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

LOUIS HAMILTON, et al.,	:	Civil Action No. 69-2443 & Consolidated Cases
Plaintiffs,	:	Section LLM (5)
v.	:	
ERNEST N. MORIAL, et al.,	:	
Defendants.	:	
----------	:	

PLAINTIFFS' MOTION TO COMPEL PRODUCTION

Plaintiffs, pursuant to Fed. R. Civ. P. 37(a), hereby request that the Court enter an Order compelling Defendants to produce all documents they possess that relate to the incarceration and death of Matthew Bonnette, who died at the Orleans Parish Prison on April 4, 2004. The grounds for Plaintiffs' Motion are set forth in the accompanying memorandum.

Respectfully submitted,

Eric Balaban
Elizabeth Alexander
National Prison Project
ACLU Foundation
733 15th St, NW, Suite 620
Washington, D.C. 20005
202/393-4930

William P. Quigley
Loyola Law Clinic
P.O. Box 902
7214 St. Charles Avenue
New Orleans, Louisiana 70118
504/861-5590
Bar Roll #7769

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

LOUIS HAMILTON, et al.,	:	Civil Action No. 69-2443 & Consolidated Cases
Plaintiffs,	:	Section LLM (5)
v.	:	
ERNEST N. MORIAL, et al.,	:	
Defendants.	:	
----------	:	

PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION TO COMPEL

On June 9, 2004, this Court will hold a hearing on Plaintiffs' Motion to Reconsider its April 20 and 21, 2004 Minute Entries to the extent they dismiss from this case all remaining mental health issues, other than staffing and physical plant issues regarding the new forensic facility. See Minute Entry, May 4, 2004 at 1. Plaintiffs have asked Defendants to produce documents related to the incarceration and apparent suicide of Orleans Parish Prison's (OPP) prisoner Matthew Bonnette. Mr. Bonnette's death raises serious questions regarding current and ongoing deficiencies in the OPP suicide prevention practices, and in the use of therapeutic restraints and seclusion. Defendants have refused to produce all of the requested documents. Therefore, Plaintiffs respectfully move this Court for an Order compelling Defendants to produce the requested documents.

Background

On April 4, 2004, prisoner Matthew Bonnette reportedly committed suicide on a mental health tier by hanging himself from an upper bunk. At the time of his death, Mr. Bonnette was in

four-point restraints and on suicide watch. On April 14, 2004, Plaintiffs' counsel Elizabeth Alexander wrote to Defendants' counsel John Weeks requesting copies of all health care and institutional records related to Mr. Bonnette's incarceration and death, including all incident and other investigative reports. See Ex. A, Declaration of Eric Balaban ["Balaban Dec."] ¶ 2. On or about May 21, 2004, Ms. Alexander received a set of records regarding Mr. Bonnette. Mr. Weeks' accompanying letter states that Defendants did not "includ[e] any OPCSO [Orleans Parish Criminal Sheriff Office] reports which may have been compiled as a result of Mr. Bonnette's suicide, as they are not subject to general disclosure pursuant to the . . . court orders." Ex. B, Balaban Dec.

The records that were submitted to Plaintiffs establish the following facts: On April 3, 2004, Mr. Bonnette was examined at the Medical Center of Louisiana after refusing a breathalyser test following a hit and run accident. Balaban Dec. ¶ 3. The treating physician assessed Mr. Bonnette as suffering from depression and suicidal ideation, and noted a history of suicide attempts. Id. The physician discharged Mr. Bonnette to the custody of the New Orleans police with a treatment plan recommending that he be placed on suicide watch, and prescribed Remeron, an antidepressant. Id. Mr. Bonnette was booked at the OPP at 3:15 a.m. on April 4, 2004. Id. In his initial mental health screening, Mr. Bonnette reported that he was thinking of killing himself or someone else, he had a history of suicide attempts, and he was currently prescribed psychotropic medication. Id. At 4:50 a.m., an LPN entered a medical order per an oral order from Dr. Ganals for Mr. Bonnette to be moved to the psychiatric unit on the 10th floor at the House of Detention (HOD), and put in four-point restraints. Id. There is no progress note from Dr. Ganals in Mr. Bonnette's medical record. Id. A chart transfer form in Mr. Bonnette's record indicates that he was moved to the 10th floor of HOD at 5:00 a.m. Id. There is no

indication in the records produced of when Mr. Bonnette was placed in restraints, though he did remain restrained for at least eight, and up to eleven, hours. Id.

