. Jail v. Jackson*, No. 75-1668 (D.D.C.).

3. My experience in federal district court includes actions under the Freedom of Information Act, *Morrison v. DOJ*, No. 02:01552 (D.D.C.); *Puerto Rican-Am. Research Inst. v. U.S. Dep't of the Army*, No. 02:02082 (D.D.C.); *Kothari v. DOT.*, No. 03:00223, (D.D.C.); and

under Title VII of the Civil Rights Act of 1964, *Johnson-Harrison v. Beverly Health*, No. 01:01677 (D.D.C). In addition to my work in district court, I have made several appearances in various courts of appeals. I represented amicus curiae, the Project on Government Oversight, in an employment discrimination matter in the Tenth Circuit. *Bastien v Campbell*, No. 02:1342 (10th Cir.). I have also briefed and argued civil rights actions in the Ninth and Eleventh Circuits. *Love v. Delta Air Lines*, 310 F.3d 1347 (11th Cir. 2002) (disability rights claim under the Air Carrier Access Act); *Antonio-Martinez v. INS*, 317 F.3d 1089 (9th Cir. 2003) (appeal of asylum denial).

4. As an attorney with the Southern Poverty Law Center, I have participated as counsel in numerous class action lawsuits involving the constitutional rights of incarcerated or institutionalized persons including: *C.B. et.al v. Walnut Grove Correctional Authority et al*, No.3:10-cv-633 DPJ-FKB (S.D. Miss) (class action on behalf teenagers and young men imprisoned in an adult prison); *M.T. v. Forrest County,* No. 2:11cv91KS-MTP (S.D. Miss.) (class action on behalf of children detained in a county-run juvenile detention center); J.*H. v. Hinds County*, 3:11-CV-327 DPJ-FKB (same); *Troupe v. Barbour*, No. 3:10-cv-153 HTW-LRA (S.D. Miss) (class action on behalf of children with mental health needs who were unlawfully institutionalized or otherwise denied Medicaid services); *J.W. v. Vallas*, 2:10-cv-01925 (E.D. La) (class action filed on behalf of school children subject to unlawful restrain policies and procedures); *E.W. v. Lauderdale County,* No. 4:09-cv-137 TSL-LRA (class action on behalf of children detained in the Lauderdale County Juvenile Detention Center)*; D.W. v. Harrison County*, No. 1:09-cv-267 LG-RHN (S.D. Miss.) (class action on behalf of children detained in the Harrison County Juvenile Detention Center); *J.A. v. Barbour*, No. 3:07-cv-00394, (S.D. Miss) (class action on behalf of children incarcerated at the Columbia Training School); *K.L.W.*

v. James, No. 04-CV-149, (S.D. Miss.) (class action on behalf of children incarcerated at the Columbia Training School); *Morgan v. Sproat*, 432 F. Supp. 1130 (S.D. Miss. 1977) (monitoring State of Mississippi's compliance with judgment in conditions case on behalf of a class of incarcerated youth at Oakley Training School); and *Baker v. Campbell*, No. CV-03-1114-M (N.D. Ala.) (class action on behalf of chronically ill prisoners at Alabama correctional facility). I also have filed several special education complaints on behalf of classes of youth and currently am representing students with disabilities in *P.B. v. Pastorek*, No. 2:10-cv-04049 (E.D. La.), a class action filed in U.S. District Court in New Orleans under the IDEA, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act.

5. Co-counsel in this case is a highly qualified attorney who has a tremendous amount of experience litigating federal claims:

Civil Rights Attorney Katie Schwartzmann has 9 years experience litigating complex civil rights matter before the federal courts. Attorney Schwartzmann is currently the managing attorney of the Southern Poverty Law Center's Louisiana office, where she specializes in civil rights litigation. Her previous practice as legal director for the ACLU of Louisiana included trial and appellate work in all federal district courts in Louisiana, as well as briefing and arguments in the United States Court of Appeals for the Fifth Circuit, and representing *amicus curiae* before the Louisiana Supreme Court and United States Supreme Court. Attorney Schwartzmann has handled dozens of cases involving questions of constitutional law, including many specifically involving Eighth and Fourteenth Amendment claims.

6. I am a member in good standing of the bars of the state of Mississippi and the U.S. District Court for the Southern District of Mississippi. I meet the requirements of *pro hac vice* admission and intend to seek permission from this Court to appear in this matter pursuant to

the Court's rules governing *pro hac vice* admission.

7. The Southern Poverty Law Center has sufficient funds available to finance the costs of this litigation.

I declare under penalty of perjury that the foregoing is true and correct.

Date: April 2, 2012

Sheila A. Bedi, Miss. Bar. No. 101652

U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20530*

SEP 11 2009

Marlin N. Gusman
Orleans Parish Criminal Sheriff
2800 Gravier Street
New Orleans, LA 70119

Re: Orleans Parish Prison System
New Orleans, Louisiana

Dear Sheriff Gusman:

I am writing to report the findings of the Civil Rights Division's investigation of conditions of confinement at the Orleans Parish Prison ("OPP"). On February 12, 2008, we notified you of our intent to conduct an investigation of conditions at OPP pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On June 23-27, 2008, August 18-20, 2008, and November 17-20, 2008, we conducted on-site inspections at OPP with expert consultants in corrections, use of force, custodial medical and mental health care, and sanitation.[1] We interviewed administrative staff, security staff, medical and mental health staff, facilities management staff, training staff, and inmates. Before, during, and after our visits, we reviewed an extensive number of documents, including policies and procedures, incident reports, use of force reports, investigative reports, inmate grievances, disciplinary reports, unit logs, orientation materials, medical records, and staff training materials. In keeping with our pledge of transparency and to provide technical assistance where appropriate, we conveyed our preliminary impressions to OPP officials and legal counsel for the Sheriff's Office at the close of each of our site visits.

[1] Our corrections expert was the only expert who accompanied us on the August on-site visit, and our medical health care expert was the only expert who accompanied us on the November on-site visit.

We remain sensitive to the fact that OPP is still recovering from the devastating effects of Hurricane Katrina and commend the Sheriff and his staff for their extraordinary efforts to structurally rebuild the facilities. We also note the tremendous strides and improvements that the Sheriff and his staff have made in light of the scope and depth of destruction caused by Hurricane Katrina.

We commend the OPP staff for their helpful and professional conduct throughout the course of the investigation. We received complete cooperation with our investigation and appreciate the receptiveness to our consultants' on-site recommendations. Accordingly, we have every reason to believe that the Sheriff, his office, and the City are committed to remedying all known deficiencies at OPP. We hope to be able to work cooperatively to such a resolution.

Prior to our investigation, many media reports, allegations, and even rumors circulated regarding conditions at the Jail following the Hurricane. Our review of documents, investigative files, and interviews of staff and inmates has been to ascertain if the Constitution has been violated in a systemic manner. Again, commendably, we recognize the Sheriff's efforts in safely and efficiently evacuating the inmates and his efforts to secure the necessary funding to rebuild.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 § U.S.C. 1997b. As described more fully below, we conclude that certain conditions at OPP violate the constitutional rights of inmates. In particular, we find that inmates confined at OPP are not adequately protected from harm, including physical harm from excessive use of force by staff and inmate-on-inmate violence. In addition, we find that inmates do not receive adequate mental health care, including proper suicide prevention. While OPP meets constitutionally required standards of medical care in many areas; however, we found specific deficiencies in medication management. OPP inmates also face serious risks posed by inadequate environmental and sanitation conditions.

I. BACKGROUND

Located in downtown New Orleans, OPP is one of the largest correctional facilities in Louisiana. Despite its name, OPP operates like a county jail (Louisiana's parishes are equivalent to other states' counties). Like most county jails, OPP houses a large number of pre-trial detainees and inmates serving short misdemeanor sentences. Currently, OPP is able to accommodate 2,545 inmates and serves as overflow for the Louisiana Department of Corrections and the federal prison system.

Prior to its loss of physical plant space, due to damages sustained in Hurricane Katrina, OPP's capacity was 8,000 and the facility housed an average of 6,500 inmates daily. Again, it currently can house 2,545 inmates. OPP currently operates six of the original 12 jail buildings and is staffed by approximately 450 security officers. At the time of our visits, OPP housed inmates in the House of Detention ("HOD"), South White Street, Templeman V, Conchetta,

eight windowless tents constructed with FEMA financial assistance ("The Tents"), and the Broad Street work-release facility.

