ACLU
AMERICAN CIVIL LIBERTIES UNION of LOUISIANA
FOUNDATION

P.O. BOX 56157
NEW ORLEANS, LA 70156
P: (504) 522-0617

MARJORIE R. ESMAN
EXECUTIVE DIRECTOR

September 7, 2012

OPEN LETTER REGARDING CONDITIONS AT DAVID WADE CORRECTIONAL CENTER

Via fax and Regular Mail

225-342-3095
James LeBlanc, Secretary
Louisiana Department of Corrections
P.O. Box 94304
Baton Rouge, LA 70804-9304

318-927-0433
Mr. Jerry Goodwin, Warden
David Wade Correctional Center
670 Bell Hill Road
Homer, LA 71040

Re: Inmate suicide attempt

Dear Secretary LeBlanc and Warden Goodwin:

We have received a report that a David Wade inmate recently attempted suicide after prison officials failed to properly respond to threats of self-harm. If the report is accurate, we are seriously concerned about the adequacy of both inmate supervision and mental healthcare at David Wade. We write to express those concerns, and to request additional information about the inmate's status and the alleged incident.

I. Factual Allegations

The report stated that in early July, inmate Anthony Smith began repeatedly threatening to kill himself. In response, DWCC officials put Smith on suicide watch, moved him into a cell with another inmate and placed the two on lockdown. According to the report, Smith was not seen by medical personnel at that time.

Over the next three days, Smith continued to express suicidal thoughts and repeatedly asked to see a mental health professional. At first, guards told Smith that if he continued to complain, he would be pepper sprayed. When he persisted, however, he was taken to see a DWCC nurse, who did little more than return Smith to his cell after a brief consult. The following morning, Smith again threatened suicide and asked to speak to a mental health professional, but again was told he could speak only to the prison nurse.

That night, Smith continued his pleas for help, telling several guards that he was considering hurting himself and others, and needed to see a mental health professional. The

guards responded not by getting Smith psychiatric help, but *by putting Smith's cellmate in charge of monitoring Smith* until he could be seen by the prison nurse. When the nurse arrived, she spoke with Smith, but again left him on lockdown with his cellmate.

The following day, Smith told the guards that he was planning to kill himself, and again, the guards took no precautions other than to leave Smith on lockdown in the company of his cellmate. A few hours later, Smith's cellmate left briefly to shower, and when he returned, Smith was hanging from the cell door, the cellmate's bedsheet around his neck.

The report does not state conclusively whether Smith had died, but only notes that guards had trouble cutting him down, that Smith's cellmate attempted to help, and that Smith, either unconscious or dead, was quickly removed from the cell.

II. Applicable Law

Assuming the above allegations are true, they suggest serious civil rights problems at DWCC with the observation and treatment of mentally ill and suicidal inmates:

A. Overall inadequate psychiatric care

We are most concerned that DWCC officials were deliberately indifferent to Smith's suicidal threats, and that that indifference may have led to Smith's death.

Deliberate indifference to an inmate's serious medical needs violates the Eighth Amendment. *Gates v. Cook*, 376 F.3d 323, 343 (5th Cir. 2004). Threats or risk of suicide almost certainly create a serious medical need. *Jacobs v. West Feliciana Sheriff's Dept.*, 228 F.3d 388, 393 (5th Cir. 2000). And prison officials' failure to provide adequate follow-up care – including adequate monitoring, referral to mental health professionals, and, if necessary, transfer to an appropriate psychiatric facility – to inmates with known psychiatric problems has widely been held unconstitutional. *Rhyne v. Henderson County*, 973 F.2d 386 (5th Cir. 1992) (Goldberg, concurring) ("Suicide is a real threat in the custodial environment. Showing some concern for those in custody, by taking limited steps to protect them, will not pass muster unless the strides taken to deal with the risk are calculated to work: Employing only 'meager measures that [jailers and municipalities] know or should know to be ineffectual' amounts to deliberate indifference.)

Here, DWCC officials, including guards and a nurse, were aware of Smith's suicidal ideations for several days before he hanged himself. During that time, they responded with gross inadequacy at best, and outright indifference at worst. They declined to provide psychiatric care, threatened to pepper spray Smith unless he stopped complaining, refused to transfer him to an appropriate cell or medical facility, ignored him for extended periods, and foisted their duty to protect Smith onto one of his fellow prisoners. Their inaction raises serious concerns about the treatment of mentally ill or suicidal inmates at DWCC, and could subject DWCC to liability for violating either Smith's or his cellmate's civil rights.

B. Undertrained or underprepared staff

DWCC refused to provide Smith with psychiatric care, limiting his treatment to a few conversations with the prison nurse, who was not a mental health professional. That too raises

serious constitutional concerns, as failure to train or provide properly trained mental healthcare professionals may also constitute deliberate indifference. *See Greason v. Kemp*, 891 F.2d 829, 835-36 (11th Cir. 1990) ("Where prison personnel directly responsible for inmate care have knowledge that an inmate has attempted, or even threatened, suicide, their failure to take steps to prevent that inmate from committing suicide can amount to deliberate indifference"); *Waldrop v. Evans*, 871 F.2d 1030, 1033 (11th Cir. 1989) (prison officials' failure to refer suicide risk to psychiatrist deliberate indifference). Young v. City of Augusta, 59 F.3d 1160, 1171 (11th Cir. 1995) (liability where jail employees are "inadequately selected or trained to recognize the need to remove a mentally ill inmate to a hospital. . .").

C. Improper housing

Lastly, DWCC's placement of Smith with a cellmate and delegation of Smith's care to that cellmate also present civil rights problems. Housing mentally ill inmates with otherwise healthy ones violates the civil rights of both, *Gates*, *supra*, 342-343, and the circumstances of Smith's attempted suicide perfectly illustrate why. Smith allegedly hung himself using his cellmate's bedsheets, to which he would not have had access had he been housed alone and deprived of potentially dangerous items. Moreover, Smith's cellmate not only was forced to endure Smith's pleas for help, but also was *placed in charge of Smith's care* shortly before Smith hanged himself. Neither Smith nor his cellmate should have been subjected to such conditions.

III. Our Request

First and foremost, we would like to know whether Smith survived his suicide attempt, and whether, if he survived, he currently is receiving appropriate treatment. Second, we would like DWCC to provide this office with its current policies and procedures for the monitoring and treatment of inmates who threaten suicide. These documents are public records, and please consider this a request under Louisiana's public records laws. Lastly, we would like the assurance of DWCC and DOC officials that this matter is being investigated and that appropriate measures are being taken to ensure that it does not happen again.

We would be happy to discuss this matter with you at any time, and we look forward to your response.

Sincerely,

Marjorie R. Esman
Executive Director