An officer performed 15-minute checks on Mr. Bonnette from 8:45 a.m. to 4:30 p.m., and there was a psychiatric nursing assessment form completed at 8:50 a.m. Id. There are no observation notes by the nurse indicating Mr. Bonnette's mental status during his time in restraints, no indication that Mr. Bonnette was offered either food or drink, and no indication that he was examined by a physician or psychiatrist at any time. Id. At 4:56 p.m. detainee Peter Adams notified nursing and correctional staff that Mr. Bonnette was hanging from an upper bunk. Id. At 5:07 p.m., a physician was called to examine Mr. Bonnette. Id. The physician found Mr. Bonnette unresponsive at 5:07 p.m., noting marks around his neck and swelling around his larynx, and pronounced him dead at 5:08 p.m. Id. At no time during his eleven hours on the mental health tier was he examined by a psychiatrist. Id.

The coroner performed an autopsy on Mr. Bonnette on April 5, 2004, ruling the death a suicide. Id. at ¶ 4. The cause of death was asphyxia secondary to hanging. Id. The coroner reported that Mr. Bonnette "was found to be partially hanging by his neck via a leather belt which has been looped through the bottom of the upper level bunk." Id. It is unclear if the leather belt Mr. Bonnette used to hang himself was part of the restraint device,[1] or was Mr. Bonnette's own belt. At the time of the autopsy, Mr. Bonnette was "still restrained, ankles and wrists, by leather restraint devices." Id. The coroner noted substantial injuries to Mr. Bonnette's neck and larynx, but noted no evidence of larynx or cervical spine fracture. Id.

I. PLAINTIFFS ARE ENTITLED TO REVIEW ALL DOCUMENTS RELATED TO

[1] In relevant OPCSO Policy, the restraints used on Mr. Bonnette are described as follows: "The inmate wears a waist belt with secured wrist cuffs attached which keeps hands restrained at waist level. Ankles are also secured in cuff(s) but inmate remains ambulatory." OPCSO Policy J-64 (Medical Restraints and Therapeutic Seclusion) at 2.

MR. BONNETTE'S INCARCERATION AND DEATH TO SUPPORT THEIR ALLEGATIONS THAT DEFICIENCIES IN OPSCO'S SUICIDE PREVENTION, THERAPEUTIC RESTRAINT, AND SECLUSION PRACTICES ARE UNCONSTITUTIONAL.

In their Motion to Reconsider, Plaintiffs argue that the termination provisions of the Prison Litigation Reform Act ["PLRA"], 18 U.S.C. § 3626(b) (2000), do not support the Court's dismissal of the mental health claims in this case. See Motion to Reconsider at 3-4. Under the PLRA, this Court is obligated to hold an evidentiary hearing before terminating relief if "plaintiffs' submissions . . . allege specific facts which, if true, would amount to an ongoing violation." Guajardo v. Texas Dept. of Criminal Justice, 363 F.3d 392, 397 (5th Cir. 2004) (finding no abuse of discretion for termination without a hearing where "none of the plaintiffs' allegations satisfied that requirement."); see also Hadix v. Johnson, 228 F.3d 662, 671 (6th Cir. 2000) ("Because the PLRA directs a district court to look to *current conditions*, and because the existing record at the time the motion for termination is filed will often be inadequate for purposes of this determination, the party opposing termination must be given the opportunity to submit additional evidence in an effort to show current and ongoing constitutional violations."); Laaman v. Warden, New Hampshire State Prison, 238 F.3d 14, 18-19 (1st Cir. 2001) (noting that the extent of fact-finding is discretionary and should be informed by the availability of current and comprehensive information to the court; abuse of discretion found in refusal of hearing where several years had passed since the record had been supplemented and the case had been transferred to a new judge); Loyd v. Alabama Dept. of Corrections, 176 F.3d 1336, 1342 (11th Cir. 1999) (holding that plaintiffs were entitled to an evidentiary hearing despite the existence of eleven reports–the most recent of which was two months old--filed by the Special Master documenting conditions at the jail. "A report alone cannot be cross-examined or disputed. The party opposing termination must be given the opportunity to challenge or supplement the