Recently, the Orleans Law Enforcement District ("LED") was statutorily created to provide financing to the Criminal Sheriff's Office. Further the LED is authorized to issue bonds for equipping and furnishing facilities for the Criminal Sheriff and for agencies where there is a use or benefit to the LED and the Sheriff. Of the $63,225,000 in bonds issued for the LED, $40,890,000 have been designated to the Sheriff for the jail and other facilities, which should impact the constructing, improving, renovating, and repairing of various facilities at OPP.

In making our findings, we acknowledge that there have been ongoing improvements at OPP during the course of our investigation. The damaged Intake Processing Center ("IPC") was demolished and a new IPC opened in June 2008. In addition, we are aware that the 80-year-old original Orleans Parish Prison Jail re-opened in February 2009. The refurbished jail is designed to hold more than 800 inmates. We understand that the Sheriff plans to occupy the jail with inmates currently housed in temporary facilities or facilities in need of work. Despite these commendable improvements, we believe there are serious constitutional deficiencies at OPP, as will be discussed in detail below.

II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to investigate and, when necessary, initiate civil action to obtain appropriate relief from egregious jail conditions that subject inmates to a pattern or practice of deprivation of their constitutionally protected rights. 42 U.S.C. § 1997. In defining the scope of jail inmates' Eighth and Fourteenth Amendment rights, the Supreme Court has held that corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer v. Brennan, 511 U.S. 825, 832 (1994); Bell v. Wolfish, 441 U.S. 520 (1979) (holding pre-trial detainees protected by Fourteenth Amendment); Scott v. Moore, 85 F.3d 230, 235 (5th Cir. 1996) (finding that a municipality assumed a constitutional obligation under the Fourteenth Amendment to provide pre-trial detainees with minimal levels of safety and security); Hare v. City of Corinth, 74 F.3d 633, 639 (5th Cir. 1996) (en banc), rev'd on other grounds, 135 F.3d 320, 324 (5th Cir. 1998) ("[T]he State owes a duty to both [detainees and convicted prisoners] that effectively confers upon them a set of constitutional rights that fall under the Court's rubric of 'basic human needs.'"). The Fifth Circuit has held that the protection of pretrial detainees' rights under the due process clause of the Fourteenth Amendment is "at least as great as the Eighth Amendment protections available to a convicted prisoner." Id. (quoting City of Revere v. Mass. Gen. Hosp., 463 U.S. 239, 244 (1983)).

A jurisdiction's constitutional obligation to provide adequate medical care to inmates includes the duty to provide adequate psychological and psychiatric mental health care. Farmer, 511 U.S. at 832; Gates v. Cook, 376 F.3d 323, 332 (5th Cir. 2004) (finding that "mental health needs are no less serious than physical needs"); Woodall v. Foti, 648 F.2d 268, 272 (5th Cir.

1981) (finding that an inmate stated a claim of deliberate indifference where prison officials refused to treat him and knew that he had been diagnosed as a pedophile and as a manic depressive with suicidal tendencies). Consequently, a prison's failure to take any steps to save a suicidal detainee from self harm may constitute a constitutional violation. Partridge v. Two Unknown Police Officers of the City of Houston, 791 F.2d 1182, 1187 (5th Cir. 1986).

The standard for adequate mental health care follows the standard for medical care, requiring a showing of both the subjective and objective components of "deliberate indifference." Gates v. Cook, 376 F.3d at 333. The jail officer's subjective knowledge must be determined by the finder of fact through circumstantial evidence or the obviousness of the risk. Id. The Fifth Circuit emphasized "that the essential test is one of medical necessity and not one simply of desirability." Woodall v. Foti, 648 F.2d 268, 272 (5th Cir. 1981). In determining the adequacy of mental health care, the Court makes a holistic assessment of the prisoner's conditions of confinement. Gates v. Cook, 376 F.3d at 343 (acknowledging that "the isolation and idleness of Death Row combined with the squalor, poor hygiene, temperature, and noise of extremely psychotic prisoners create an environment 'toxic' to the prisoners' mental health.").

The Eighth and Fourteenth Amendments forbid prison officials from using excessive physical force against inmates and pre-trial detainees. See Hudson v. McMillian, 503 U.S. 1 (1992), Farmer, 511 U.S. at 832; see also United States v. Walsh, 194 F.3d 37, 48 (2d Cir. 1999) ("the right of pre-trial detainees to be free from excessive force amounting to punishment is protected by the Due Process Clause of the Fourteenth Amendment.") (citing Bell, 441 U.S. at 535 [citations omitted] [emphases in the original]). The Fifth Circuit has held that this is true even when the use of force does not result in significant injury. Gomez v. Chandler, 163 F.3d 921, 924 (5th Cir. 1999) (concluding that there is no categorical requirement for an Eighth Amendment excessive force claim to be supported by a prisoner's significant, serious, or more than minor physical injury).

The standard for measuring the appropriateness of the force used is "whether force was applied in a good-faith effort to maintain or restore discipline or maliciously and sadistically for the very purpose of causing harm." Hudson, 503 U.S. at 6 (quoting Johnson v. Glick, 481 F.2d 1028, 1033 (2d Cir. 1973)). In determining whether force was used in good faith or in excess, courts examine a variety of factors, including:

> "[T]he need for the application of force, the relationship between that need and the amount of force used, the threat reasonably perceived by the responsible officials, and any efforts made to temper the severity of a forceful response."

Id. at 7-8.

Prison officials have a duty, under the Eighth Amendment, to protect prisoners from violence at the hands of other inmates. Farmer, 511 U.S. at 832-833; Longoria v. Texas, 473 F.3d 586, 592 (5th Cir. 2006). The standard for adequate protection from inmate violence is the

same as the standard for medical and mental health care, laid out in Farmer and discussed above, requiring a showing of "deliberate indifference." Id. at 837-839. The Fifth Circuit has determined that prison officials can be held liable for their failure to protect an inmate if they are deliberately indifferent to a risk of serious harm posed by another inmate's violent acts. Cantu v. Jones, 293 F.3d 839, 843-844 (5th Cir. 2002) (affirming verdict against prison-guard defendants found to have manifested the requisite deliberate indifference when they left the door to inmate's cell open, allowing him to escape and assault another inmate).

Prison officials must minimize inmate exposure to unhygienic conditions. Palmer v. Johnson, 193 F.3d 346, 352-353 (5th Cir. 1999) (finding that deprivation of toilet privileges for 17 hours forcing prisoners to urinate and defecate in a confined area with 48 other inmates constituted cruel and unusual punishment); Gates, 376 F.3d at 338 (holding that filthy cell conditions constituted an Eighth Amendment violation). Prisoners must be protected from both present and continuing exposure to harm caused by unsafe conditions, including mingling with inmates with contagious diseases. Helling v. McKinney, 509 U.S. 25, 33-34 (1993)(asserting that the Eighth Amendment protects against sufficiently imminent dangers as well as current unnecessary and wanton inflictions of pain and suffering).

The Fifth Circuit has held that both objective and subjective components are needed to establish an Eighth Amendment violation caused by unhygienic conditions. Harper v. Showers, 174 F.3d 716, 720 (5th Cir. 1999). First, there must be an objective showing of conditions "so serious as to deprive prisoners of the minimal measure of life's necessities." Id. (quoting Woods v. Edwards, 51 F.3d 577, 581 (5th Cir. 1995)). Second, there must be a subjective showing that the prison official was deliberately indifferent to such serious conditions. Id.

III. FINDINGS

We find that OPP fails to adequately protect inmates from harm and serious risk of harm from staff and other inmates; fails to provide inmates with adequate mental health care; fails to provide adequate suicide prevention; fails to provide adequate medication management; fails to provide safe and sanitary environmental conditions; and fails to provide adequate fire safety precautions.

A. INADEQUATE PROTECTION FROM HARM

Corrections officials must take reasonable steps to guarantee inmates' safety and provide "humane conditions" of confinement. Farmer, 511 U.S. at 832. Providing humane conditions requires that a corrections system must satisfy inmates' basic needs, such as their need for safety. Additionally, jail officials have a duty to take reasonable steps to protect inmates from physical abuse.