findings of the monitor and to present evidence . . . whether there are 'current and ongoing' violations of federal rights in the prison."); Benjamin v. Jacobson, 172 F.3d 144, 165-66 (2d Cir. 1999) (en banc) (plaintiffs entitled to present evidence of current and ongoing violations in opposing termination).

The opportunity for a hearing necessarily includes the opportunity to prepare for it, and Plaintiffs' burden of alleging specific facts in order to be entitled to a hearing must carry with it an opportunity to gather these facts. Therefore, Plaintiffs are entitled to discovery in opposing termination, as in any other federal court fact-finding proceeding.[2] See Loyd, 176 F.3d at 1342 ("[i]t would read all meaning out of [§ 3626(b)(3)]" to deny the party opposing termination an opportunity to present evidence relevant to the statute's requirements."); Ginest v. Board of County Comm'rs of Carbon County, Wyo., 295 F. Supp.2d 1274, 1275 (D.Wyo. 2003) (holding that plaintiffs may pursue discovery on termination motion).

It is well-established that prisoners have a constitutional right to adequate treatment for serious mental health conditions. See, e.g. Partridge v. Two Unknown Police Officers of the City of Houston, 791 F.2d 1182, 1188 (5th Cir. 1986) ("the defendants had a duty, at a minimum, not to be deliberately indifferent to Partridge's serious medical needs. A serious medical need may exist for psychological or psychiatric treatment, just as it may exist for physical ills. A psychological or psychiatric condition can be as serious as any physical pathology or injury,

---

[2] Plaintiffs likewise would be entitled to an evidentiary hearing if dismissal of their mental health claims were sought under Fed. R. Civ. P. 60(b)(5). Cf. Cooper v. Pentecost, 77 F.3d 829, 831 (5th Cir. 1996) (noting that the district court held an evidentiary hearing before denying defendants' motion for relief from judgement under Rule 60(b)(5) and (6)); North State Law Enforcement Officers Ass'n. v. Charlotte-Mecklenburg Police Dep't., 862 F. Supp. 1445, 1447 (W.D.N.C. 1994) (district court granted plaintiffs' request for discovery prior to conducting an evidentiary hearing on defendant's motion to terminate a consent decree under Rule 60(b)(5)).

especially when it results in suicidal tendencies. And just as a failure to act to save a detainee from suffering from gangrene might violate the duty to provide reasonable medical care absent an intervening legitimate government objective, failure to take any steps to save a suicidal detainee from injuring himself may also constitute a due process violation under Bell v. Wolfish.").

Jail officials may be held constitutionally liable for failing to treat, house, and monitor suicidal prisoners appropriately,[3] or for improperly using restraints on mentally ill prisoners,[4] or for failing to provide adequate training and supervision to corrections officers who are responsible for identifying and monitoring mentally ill prisoners.[5]

---

[3] Jacobs v. West Feliciana Sheriff's Dep't., 228 F.3d 388 (5th Cir. 2000) (affirming a district court's denial of summary judgment against sheriff and deputy sheriff, finding sufficient evidence to conclude that providing an inmate known to be suicidal with loose bedding and a room with a bind spot and multiple "tie-off" points, and leaving her unobserved for an undetermined period of time, in a jail where there had been a previous suicide under similar circumstances, created a material issue of fact as to whether sheriff and his deputy were deliberate indifferent, despite the fact that the sheriff "did not completely ignore [the inmate's] suicidal condition, and in fact instituted some preventative measures.")

[4] Wells v. Franzen, 777 F.2d 1258, 1261-62 (7th Cir. 1985) (summary judgment reversed where there was a material issue of fact regarding whether therapeutic restraints ordered for prisoner absent a complete examination by a physician complied with professional mental health standards of care); Campbell v. McGruder, 580 F.2d 521, 551 (D.C. Cir. 1978) (district court remedial order establishing procedure for using therapeutic restraints upheld where there was evidence that restraints had been used on unsupervised prisoners without a doctor's order).

[5] Cf. Partridge, 791 F.2d at 1188 (dismissal reversed on civil rights claim against the city of Houston brought by parents of pretrial detainee who committed suicide where the complaint alleged that the city and the police department failed to adequately train the jail personnel to handle arrested citizens with known mental problems. The Fifth Circuit held that "[a]rguably, inadequate training of police personnel may be the basis for finding a municipal custom of deliberate indifference to the constitutional rights of citizens."); Olsen v. Layton Hills Mall, 312 F.3d 1304, 1319-20 (10th Cir. 2002) (summary judgment on county jail detainees' claim of inadequate mental health care reversed where there was a material issue of fact as to whether county was deliberately indifferent to rights of prisoners with whom jail's booking officers came into contact by failing to train the officers to recognize detainees with obsessive compulsive disorder and handle those persons appropriately).

Even the incomplete record regarding Mr. Bonette's death made available to Plaintiffs demonstrates that there are deficiencies in OPSCO's suicide prevention practice, and in the use of therapeutic restraints and seclusion, that violate Plaintiffs' rights to adequate mental health treatment. It goes without saying that a prisoner in four-point restraints should be rendered unable to commit suicide or otherwise harm himself. At a minimum, Mr. Bonnette's death is the result of a catastrophic failure of OPP staff to use proper restraint techniques or monitor his activities and behavior. During what was at least a 26-minute gap when correctional and health care staff failed to observe him, Mr. Bonnette apparently was able to free himself from four-point restraints and apparently use the waist belt from the restraint device to hang himself from an upper bunk before he was observed lifeless by a fellow prisoner. During the eleven hours that Mr. Bonnette was housed on the mental health tier, he was never assessed by a psychiatrist, and the nurse who did see him failed to note his mental status or any physical findings other than his temperature and blood pressure. Defendants' refusal to produce the requested incident reports and internal investigation reports, or other medical records, makes it impossible for Plaintiffs to prove which of OPP staff was deliberately indifferent to Mr. Bonnette's serious mental health needs, resulting in his death.

Plaintiffs do not know how the problems in OPCSO mental health services evident from Mr. Bonnette's death have affected other prisoners. Prompted by their review of the limited records they have been provided, Plaintiffs are now seeking additional discovery on other instances of prisoners who have been injured, harmed, or died while restrained, secluded, or on suicide watch, so that they can determine the extent to which systemic deficiencies in the jail's suicide prevention and restraint practices have led to unnecessary suffering of mentally ill

prisoners.[6] Plaintiffs are entitled to gather this evidence and present it to the Court before their mental health claims are terminated.

II. PLAINTIFFS ARE ENTITLED TO REVIEW DOCUMENTS TO SHOW DEFENDANTS' FAILURE ADEQUATELY TO TREAT MR. BONNETTE'S SERIOUS MENTAL HEALTH NEEDS RESULTED FROM THEIR DISREGARD OF NCCHC GUIDELINES, OPCSO POLICY, AND THE COURT'S SEPTEMBER 9, 1991 REMEDIAL ORDER.