To reasonably ensure safe conditions, officials must take measures to prevent the use of unnecessary and inappropriate force by staff. Officials must also take reasonable steps to protect

inmates from violence at the hands of staff and other inmates. In addition, officials must provide adequate systems to investigate incidents of harm, including staff misconduct and alleged physical abuse of inmates. Finally, a jail has an obligation to protect vulnerable inmates from harm, such as those who are at risk from other inmates. For the reasons set forth below, OPP fails to meet constitutional standards in all of these regards.

1. **Unnecessary and Inappropriate Uses of Force**

Although the violence present in a correctional setting necessarily permits the appropriate use of force, the Constitution forbids excessive physical force against inmates. A determination of whether force is used appropriately requires an evaluation of the need for the use of force, the relationship between that need and the amount of force used, the seriousness of the threat reasonably believed to exist, and efforts made to temper the severity of a forceful response. Hudson v. McMillian, 503 U.S. 1, 7 (1992). Generally accepted correctional practices provide that appropriate uses of force in a given circumstance should include a continuum of interventions, and that the amount of force used should not be disproportionate to the threat posed by the inmate. Absent exigent circumstances, lesser forms of intervention, such as issuing disciplinary infractions or passive escorts, should be used or considered prior to more serious and forceful interventions.

Our investigation included an intensive examination of documents provided by OPP concerning the incidents listed below and various others occurring between January 2007 and August 2008. We also conducted a great many staff and inmate interviews. In many cases, our findings of inappropriate or excessive uses of force are in accord with OPP's own conclusions.

We believe that there is a pattern and practice of unnecessary and inappropriate uses of force by OPP correctional officers. Indeed, we found several examples where OPP officers openly engaged in abusive and retaliatory conduct, which resulted in serious injuries to inmates. According to our expert, in some instances, the officers' conduct was so flagrant it clearly constituted calculated abuse.

The following examples, derived from OPP's own internal documents, reflect disturbing evidence of officers openly engaging in retaliatory and abusive conduct:

- In July 2008, A.A. and B.B. were ordered into an empty holding cell on the OPP receiving docks.[2] Once in the cell, an officer entered the cell and began hitting and repeatedly beating both inmates. A.A. was beaten in the face, chest, and stomach. After knocking A.A. to the ground, the officer continued to beat and drag A.A. on the floor before finally choking and threatening to kill him. The officer then began beating B.B. in the arm, chest, and stomach area. After beating B.B., the officer placed his fist against B.B.'s jaw and stated, "I should break your

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[2] To protect inmates' privacy, we have used initials other than their own.

f------ jaw." Notably, this incident lasted for more than 10 minutes while several other officers observed the beatings without intervening or reporting the abuse. It was later determined that the officer beat the inmates because he believed that one of the inmates had robbed him several weeks earlier on the street. Defense attorneys for both A.A. and B.B. filed a formal complaint. OPP's Special Operations Division ("SOD") sustained allegations of abuse and recommended that the officer be suspended. After the officer's initial suspension, the Sheriff terminated the officer involved in the battery along with the four other officers who observed the beatings.

- In September 2007, C.C. was beaten in the Tents. While lying on his bunk smoking a cigarette, an officer ordered C.C. to go outside to the security area. Once in the security area, the officer then ordered C.C. to "tie his shoes" (a code we learned at OPP is an invitation to fight). At which point, C.C. refused to fight the officer. The officer then slapped C.C. in the face, knocked him to the ground, and continued to punch him several times in his back. The officer then took C.C. into a bathroom and continued to beat him. According to OPP reports, this incident was witnessed by another officer, yet the incident was never reported. C.C.'s grandfather filed a complaint on his behalf. OPP's Internal Affairs Division ("IAD") reviewed the incident and found that an assault did occur, but only charged the officer with untruthfulness (for not reporting that he pushed C.C. to the ground several times) and failure to keep the commanding officer informed (for not reporting C.C.'s alleged smoking violation). The Sheriff placed the officer on 90 days probation as a result of this incident.

- In August 2007, D.D. was beaten by an officer in HOD. According to OPP reports, D.D. was transferred to HOD after he exposed himself to a female officer. An HOD sergeant reported the incident to the female officer's boyfriend, an OPP corrections officer. The sergeant gave the boyfriend/officer the "green light" to physically abuse the inmate. The officer went into D.D.'s cell and began repeatedly punching and kicking him. The officer knocked D.D. to the floor then he dragged D.D. out of the cell and continued to beat him on the tier. The officer finally stopped beating him after D.D. started bleeding under his eye. D.D. sustained bruising under both eyes and bruising to his body. This assault, witnessed by at least one other officer, was unreported. D.D.'s injuries were eventually observed by an uninvolved officer, who made a report of them. OPP's SOD sustained allegations of abuse. The officer involved in the beating, the sergeant, and the officer witness were all suspended for 14 days.

- In August 2007, E.E. was beaten by two officers in his cell. While lying asleep in his bed, two officers entered E.E.'s cell and beat him for nearly 10 minutes, before leaving the cell. E.E. sustained two black eyes and bruises on his upper, middle, and lower back. Several inmates witnessed the beating. The officers failed to

document the incident. Again, it was only after an uninvolved officer observed E.E.'s injuries that any report was made. When questioned by SOD investigators on why they failed to notify the Watch Commander of the incident with E.E., one of the involved officers replied, "the rank (referring to supervisors) does not like to be bothered." OPP's SOD sustained allegations of abuse and recommended that both officers be suspended for 14 days.

- In April 2007, F.F. was severely beaten by two officers in IPC. While in IPC, two officers placed F.F. in an empty cell and began beating him in his face and head area. Even after F.F. requested medical attention, the officers returned to the cell and continued to beat and kick him in his face and head area. F.F. received serious trauma to his head and face. This incident was not reported by either OPP officer. As soon as he was released from OPP, F.F. was taken to the emergency room where he was treated for injuries sustained as a result of the beating. F.F.'s brother reported the injuries to OPP's Internal Affairs Division ("IAD").[3] After its internal investigation, IAD sustained the allegations of abuse against both officers involved. Despite IAD's findings, it was not until our expert consultant made repeated inquiries related to the beating and the outcome that the Sheriff's office took disciplinary action (the officers were terminated).

a. Inadequate Policies and Procedures

Adequate policies and procedures regarding the appropriate use of force are essential to ensuring that inmates are not abused by security staff. The policies should be comprehensive, clear, up-to-date, and reflect currently acceptable practices. OPP's policies and procedures are lacking in all respects.

OPP's current Use of Force policy requires that each officer and witness to a use of force file a report, however, the policy fails to define what constitutes a use of force. Without a definition, staff are left to their own subjective interpretations, which results in inconsistent use and reporting on the use of force. Furthermore, the policy does not provide guidance on levels of resistance versus levels of response - e.g., passive resistance versus active aggression and empty hands controls versus impact strikes. In addition, the policy fails to identify approved self-defense tactics, approved less lethal weaponry, and fails to list general prohibitions - e.g., to punish, to retaliate, or to restrict respiration. Moreover, the policy does not contain any requirement to employ verbal strategies when appropriate and fails to require video of anticipated or calculated force. Further troubling on a systemic level, the current use of force policy does not require or have an established criteria for administrative review of investigations.

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[3] This incident was reported by F.F.'s brother, an Orleans Parish Sheriff's Office Lieutenant.

b. Inadequate Use of Force Reporting

Although OPP's current Use of Force policy requires that each officer and witness to a use of force file a report, we found that the policy is not consistently followed. In our review of hundreds of use of force incident reports, it was clear that officers routinely fail to adequately document incidents. In many instances, use of force reports prepared by officers lacked sufficient detail necessary to determine what type of force was used and whether the force used was justified. Also, we reviewed several reports which mention several officers, but that contain only one officer-filed report. This is a stark contrast from what the reporting policy requires. Compounding the reporting problem, we found that OPP does not have a standardized use of force form or format, resulting in a system in which the reporting officer has wide discretion in determining what details to include in the report. As a result, administrative review is limited and officer conduct is not effectively evaluated. We found that OPP's deficient reporting practices likely accounted for the dearth of incidents referred to IAD for investigation.

OPP's deficient reporting practices are best illustrated by the examples noted below:

- In the July 2008 incident involving A.A. and B.B., there is no indication that the incident occurred, no indication of the inmates' injuries, and no indication that any officer reported the incident;
- In the August 2007 case of E.E., there is no indication of any injury in the OPP reports, no witness statements gathered, and no indication that the officers reported the incident; and
- In the August 2007 case of D.D., there is no indication of any injuries D.D. sustained, no indication that any officers reported the incident, and no indication that any statements were taken.