Plaintiffs argue in their Motion to Reconsider that a dismissal of the mental health claims is unwarranted since Defendants have failed to achieve full compliance with the Court's September 9, 1991 Order. See Memorandum in Support of Motion to Reconsider at 10-12. The September 9 Order requires the Defendants to draft and implement health care policies and procedures that are consistent with the guidelines established by the National Commission on Correctional Health Care (NCCHC).

Mr. Bonnette's death raises questions regarding Defendants' compliance with the September 9 Order. At a minimum, the serious operational issues in mental health services involved in Mr. Bonnette's death entitle Plaintiffs to engage in discovery in order to gather evidence that can demonstrate that Defendants have violated NCCHC Guidelines, OPCSO health care policies, as well as constitutional norms. For example, NCCHC Standard J-A-10 (Procedure in the Event of an Inmate Death) requires a clinical mortality review of every in-custody death, which includes an assessment of clinical care provided, the incident and facility procedures used, the training received by involved staff, all pertinent health care records and institutional reports; as well as any recommendations for changes in policies, training, physical plant, health care services, or operational procedures. In the case of a suicide, a psychological

[6] Plaintiffs have filed along with this Motion a Motion to Shorten the Time for Discovery Responses, so that all discovery regarding Defendants' restraint/suicide prevention practice can be expedited, and appropriate relief sought from this Court.

autopsy is recommended, which includes a review of all file information, and examination of the suicide site, and interviews with staff, inmates, and family members. OPCSO J-10-1 (Procedure in the Event of an Inmate Death) requires the preparation of a mortality report for in-custody deaths. The report, which is maintained in the Quality Improvement Department and in Medical Administration, is based on a review of medical records, the mortality review, and the autopsy report.

Defendants have failed to produce a mortality report, or mortality review. These documents would show if Defendants themselves have identified problems in either medical or correctional performance, training, or policies that contributed to Mr. Bonnette's death. If these records do not exist, then Defendants should be compelled to so state, which alone would establish that they have failed to comply with the NCCHC Guidelines and their own policy. Defendants also failed to produce an autopsy report, even though the report was completed some two months ago. If Defendants do not have the autopsy report, they not only are violating their own policies, they have also failed to implement a timely system for reviewing prisoner deaths. It is unlikely that the coroner's office would be responsible for Defendants' failure to have the autopsy report, since Plaintiffs received a copy of the report from the coroner's office three days after their request. Balaban Dec. ¶ 4.

NCCHC Standard J-G-05 (Suicide Prevention) requires jails to adopt comprehensive suicide prevention precautions. Suicidal prisoners are prohibited from being housed in isolation, unless constant supervision is maintained. Rather, prisoners on suicide watch are to be housed in a general population mental health unit or in the infirmary, close to staff, in cells that are suicide-resistant. They are to be monitored closely, and monitoring is to be documented. OPCSO J-51 (Suicide Prevention) requires that all prisoners who are moved to a mental health tier for suicide

watch receive a mental health evaluation from qualified mental health care personnel.

The facts of Mr. Bonnette's death also raise serious questions as to whether Defendants violated NCCHC Guidelines and OPCSO policy regarding suicide prevention: Mr. Bonnette was able to free himself from four-point restraints and apparently hang himself without being observed by any OPP staff. It was a prisoner, not an officer or nurse, who first found Mr. Bonnette hanging lifeless from the upper bunk in his cell. During the eleven hours Mr. Bonnette spent on the mental health tier, he was assessed by a mental health nurse once--the one-page mental health assessment form fails to note Mr. Bonnette's mental status, has no physical findings other than a blood pressure and temperature reading, and does not include an assessment of the appropriateness of continued restraint. Mr. Bonnette was never assessed by a physician, and there is no indication why OPP staff chose to put Mr. Bonnette in ambulatory four-point restraints as a suicide precaution, as opposed to other suicide precautions (such as constant supervision, or five-point restraints).

Again, Defendants' failure to produce the mortality review and pertinent incident and investigative reports[7] leaves Plaintiffs with a host of unanswered questions: The autopsy report suggests that Mr. Bonnette used the waist belt from his four-point restraints to hang himself. However, Plaintiffs did not receive any information from OPCSO on how Mr Bonnette hanged himself, what he used to hang himself, or the condition of Mr. Bonnette's cell at the time of his

[7] On information and belief, Mr. Bonnette's death should have resulted in an incident report by correctional staff, as well as a referral to the Sheriff's Special Investigation Division (SID) for an internal investigation and report. Defendants refused to produce any incident or investigative reports regarding Mr. Bonnette's death. Plaintiffs have previously had access to SID and incident reports when conducting on-site inspections, including inspections regarding the OPP's restraint practice. Plaintiffs' mental health expert Dr. Jeffrey Metzner, reviewed the SID report regarding prisoner Shawn Duncan's death for his December 21, 2001 report and March 2002 testimony. See December 29, 2001 Report of Jeffrey Metzner, M.D., P.C. at 16-17, filed with Plaintiffs' Report of Evaluation of Mental Health Care Delivery System of Orleans Parish Prison (Jan. 14, 2002).

death. Because Defendants have refused to provide incident and SID reports, Plaintiffs have no witness statements from staff and prisoners, such as a statement from Mr. Adams, who found Mr. Bonnette's body and alerted staff, and could confirm if Mr. Bonnette used the restraint belt itself to commit suicide. The incident and SID reports would also allow Plaintiffs to assess the actions of corrections staff in monitoring Mr. Bonnette, the actions of OPP supervisors in assessing staff performance, or the remedial efforts (if any) Defendants have taken in light of Mr. Bonnette's death. All of these facts may demonstrate Defendants' compliance with NCCHC Guidelines and OPCSO policy, and will allow Plaintiffs to assess whether Defendants were deliberately indifferent to Mr. Bonnette's serious mental health needs.

Finally, NCCHC Standard J-1-01 (Use of Restraint and Seclusion in Correctional Facilities) requires the adoption of policies and procedures specifying the types/circumstances/conditions under which restraints or seclusion may be used, and mandates that prisoners who are restrained must be monitored by health-trained staff, they must be restrained such that proper peripheral circulation is maintained, and provided with proper nutrition, hydration, and toileting. OPCSO policy J-19 (Training for Correctional Officers) requires that security staff who are assigned to mental health units be trained in evaluating inmates in mechanical restraints. OPCSO J-64 (Medical Restraints and Therapeutic Seclusion) prohibits the restraint of prisoners on an upper bunk. While a prisoner can be restrained based on a verbal order, the restraint may not exceed nine hours. A physician must conduct a face-to-face examination of all restrained prisoners at least once per eight-hour shift, and complete a progress note describing the behavior of the prisoner, the results of the assessment, and the explanation given to the prisoner of the behavior that must be demonstrated before restraints are removed. In addition OPCSO J-64 requires that health care staff assess prisoners in four-point restraints once

per shift. The staff performing the assessment is required to check the prisoner for circulation/nerve damage or airway obstruction, encourage the prisoner to stand, walk, and move extremities, inquire about the prisoner's comfort level, and document all of these activities in a progress note.

Again, Defendants have failed to produce any records that show that this NCCHC Guideline and OPCSO policy were followed. In fact, it is impossible to determine when Mr. Bonnette was first put in restraints from the incomplete records that Defendants have produced: Mr. Bonnette was transferred to the 10th floor of HOD and ordered to be put into four-point restraints no later than 5:00 a.m.; however, the corrections officer assigned to the tier did not initiate restraint observations until 8:45 a.m.–Mr. Bonnette's status during the intervening four hours is undocumented in the record Plaintiffs reviewed. Therefore it is not possible to determine if Defendants violated their own nine-hour limit on verbal restraint orders, or whether Defendants violated policy by not observing Mr. Bonnette for the first three hours he was restrained. Also, there were no progress notes from a physician documenting a face-to-face examination while Mr. Bonnette was restrained. There is no documentation on Mr. Bonnette's mental and physical status, the reason for the restraint, or why four-point restraints were chosen as the restraint method. The cursory nursing assessment in Mr. Bonnette's medical record fails to document any of the physical findings required by OPCSO J-64. Without the relevant incident reports, SID reports, and mortality review, Plaintiffs cannot fully assess whether corrections staff conducted appropriate monitoring of Mr. Bonnette before his death, whether Mr. Bonnette did use the waist belt from the restraint device to hang himself, or whether inadequate training or performance of the officers involved may have contributed to Mr. Bonnette's death.