These incidents were not reported, indicating either a recognition of officer wrongdoing or a failure to recognize and report officer conduct believed to be within policy. In all of the above-mentioned examples, the incidents were not reviewed until a third party reported the officers' conduct. An effective reporting system would provide more detailed use of force and incident reports and ensure sufficient supervisory and administrative review.

c. Inadequate Management Review of Use of Force

The principal purpose of administrative review and investigation of each use of force is to ensure that no criminal activity has occurred, that facility procedures have been followed, that no remedial training is necessary, and that no review or change in policies is required. OPP's current use of force policy does not include a provision for administrative review. Therefore, there is an apparent gap in the review process where officer misconduct is not captured and

reviewed. Incidents that typically should be referred to IAD and SOD for further review are not forwarded. This lapse of review does not comport with generally accepted correctional standards.

On the rare occasion where we found that an incident was referred for management review, it was apparent that reviewers were not adequately trained to review officer conduct and the reviewers operated without any criteria for determining whether the level of force used was appropriate. Again, appropriate referrals to IAD or SOD were not made. Moreover, we spoke to various OPP officials about self-initiated reviews and we were unable to determine what division, if any, was qualified or assigned the duty to review use of force incident reports other than IAD. We find this system inadequate.

d. Lack of Investigative Policies and Procedures

Generally accepted correctional practices require clear and comprehensive policies and procedures governing the investigation of staff use of force and misconduct. Adequate policies and procedures include, at a minimum, screening of all use of force and incident reports, specific criteria for initiating investigations based upon the report screening, specific criteria for initiating investigations based upon allegations from any source, timelines for the completion of internal investigations, and an organized structure and format for recording and maintaining information in the investigatory file. OPP's investigatory practices fail to comport with these generally accepted correctional standards.

OPP does not have an IAD standard operations manual for use of force investigations. In fact, the only guidance that investigators have is a two-page draft memo (dated January 3, 2007) that offers vague descriptions of procedure, which include: "[i]f a complaint appears to be worthy of an investigation it is assigned to one of the IAD investigators." The memo fails to offer any guidance as to what constitutes a "worthy" complaint and fails to require IAD to gather essential documentation from use of force and incident reports. Virtually all of the investigations that we reviewed contained significant investigatory flaws. The deficiencies in OPP's practice is reflected in the following examples:

- An IAD case file we reviewed indicates that in March 2007, an officer observed another officer deliver a series of multiple closed fist strikes to G.G. in a holding cell. The eyewitness officer observed the assaulting officer strike G.G. in the face, knocking him to the floor. While on the floor, the officer continued to strike G.G. even though the eyewitness officer yelled at the assaulting officer to "stop." The eyewitness officer filed a report with IAD the next day detailing her observations. The investigator concluded that only necessary force was used. The investigator, however, failed to interview or attempt to interview G.G., failed to locate and question additional witnesses, failed to collect incident reports, and failed to determine if the officer filed a contemporaneous report. The investigator

based his findings on the absence of injury and G.G. not seeking medical treatment.

- Another, IAD case file indicates that in January 2007, an inmate was beaten by several officers in IPC. The investigation only contained the inmate's statement and an undated memo from one of the officers involved. The officer acknowledged during the investigation that he and three other officers had to "restrain" the inmate. The officer also states they escorted the inmate to "medical with no injuries found." The IAD investigation failed to contain any incident reports or interviews with the other officers, failed to contain medical reports, and failed to determine if this was an unreported use of force.

2. **Inadequate Classification System**

An adequate classification system is a fundamental management tool to aid in providing a reasonably safe environment in a correctional institution. The primary goal of a classification system is to determine the degree of supervision required to control each inmate and to maintain the safety and security of the institution and the community. The classification system at OPP contributes to its deficiencies in safety and security. Generally accepted correctional practices for classification systems utilize a variety of objective, behavior-based factors to determine the appropriate level of custody. Factors considered include: severity of offense, prior convictions, prior incarcerations, and personal characteristics such as age, residence, and employment. Typically, inmates are divided into high, medium, and low security classifications, and thereafter receive the appropriate level of freedom and staff supervision for that classification level.

In contrast to generally accepted practices, OPP relies on an antiquated charge-based classification scheme that uses the amount of an inmate's bond as the primary classification factor for general population inmates (aside from the obvious separation factors such as male or female). For example, inmates with bonds of $100,000 and over were housed in the HOD; federal inmates and bonds of $100,000 and less were housed in Templeman V; bonds of $75,000 and over were housed in the Tents; all females were housed at South White Street; and all work-release inmates were housed at Broad Street.

The current classification system does not consider an inmate's prior convictions, prior assaultive behavior, or true potential for violence. Even after inmates are classified, we learned from various OPP officials that housing assignments were predicated on space availability. As a result, we found instances where inmates with differing classification levels were assigned to ten-person cells at HOD. Under this system, there is very little to safeguard against housing predatory inmates with vulnerable inmates. Not surprisingly, we found a disturbingly high number of assaultive incidents in the multiple-occupancy cells at HOD.

Although we identified incidents throughout the facility, we are particularly concerned with the seriousness and frequency of incidents in the HOD and the Tents. We reviewed the

emergency route tracking log for July thru August 2008, which documents the referrals from OPP to the emergency room, and found a litany of serious injuries normally associated with assaultive behaviors including: blunt head trauma, facial fractures, jaw fractures, stab wounds, lip lacerations, and eye socket fractures. The majority of these injuries resulted from inmate-on-inmate assaults.

3. **Inmate-on-Inmate Assaults**

The high incidence of inmate-on-inmate violence at the HOD and the Tents demonstrates OPP's inability to keep its inmates reasonably safe. The following examples, derived from our review of OPP's own incident reports, illustrate our concerns:

- In August 2008, an 18-year-old inmate housed in a ten-person cell with 10-13 other inmates, all of whom were older, was attacked and beaten. At least four inmates assaulted him before officers arrived. The inmate sustained a fractured jaw and loosened teeth from the beating. The inmate had to be transferred to the medical floor as a result of the injuries he sustained.

- In June 2008, a 50-year-old inmate, who was recently arrested for public intoxication, was housed in a cell with 15-17 other inmates in the HOD. While in the cell, he was jumped by three inmates and sustained an eye injury and a head wound that required sutures.

- In June 2008, an inmate who was recently charged with a misdemeanor domestic violence offense was beaten in the Tents by another inmate. The inmate sustained a broken jaw and had to be taken to the emergency room for medical care.

- In May 2008, an inmate charged with aggravated rape was attacked by multiple inmates in a stairwell between the third and fourth floors of the HOD. The inmate was later moved to protective custody.

- In April 2008, another sex offender housed in HOD was beaten by several inmates after they learned of his offense. The inmate sustained two black eyes and injuries to his forehead and temple. After the beating, the inmate was moved to protective custody.

- In April 2008, an inmate was attacked by another inmate with a knife in the Tents because of an argument over the television. We learned from a tier representative (inmate trustee) that the inmate with the knife was a "known trouble maker" and had a history of assaultive behavior at the facility.

- In April 2008, an inmate was seriously injured after a fight over cigarettes. An officer observed the injured inmate washing blood from his face. The inmate was

immediately taken to the emergency room where he was treated for a fractured nose and injuries to his jaw, head, and back.

- In March 2008, an inmate suffered injuries to his eye, shoulder, elbow, and knee after multiple inmates jumped and beat him in a bathroom in the Tents.

- In February 2008, while in the Tents, an inmate was beaten by another inmate. We learned through OPP documents that the same two inmates were involved in a prior altercation in which one inmate was stabbed. It was only after the second incident that OPP placed the inmates in separate tents.

- In May 2007, a sex offender housed in the HOD in a 10- person cell was attacked and beaten by several other inmates and sustained a stab wound to his eye and a fractured jaw.

The frequency and serious nature of injuries sustained by OPP inmates represent a systemic level of violence that poses a serious risk of harm to both inmates and correctional staff at the jail.

4. **Inadequate Staffing and Inmate Supervision**

Staffing levels at OPP are inadequate to protect inmates from harm. Correctional facilities must protect inmates from harm by providing adequate staff supervision. Because of the jail's size and the physical configuration of its most densely populated facility (HOD), we found instances where officers failed to conduct scheduled rounds and were required to supervise an entire floor because of staff shortages. We also noted instances at other jail facilities (The Tents) where officers were required to supervise an entire pod (more than 80 inmates) during shifts. In both examples, it appears that OPP failed to adequately staff the buildings with this highest frequency and nature of injuries by inmates.