III. PLAINTIFFS' DOCUMENT REQUEST IS NOT FORECLOSED BY THE

COURT'S DECEMBER 24, 2003 REPORT AND RECOMMENDATION.

Mr. Bonnette's death is at least the second in the past three years of a prisoner who was under a restraint order on the 10th floor of the HOD at the time of his death. OPP prisoner Shawn Duncan died of dehydration on August 10, 2001 after he had been held for 42 hours in five-point restraints. The circumstances of Mr. Duncan's death have already been subject to an evidentiary proceeding in this case. On March 4, 2002, this Court held a hearing on Plaintiffs' Motion for Evidentiary Hearing (Rec. Doc. 1629) challenging "the constitutionality of jail policy, practice, and procedure attendant to restraint of inmates." Report and Recommendation, Dec. 24, 2003 ["December 24 Report"], at 2. Mr. Duncan's was the only restraint episode about which Plaintiffs presented evidence at the hearing. See id. at 11. Following the hearing, the Court recommended denying Plaintiffs' request that the existing restraint policy and practice be invalidated. Id.

The December 24 Report does not divest this Court of the authority to order Defendants to produce the documents regarding Mr. Bonnette's death that they have refused to disclose. First, the Court premised its denial of relief on the fact that Plaintiffs had failed to present any instances other than Mr. Duncan's in which a prisoner had been harmed or injured while restrained. December 24 Report at 11. Now a second prisoner has died while restrained on suicide watch. Mr. Bonnette's and Mr. Duncan's deaths are strikingly similar: Both men were put in restraints on suicide watch on the 10th floor of HOD, both men were restrained in excess of eight hours, the medical records of both men lack progress notes from the physicians who ordered the restraints that explain why restraints were ordered, there is no indication in either man's record that he was given food or drink at regular intervals, neither man was assessed by nursing staff consistent with OPCSO policy, and both men were first found, lifeless, by fellow

prisoners, as opposed to security or health care staff. The documents that Defendants have refused to provide may show that there are serious operational problems at OPP that contributed to Mr. Bonnette's death, and may pose a substantial risk of contributing to more deaths and injuries to restrained prisoners.

Second, facts regarding Mr. Duncan's death have been developed since the March 4, 2002 hearing which shed a new light on the Court's rationale for denying relief. The Court found that "there is no evidence presently before the Court that establishes that it is more probably so than not so that Mr. Duncan would be alive today if there were a different [restraint] policy and procedure in place at the jail." December 24 Report at 11. Since the Court filed its decision, the Sheriff has admitted that the absence of a qualified psychiatrist on duty to assess Mr. Duncan led to his death. On January 28, 2004, Sheriff Hunter and Orleans Parish authorities filed a lawsuit against LSU Health Sciences Center. See Hunter v. Bd. of Supervisors of LSU, No. 04-1407, Civil District Court for the Parish of Orleans, Division I. The complaint is filed with this Memorandum. See Ex. C, Balaban Dec. In the complaint, Sheriff Hunter alleges that the OPCSO had a contract with LSU to provide professional medical/psychiatric services to OPCSO. Id. at 3. Under the contract, LSU was required to provide a psychiatrist to OPCSO to serve as the director of psychiatric services. Id. At the time of Mr. Duncan's death, Dr. Michael Higgins, then director of psychiatric services, was on leave, which had been approved by Dr. Osofsky, the director of LSU's psychiatry department. Id. at 4-5. However, Dr. Osofsky and LSU failed to retain a psychiatrist to replace Dr. Higgins, in violation of the contract. The Sheriff further alleges the following:

> As a result of this breach, the morning sick call was not conducted, Shawn Duncan remained in five-point restraints and [died] later that day. This failure to appoint a psychiatrist from the LSU School of Medicine, Department of Psychiatry constitutes a breach of contract by LSU, and was the cause in fact and legal cause of the death of Shawn Duncan.

Id at 5.

Given the gravity of the issues presented by the second death of a prisoner in restraints on suicide watch, this Court should not consider itself barred by its December 24 Report from permitting Plaintiffs to conduct a basic inquiry into the facts and circumstances of Mr. Bonnette's death.

Third, the only issue considered by the Court in its December 24 Report was Plaintiffs' motion for additional injunctive relief regarding the jail's restraint policy. While Defendants opposed Plaintiffs' motion, they did not seek dismissal of Plaintiffs' claims regarding the jail's restraint practice. In denying the requested relief, the Court therefore did not recommend dismissing Plaintiffs' claims, since a request for dismissal was not before it. Until such time as the claims are dismissed by the district court, this Court has the authority to order discovery regarding Plaintiffs' restraint claims.

Conclusion

Matthew Bonnette's death raises serious questions regarding OPP's suicide prevention and therapeutic restraint practices and Defendants' compliance with this Court's mental health remedial order. However, Defendants refusal to produce all relevant health care, incident, and investigative reports makes it impossible for Plaintiffs to assess fully whether Mr. Bonnette's death was the result of Defendants' failure to abide by the NCCHC Guidelines, their own policies, and constitutional norms. Plaintiffs therefore request that Defendants be compelled to produce all documents related to Mr. Bonnette's death.

Respectfully submitted,

Eric Balaban
National Prison Project
ACLU Foundation

733 15th St., NW, Suite 620
Washington, D.C. 20005
202/393-4930

William P. Quigley
Loyola Law Clinic
P.O. Box 902
7214 St. Charles Avenue
New Orleans, Louisiana 70118
504/861-5590
Bar Roll #7769

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

LOUIS HAMILTON, et al.,	:	Civil Action No. 69-2443 & Consolidated Cases
Plaintiffs,	:	Section LLM (5)
v.	:	
ERNEST N. MORIAL, et al.,	:	
Defendants.	:	
----------	:	

CERTIFICATE OF COUNSEL

Pursuant to Local Rule 37.1, Plaintiffs state that counsel for the parties have conferred by telephone for purposes of amicably resolving the issues raised in the accompanying Motion to Compel. Defendants' counsel John Weeks has informed undersigned counsel that Defendants have no additional documents to produce, and will not produce any additional documents they have declined to produce in response to Plaintiffs' April 14, 2004 request.

Respectfully Submitted,

Eric Balaban
Elizabeth Alexander
National Prison Project
ACLU Foundation
733 15th St, NW, Suite 620
Washington, D.C. 20005
202/393-4930

William P. Quigley

Loyola Law Clinic
P.O. Box 902
7214 St. Charles Avenue
New Orleans, Louisiana 70118
504/861-5590
Bar Roll #7769

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

LOUIS HAMILTON, et al.,	:	Civil Action No. 69-2443 & Consolidated Cases
Plaintiffs,	:	Section LLM (5)
v.	:	
ERNEST N. MORIAL, et al.,	:	
Defendants.	:	
----------	:	

ORDER

For good cause shown, Plaintiffs' Motion to Compel Production is GRANTED; and it is hereby ORDERED that Defendants shall produce any and all documents in their possession that relate to the incarceration and/or death of Matthew Bonnette.

New Orleans, Louisiana this _____ day of _____, 2004

ALMA CHASEZ
UNITED STATES MAGISTRATE JUDGE