Exacerbating the staffing shortages, we found that OPP operates its facility without a staffing plan or analysis to establish the minimum number of security staff needed to safely manage OPP's population. Generally accepted professional standards provide that a staffing plan or analysis is vital in determining supervision posts, the span of control for each post, and what posts are essential to adequately staff OPP. Although we found staffing shortages throughout the facility, we are particularly concerned with the staffing levels at the HOD and the Tents - the two facilities where we found unacceptably high levels of serious inmate-on-inmate violence

We reviewed HOD's monthly squad status report for June 2008 and found that the total number of security staffing assigned to HOD for the month was 68 officers. During this same period, the average daily population was 868. In our expert's opinion, this 1:13 officer-to-inmate ratio per month is clearly deficient for the largest facility in OPP. We also found several instances during January 2007 and June 2008 where the HOD average daily population was 900

and only 12 officers were on shift, a 1:75 officer-to-inmate ratio. On these occasions, the majority of the multiple occupancy cells housed more than 10 inmates and four of the eight floors had only one officer responsible for over 140 inmates. We found several instances where staff failed to conduct daily rounds in the HOD and one officer had to monitor and supervise an entire floor for extended periods. During our review, we found the most densely populated facility (HOD) at OPP also was the most understaffed, which likely explains the high incidence of violence.

Similarly, we found deficient staffing levels at the Tents, the second largest facility in OPP. This facility comprises eight separate tent-like structures with metal framing and a polyester membrane covering. Each housing unit, known as a "pod," has a bed capacity for 88 inmates (44 double bunk beds). Each pod is equipped with an elevated officer station situated mid-way between the 44 beds. During our review of the June 2008 monthly squad staffing report, we found the total security staff was 33 officers, while the average daily population was 528. Again, we found several instances during February 2007 thru May 2008 where the inmate average daily population was more than 580 and the facility only had seven officers on shift, allowing only one officer to each pod during the shift. This deficient staffing places both inmates and staff at risk.

C. INADEQUATE MENTAL HEALTH AND MEDICAL CARE

1. Mental Health Care

OPP fails to provide inmates with adequate mental health care that complies with constitutional standards. Specifically, we found the following deficiencies: (a) inadequate suicide prevention; (b) inadequate intake and referral process; (c) inadequate staffing; (d) inadequate assessment and treatment; and (e) inadequate quality assurance review.

a. Inadequate Suicide Prevention

Suicide prevention practices at OPP are grossly inadequate. Generally accepted professional standards of correctional mental health care mandate the development of suicide prevention measures, including evaluation by a psychiatrist and development of a management plan. While OPP's suicide prevention policy requires that all inmates with suicidal ideation be directly observed by staff immediately and at all times, our investigation revealed practices inconsistent with generally accepted standards and OPP's own policy.

OPP inmates with suicidal ideation are transferred to HOD-10 and placed in five-point restraints before they are evaluated by a psychiatrist. The practice of initiating restraints, the most restrictive of suicide precautions, without medical or mental health review is inconsistent with generally accepted professional standards. Furthermore, we found that restraints are used as the first response to inmates with suicidal ideation and are seemingly used in a punitive fashion.

Moreover, we found that OPP fails to protect inmates from harm while in restraints. The following examples are illustrative:

- On January 6, 2009, H.H., a 43-year-old woman, stopped breathing while in restraints at OPP. H.H. was sent to HOD-10 hours after intake because she was considered hostile and suicidal. While in HOD-10, H.H. was placed in five-point restraints even after she repeatedly complained of asthma and breathing distress. H.H. did not receive physician or psychiatric care to determine if medication was appropriate or if placing an asthmatic individual in a five-point restraint was acceptable. Although she was under direct observation, H.H. was reportedly seen attempting to get out of the restraints. As OPP staff intervened and placed her in the restraints, H.H.'s body went limp. OPP medical staff responded to assess her condition. She was sent to the emergency room, where she was later pronounced dead.

- In June 2008, I.I. was placed in five-point restraints for more than 24 hours after he reported suicidal ideation. I.I. had a history of mental illness and taking psychotropic medications. Even though OPP staff received medical orders prescribing a nine hour time-frame for restraints, OPP placed him in restraints for over 24 hours without appropriate observation. OPP did not follow its own suicidal ideation policy, failed to provide I.I. with one-to-one observation, and went beyond the medical orders for restraint usage.

- On March 27, 2008, J.J. was placed in five-point restraints for more than 35 hours after he reported suicide ideation. The restraints were intermittently maintained by three consecutive orders from March 27, 2008 at 11:20 a.m. to March 29, 2008 at 5:00 a.m. Records showed that J.J. was neither agitated nor disruptive and OPP did not follow its own suicidal ideation policy and provide J.J. with one-to-one observation. We found that J.J.'s care and treatment was inconsistent with generally accepted professional standards of care and, indeed, inhumane.

Compounding the risks inherent in these practices, OPP has neither a restraint chair nor a safe cell. Inmates are restrained to metal beds affixed to a cell wall. The positioning of the bed prohibits 360 degree access to the inmate and, ironically, is itself a suicide hazard as even restrained individuals can strangle themselves by affixing clothing or sheets to this type of bed.

b. Inadequate Intake and Referral Process for Inmates with Mental Illness

OPP fails to properly identify inmates with mental illness through adequate intake screening and referral. The identification and follow-up of known mental illness should be a key focus of intake screening. In addition, mental health screening information should be incorporated into an inmate's medical record. This ensures the prompt continuation of necessary

medication for all inmates with chronic mental health conditions. Persons with potentially serious chronic mental illness (i.e., active psychosis, suicidal) should be referred from screening for prompt mental health evaluation and examination by a psychiatrist. We found the systems for intake and referral at OPP to vary markedly from generally accepted correctional mental health standards.

The average percentage of inmates receiving mental health services in city jails ranges from 18 to 30 percent. OPP's staff reported that 150 inmates were on the mental health caseload, approximately 6% of OPP's total inmate population, indicative of the failure to adequately identify and refer inmates with mental illness. This indicator was confirmed by our expert consultants' review of OPP medical records and inmate interviews which indicated that the numbers of OPP inmates referred for mental health services should be significantly higher.

We found OPP's intake and referral services inadequate and delayed. As a result, an alarmingly high number of inmates with mental health issues, including past mental health treatment, history of suicidal behavior or attempts, and/or being on psychotropic medications fail to consistently be referred to mental health service providers. In addition, we found that OPP does not have a formal referral process. As a result, inmates are not seen, as a matter of practice, on an emergent (immediate), urgent (within 24 hours), or routine basis (within five days) by the psychiatrist. Therefore, inmates who either received mental health services prior to incarceration or present with significant mental health concerns, typically have substantial delays before being referred to a mental health provider. Inmates who are not timely referred remain untreated and have suffered from a worsening of their symptoms, including suicidal and homicidal ideation. The deficient intake and referral process is illustrated in the following examples:

- In April 2008, during intake, K.K. reported that he attempted suicide five times in the last nine months. Even with this self-report, OPP staff failed to note his prior history and failed to refer K.K. to a psychiatrist. Due to this failure, K.K was not assessed for six weeks. When he was finally assessed, he was diagnosed with Chronic Schizophrenia and was on a hunger strike. OPP's failure to properly note his mental health status and history at intake, contributed to his delayed treatment and degenerative mental health state.

- In May 2007, L.L., a 57-year-old man, was sent to general population, even though he suffered from a brain disease affecting his mental capabilities. While in general population, L.L. showed signs of memory loss but did not receive any mental health care or services. Five months after intake, L.L. was finally seen by mental health staff and diagnosed with probable dementia. OPP's deficient intake process failed to give L.L. adequate care and agitated his mental condition.

c. Inadequate Staffing

We found that OPP fails to employ sufficient mental health staff to ensure that inmates receive adequate services. The HOD-10 unit, which serves as the House of Detention crisis unit for all mental health inmates, has only one full-time psychiatrist and one part-time psychiatrist. HOD-10 also has four licensed practical nurses, supervised by one registered nurse. During our site visits, we noted that there were no licensed drug counselors or social workers on staff. We found inadequate mental health staffing resulting in delays in inmates being assessed and treated.

In the South White Street Facility, we found that female inmates were not receiving necessary and adequate mental health care because of inadequate staffing. Even though some of these inmates received previous community mental health treatment, psychotropic medications, or been placed on suicide watch, they received deficient mental health care. Without adequate mental health staffing, including social workers and drug counselors, many of these women will not receive needed mental health services, such as: group or individual therapy, substance or physical abuse counseling, and other services to address their underlying mental disorders. The following examples are illustrative of OPP's failure to provide adequate mental health care because of inadequate staffing:

- On May 20, 2008, M.M. was screened and sent to the segregation unit of the women's facility. Despite reporting that she had been taking psychotropic medication for depression and anxiety, the psychiatrist did not evaluate her for three weeks. Like other inmates in OPP, M.M. was given her medication via the "Keep on Person" program. This program allows inmates to keep medications in their possession and self-administer these medications. Inmates are not given appropriate instruction on use of the medications, nor are they adequately monitored. M.M. reported that no one monitored her medication and that she took it when she thought she needed it.

- On April 6, 2008, N.N. reported at intake that she had a history of depression and that she had been taking antidepressants before incarceration. The psychiatrist ordered an antidepressant via telephone but did not assess N.N. until over a month after the initial medication order. During the psychiatric assessment, N.N.'s antidepressant dosage was increased. In our expert's opinion, the psychiatrist should have interviewed and assessed N.N. in person before prescribing the initial medication. Further, N.N.'s second visit with the psychiatrist was more than two months after her initial assessment. This is insufficient since she received an increased dose of antidepressants during the psychiatric assessment.

d. Inadequate Assessment and Treatment

OPP fails to appropriately and timely assess and treat inmates with mental illnesses. Our investigation revealed a lack of attention to past mental health information and a failure to

provide timely psychiatric assessment and treatment. These failures are inconsistent with generally accepted professional standards and have resulted in mental health deterioration and unnecessary suffering The following examples are illustrative of OPP's failure to adequately assess and treat mental health inmates resulting in mental health deterioration and unnecessary suffering:

- On December 14, 2007, O.O. was screened with a history of heroin use and past psychiatric treatment. It took more than four months before he received a psychiatric assessment. When O.O. was finally assessed, he was suffering from heroin dependence, cocaine and alcohol abuse, and symptoms of seasonal affective disorder. He received treatment four months after intake.

- On August 29, 2007, P.P., a 43-year-old man, hung himself with a telephone handset cord in OPP's HOD-4 unit. P.P. was referred to a psychiatrist at OPP, but was never assessed. P.P. complained of insomnia and informed OPP that he had been on psychotropic medications. His complaints were not addressed by a psychiatrist and he committed suicide at OPP by hanging himself 22 days after the psychiatric referral. While P.P.'s suicide does not appear foreseeable, the delay of 22 days is unacceptable even for a non-emergency referral within the correctional system.

- On August 17, 2006, Q.Q. was sent to the psychiatric unit after complaints of homicidal ideation. It took OPP staff more than seven and a half months before Q.Q. received an initial psychiatric assessment. When he finally began treatment on March 3, 2007, he had a number of mental health illnesses and disorders. OPP should provide adequate mental health assessment and treatment in accordance with generally accepted professional standards of mental health care. The delay in Q.Q.'s initial psychiatric assessment is unacceptable.

Exacerbating the problem with assessment and treatment, we found that OPP lacks multi-disciplinary treatment teams where other staff, with the exception of the nurses on HOD-10, participate in the care of inmates. Effective mental health treatment of inmates often involves services provided by a multi-disciplinary treatment team that includes psychiatrists, psychologists, social workers, psychiatric rehabilitation professionals, drug counselors, and correctional officers. Under OPP's procedures, the psychiatrist writes a plan as part of the initial psychiatric evaluation, and discussions are later held with a nurse. By not having social workers as part of the treatment team, for example, inmates do not receive the benefit of group therapy. And, without the input of correctional officers, who experience daily contact with inmates, the mental health service providers will not have the benefit of the correctional officers' ongoing observations.

e. Inadequate Quality Assurance Review

Generally accepted correctional mental health standards call for adequate quality assurance review. Such review is necessary to examine the effectiveness of the mental health care delivered and to implement corrective action so that the quality of care is improved.

We found that OPP fails to engage in consistent, effective quality assurance review in order to monitor and assess the quality of mental health offered at the facility. During our site visits, we found that despite the existence of OPP's Medical Quality Improvement Committee, there is no formalized review and evaluation process for mental health services. It is essential that a consistent and effective quality assurance process exists to track and trend mental health related deficiencies at the facility. OPP fails to conduct formal quality reviews of (1) effectiveness of the intake and referral process; (2) management of psychotropic medications; (3) suicide prevention including assessment of suicide risk; (4) review and tracking of suicide attempts; (5) monitoring of inmates on suicide observation; (6) treatment planning and treatment interventions for inmates in the mental health program; (7) appropriate use of restraints and monitoring of inmates in restraints; (8) discharge planning for the effective management and continuity of care for inmates released from custody; and (9) review and audits of medical records for quality and appropriateness of documentation of services provided.

2. Medical Care

Jail officials are responsible for providing adequate medical care to inmates. Our investigation revealed that medical care provided at OPP meets constitutionally required standards of medical care in many areas; however, we found specific deficiencies in OPP's medication management.

a. Inadequate Medication Management

Generally accepted correctional medical standards require that facilities administer medication and maintain adequate medication records to meet the medical needs of the inmates and to prevent medication errors and other risks of harm. We found that OPP's practices were inconsistent with generally accepted professional standards of care.

In particular, OPP's "Keep on Person" ("KOP") medications program is deficient. The KOP program allows inmates to keep medications in their possession and self-administer these medications. Both general population and mental health inmates are provided small, unmarked envelopes with four days of medications twice per week. This distribution process is deficient because it fails to consistently provide inmates with adequate instruction on how to take the medications, fails to monitor inmates' medication intake, and fails to give the name of the prescribed medications. This lack of basic information and supervision in the KOP program fails

to protect inmates from improper use and harm. The following examples in which inmates obtained dangerous quantities of medication and overdosed are illustrative of this concern:

- On August 21, 2008, R.R. overdosed on his medication. He was rushed to the emergency room after OPP staff discovered that R.R. had ingested six antidepressant and four antipsychotic pills. We found that OPP failed to monitor R.R.'s medication intake, and did not provide him with adequate instruction regarding his medication, including informing him of the harm in ingesting high amounts. When asked about overdosing on his medication, R.R. stated he missed his earlier doses, so decided to take all of his pills at one time to "catch-up."

- On January 20, 2008, S.S. was neither screened as a mental health patient nor prescribed an antipsychotic, yet he was rushed to the emergency room after he ingested a dangerous amount of antipsychotic medication. Even though S.S. survived, we found that OPP staff was unaware of the dosage S.S. ingested, or how S.S. had obtained the medication.

- On January 8, 2007, T.T. overdosed on 40 to 50 doses of psychotropic medication. T.T. was rushed to the emergency room after OPP discovered that she swallowed large quantities of medication. We found that OPP staff failed to monitor T.T. and failed to provide adequate medication management.

In addition, we found many instances where OPP failed to maintain documentation contemporaneously with medication administration. Contemporaneous documentation of medication is the practice of maintaining records at the same time that medication is administered to inmates to ensure that errors do not occur. It provides a more accurate accounting of the time, date, and type of medication received.

We also found that OPP's system for obtaining informed consent for medications substantially departed from generally accepted standards. During intake, inmates are required to sign a form that gives blanket consent for medications. This practice is not an informed consent because OPP is not also providing inmates with sufficient information about the medication and necessary treatment throughout an inmate's incarceration. Once a diagnosis is made and an inmate is prescribed medication, there is responsibility on the part of the medical staff to address an inmate's treatment at appropriate intervals during incarceration. Furthermore such blanket inmate consent can deter the medical staff from appropriately monitoring chronic or life-saving medications.

D. INADEQUATE ENVIRONMENTAL HEALTH and SANITATION

Although several areas in the OPP have undergone recent renovations, OPP has serious environmental health and sanitation problems.

1. **Inadequate Pest Control**

OPP has a visible pest problem. Although mice and cockroaches are nocturnal by nature, we observed both during our daytime visit, indicating there is a widespread presence. We also found other evidence of their presence in several of the buildings housing inmates, as well as in the food warehouse. Additionally, inmates complained about rodents and roaches in the facilities, and several work orders noted the presence of rodents in cells. Despite the obvious extent of these infestations, OPP was unable to produce a list of services or chemicals used for pest control. When asked about how often OPP sprayed or treated for pests, staff gave inconsistent responses, ranging from weekly to every three months.

2. **Physical Plant and Housekeeping**

With the challenges OPP faced after Hurricane Katrina, it is not surprising that the maintenance of the facilities presents an ongoing struggle. We are well aware that Hurricane Katrina rendered parts of OPP inhabitable and left others severely flood damaged. In a correctional setting where inmates and staff depend on maintenance staff for water, heat, lighting, and ventilation, however, these issues must be addressed in a timely manner in order to reduce the risks of illness and injury to inmates and staff.

We found that areas of OPP that housed inmates remain in a state of disrepair. The correctional staff generate work orders to the Facilities Department, which tracks the completed tasks. During our site visit, we observed hundreds of maintenance and repair needs, including approximately 60 broken or non-operational toilets, sinks, and drains in the HOD alone. We also observed a high number of broken, missing, or hazardous tiling, vents, and flooring in need of repair or replacement. Broken tiling and flooring is significant because these materials can be fashioned into weapons. We observed The work orders from 2007 and 2008 confirmed the problems we observed, including those of numerous work orders for broken toilets, sinks, and showers, as well as for water leaks.

Ventilation in many parts of OPP is extremely poor. Air quality measurements within HOD indicated that the temperature exceeded 85 degrees for many of the cells. We observed ventilation fans covered with visible layers of dust and debris, which can contain toxic chemicals, rodent waste and insect parts. The thick layer of dust and debris obstructs proper ventilation and the circulation of these substances in the air increases the risk of transmitting and contracting airborne diseases to both inmates and staff.

During our visits, we also observed obvious electrical hazards throughout the facilities. Electrical panels were not locked in the kitchen or in the rooms adjacent to housing areas. The panels often were located in rooms scattered with litter.
Many of the panels needed repair, and other panel door covers were missing altogether. These conditions pose a safety hazard to inmates and staff.

In addition, OPP does not properly store and control chemicals, cleaning agents, and other hazardous materials. Although several chemicals were stored in the appropriately labeled boxes, these chemicals were never opened or used. Our consultant noted other unlabeled chemicals stored in cells and other housing areas throughout the facilities. These chemicals are harmful if used in wrong concentrations or on the wrong surfaces. Furthermore, many inmates had unsupervised access to these chemicals, which if used improperly could cause serious harm or be used as a weapon.

While the lighting in common areas at OPP is adequate, inmates had covered many lighting fixtures with paper, cardboard and other materials in 30 percent of the individual cells. The covering of light fixtures not only presents a fire and health hazard, but also compromises the security of those housed in the cells, especially in light of the problems with supervision and inmate violence at OPP.

Finally, the conditions in the OPP housing areas are generally unsanitary. Dirt, dust, and debris covered many parts of the facilities, including the floor, windows, and corners. The shower and toilet areas had problems with mold. In HOD, the floor drains in these areas had no covers, and the shower vents were blocked with paper and other debris. The amount of refuse led our expert to recommend that all units in HOD "should be cleaned thoroughly."

3. **Food Service**

Food service practices at OPP place inmates at risk of harm. Approximately 7,200 meals are prepared in the food service area daily. Although a new kitchen had opened just days prior to our May 2008 tour, we observed improperly stored food, unattended cleaning materials and chemicals on the floor, and insects in the food preparation area. Furthermore, the kitchen had litter on the floors, and all kitchen employees did not have access to hand-washing facilities.

Food delivery at OPP is also inadequate. The facility delivers food to the housing areas by placing food in insulated containers for delivery. Generally accepted professional standards require that hot food be served at 140 degrees. Although when originally put in the insulated transportation containers, the food temperature measured well in excess of 140 degrees, it took as long as *four hours* for food prepared in the kitchen to reach some of the housing units. For those housing units, food temperatures were well below 140 degrees when served. In some cases we measured the temperature at 88 degrees for some hot food. The range of temperature between 41 degrees and 140 degrees is typically called the food danger zone. Bacteria that causes food-borne illness multiply and grow at this temperature range.

Once the food arrives at the housing units, handling and service did not comport with generally accepted professional standards. As in many other correctional facilities, OPP relies primarily on inmates to serve food. During meal times, inmate workers placed food containers on dirty tables and did not wash their hands before serving food. We also observed instances where gloves were inconsistently used. For example, we observed a food handler at the facility

using his bare hands to serve noodles on the individual plates. These practices are unsanitary, can result in cross contamination, and greatly increase the risk of food-borne disease.

4. Fire Safety

While it appears that OPP has taken steps to protect inmates and staff in the event of fire or an emergency, they remain at serious risk of harm because of certain deficiencies in emergency preparedness in terms of accessibility of fire equipment and consistency of conducting fire drills.

OPP has an adequate number of fire extinguishers, and emergency exit procedures were posted in each facility. Fire extinguishers were inspected regularly, but often were housed in locked compartments. When asked to locate fire extinguishers, some staff took an inordinate amount of time to find the keys to unlock the compartments. In the new kitchen and intake areas, it took the staff an unacceptable length of time to locate any of the three available fire extinguishers and find a key to unlock the compartment containing the fire extinguisher.

Although OPP appears to perform fire drills, they are not conducted in a manner consistent with generally accepted correctional standards, which require monthly fire drills. Monthly drills should rotate so that they are conducted quarterly on each shift. Drills should be conducted at differing times and under differing conditions, such as using different egress routes to confirm that officers have the necessary keys and know how to use them. Records of each drill should be maintained for at least one year. While staff reported that OPP conducts monthly fire drills, it remained impossible to discern when these drills actually occurred because OPP did not document any of these drills. Some inmates claimed that the drills occurred weekly, others stated that drills took place every two months.

IV. REMEDIAL MEASURES

In order to address the identified deficiencies and protect the constitutional rights of inmates confined at OPP, the Jail should implement, at a minimum, the following measures in accordance with generally accepted professional standards of correctional practice:

A. Protection from Harm

1. Use of Force

a. Develop and maintain comprehensive and contemporary policies and procedures regarding permissible use of force.

(1) Prohibit the use of force as a response to verbal insults or inmate threats.

(2) Prohibit the use of force as a response to inmates' failure to follow instructions where there is no immediate threat to the safety of the institution, inmates, or staff, unless OPP has attempted a hierarchy of nonphysical alternatives which are documented.

(3) Prohibit the use of force as punishment.

b. Establish effective oversight of the use of force.

(1) Develop and implement a policy to ensure that staff adequately and promptly report all uses of force.

(2) Ensure prompt management review of use of force reports. The review should include:

i. case-by-case review of individual incidents of use of force; and

ii. systemic review in order to identify patterns of incidents.

(3) Ensure that incident reports, use of force reports and inmate grievances are screened for allegations of staff misconduct and, if the incident or allegation meets established criteria, that it is referred for investigation.

(4) Develop and maintain comprehensive policies, procedures, and practices for the timely and thorough investigation of alleged staff misconduct.

(5) Develop and implement a process to track all incidents of use of force that at a minimum includes the following information: the inmate(s) name, housing assignment, date and type of incident, injuries (if applicable), if medical care is provided, primary and secondary staff directly involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.

c. Develop an effective and comprehensive training program in the appropriate use of force.

(1) Ensure that staff receive adequate competency-based training in OPP's use of force policies and procedures.

(2) Ensure that staff receive adequate competency-based training in use of force and defensive tactics.

(3) Ensure that SOD and IAD management and staff receive adequate competency-based training in conducting investigations of use of force allegations.

2. Safety and Supervision

a. Ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise inmates.

b. Ensure that inmate work and housing areas are adequately supervised whenever inmates are present.

c. Ensure frequent, irregularly timed, and documented security rounds by correctional officers inside each housing unit.

d. Ensure that staff adequately and promptly report incidents.

e. Develop a process to track all serious incidents that captures all relevant information, including: location of incident, any injuries, if medical care is provided, primary and secondary staff involved, reviewing supervisor, external reviews and results (if applicable), remedy taken (if appropriate), and administrative sign-off.

f. Establish a procedure to ensure that inmates do not possess or have access to contraband. Conduct regular inspections of cells and common areas of the housing units for contraband.

g. Conduct regular inspections of cells and common areas of the housing units to identify and prevent rule violations by inmates.

h. Review, and revise as applicable, all security policies and Standard Operating Procedures ("SOPs") on an annual basis.

i. Review, and revise as applicable, all security post orders regularly.

j. To the extent possible, taking into account the different security levels and different physical layouts in the various divisions, standardize security policies, procedures, staffing reports, and post analysis reports across the divisions.

k. Provide correctional officers transferred from one division to another formal training on division-specific post orders.

l. Implement specialized training for officers assigned to special management units, which include disciplinary segregation, and protective custody units. Officers assigned to these units should possess a higher level of experience and be regularly assigned to these units for stability purposes.

3. Classification

a. Develop and implement an objective classification system that separates inmates in housing units by classification levels.

b. Update facility communication practices to provide officers involved in the classification process with current information as to cell availability on each division.

c. Update the classification system to include information on each inmate's history.

d. Provide competency-based training and access to all supervisors on the full capabilities of the OPP classification and inmate tracking system (or any replacement system).

B. Mental Health Care

1. Use of Restraints

a. Develop and implement a policy for the use of restraints that is consistent with generally accepted professional standards, including the requirement of written approval by a qualified medical or mental health professional prior to the use of restraints.

b. Develop and implement a policy regarding monitoring restrained inmates that requires adequate checks of the physical condition of restrained inmates, and adequate documentation of the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained inmates.

c. Ensure that restraints are not used to punish inmates for symptoms of mental illness and behaviors that are, because of mental illness, beyond their control.

2. Suicide Prevention

a. Develop policies and procedures to ensure appropriate management of suicidal inmates and the establishment of a suicide prevention program.

b. Ensure that OPP suicide prevention policies include an operational description of the requirements for both pre-service and annual in-service training.

c. Ensure that, prior to assuming their duties and on a regular basis thereafter, all staff who work directly with inmates have demonstrated competence in identifying and managing suicidal inmates.

d. Ensure that any staff who are exempt from suicide prevention training have limited inmate contact.

e. Ensure that intake staff are sufficiently experienced and qualified to identify inmates that pose a risk for suicide, and conduct appropriate follow-up evaluations by mental health professionals of new inmates within 14 days of intake.

f. Screen all inmates upon intake, including questioning to assess current and past suicide risk.

g. Document inmate suicide attempts at OPP in the inmate's correctional record in the classification system, in order to ensure that intake staff will be aware of past suicide attempts if an inmate with a history of suicide attempts is admitted to OPP again in the future.

h. Ensure that inmates on suicide precautions receive adequate mental status examinations by a mental health clinician.

i. Ensure that suicidal inmates are housed in an area that is safe for them with appropriate supervision and observation by staff.

j. Ensure that 15- and 30-minute checks of inmates under observation for risk of suicide are timely performed and appropriately documented.

k. Provide different levels of supervision of inmates based on the presenting risk factors for suicide.

l. Ensure that inmates placed on suicide watch are assessed adequately, monitored appropriately to ensure their health and safety, and released from suicide watch as their clinical condition indicates according to generally accepted standards of care.

m. Ensure a component of administrative review is implemented following a suicide or a suicide attempt to identify what could have been done to prevent the suicide.

3. Intake and Referral

a. Develop and implement an appropriate intake screening instrument that identifies mental health needs, and ensures timely access to a mental health professional when presenting symptoms require such care.

b. Ensure that inmates with potentially serious chronic mental health illness are referred for prompt mental health evaluations and examinations by a psychiatrist.

c. Ensure that OPP's intake evaluation process includes a mental health screening that is incorporated into an inmate's medical record.

4. Staffing

a. Provide staffing adequate for inmates' serious mental health needs.

b. Provide adequate on-site psychiatry coverage, including ensuring that psychiatrists see inmates in a timely manner.

5. Assessment and Treatment

a. Develop and implement policies and procedures for appropriate assessments of inmates with serious mental illness.

b. Provide adequate mental health assessment and treatment in accordance with generally accepted professional standards of mental health care.

c. Ensure that treatment plans adequately address inmates' serious mental health needs and that the plans contain interventions specifically tailored to the inmates' diagnoses and problems. Provide therapy services where necessary for inmates with serious mental health needs.

d. Ensure that mental health evaluations done as part of the disciplinary process include recommendations based on the inmate's mental health status.

e. Ensure that inmates receive psychotropic medications in a timely manner and that inmates have proper diagnoses for each psychotropic medication they receive.

d. Ensure that psychotropic medications are reviewed by a psychiatrist on a regular, timely basis and inmates are properly monitored.

6. Quality Assurance and Review

a. Develop and implement a quality assurance program to assist OPP in identifying and correcting serious deficiencies within the mental health system, prioritizing its efforts at reform, and developing appropriate remedies.

C. Medical Care

1. Medication Administration

a. Ensure that treatment and administration of medication to inmates is implemented in accordance with generally accepted professional standards of care.

b. Ensure that administration of medication is accurate and adequately documented. Develop policies and procedures for the accurate administration of medication and maintenance of medication records. Provide a systematic review of the use of medication to ensure that each inmate's prescribed regimen continues to be appropriate and effective for his condition.

c. Develop and implement an appropriate medication administration protocol that provides adequate direction on how to take medications, describes the name of prescribed medications, and identifies how inmates are monitored.

D. Sanitation and Environmental Conditions

1. Sanitation and Maintenance of Facilities

a. Develop and implement policies and procedures to ensure adequate cleaning and maintenance of the facilities with meaningful inspection processes and documentation. Such policies should include oversight and

supervision, as well as establish daily cleaning requirements for toilets, showers, and housing units.

b. Ensure adequate pest control, including sufficient staffing for routine and follow-up pest control services.

c. Ensure proper ventilation and airflow in all cells and housing units.

d. Ensure adequate lighting in all housing units and prompt replacement and repair of malfunctioning lighting fixtures.

e. Ensure prompt and proper maintenance of shower, toilet, and sink units.

f. Develop and implement policies and procedures for cleaning, handling, storing, and disposing of biohazardous materials.

g. Use cleaning chemicals that sufficiently destroy the pathogens and organisms in biohazard spills.

2. Environmental Control

a. Repair electrical panels; develop and implement a system for maintenance and repair of electrical panels, devices, and exposed electrical wires.

3. Food Service

a. Provide training for kitchen workers in the areas of food safety, proper food handling, and proper hygiene to reduce the risk of food contamination and food-borne illnesses.

b. Ensure that dishes and utensils, food preparation and storage areas, and vehicles and containers used to transport food are properly cleaned and sanitized.

c. Ensure that foods are served and maintained at proper temperatures.

E. Fire and Life Safety

1. Ensure that all facilities have adequate fire and life safety equipment which is properly maintained and inspected.

2. Implement competency based testing for staff regarding fire/emergency procedures.

3. Develop and implement adequate policies and procedures regarding fire prevention including emergency planning and drills.

4. Ensure that emergency keys are appropriately marked, available, and consistently stored in a quickly accessible location.

5. Inventory and store all flammable, toxic, and caustic materials in a well ventilated, but locked, compartment.

6. Ensure that emergency drills are conducted on a regular basis.

* * * * * * *

Please note that this findings letter is a public document. It will be posted on the Civil Rights Division's website. While we will provide a copy of this letter to any individual or entity upon request, as a matter of courtesy, we will not post this letter on the Civil Rights Division's website until ten calendar days from the date of this letter.

We hope to continue working with the City in an amicable and cooperative fashion to resolve our outstanding concerns regarding OPP. Assuming there is a continuing spirit of cooperation from the City, we also would be willing to send our consultants' evaluations under separate cover. These reports are not public documents. Although the consultants' evaluations and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analysis, and recommendations provide further elaboration on the issues discussed in this letter and offer practical technical assistance in addressing them. We hope that you will give this information careful consideration and that it will assist in your efforts at promptly remediating areas that require attention.

We are obligated to advise you that, in the event that we are unable to reach a resolution regarding our concerns, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies of the kind identified in this letter 49 days after appropriate officials have been notified of them. 42 U.S.C. § 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you and are confident that we will be able to do so in this case. The lawyers assigned to this investigation will be contacting the facility's attorney to discuss this matter in further detail.

If you have any questions regarding this letter, please call Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

Loretta King

Loretta King
Acting Assistant Attorney General
Civil Rights Division

cc: The Honorable C. Ray Nagin
Mayor
The City of New Orleans

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