IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

EDWARD BRAGGS, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	2:14-CV-00601-MHT-TFM
JEFFERSON DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, et al.,	)	
	)	
Defendants.	)	

PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER OR PRELIMINARY INJUNCTION REGARDING SUICIDAL PRISONERS

INTRODUCTION

A week ago, a plaintiff in this case died as a result of Defendants' failure to ensure that prisoners who are suicidal are provided

suicidal[2] is substantial. In September 2016 alone, among prisoners on the outpatient mental health caseload, there were: 9 serious suicide attempts; 3 suicide attempts, 19 self-injury incidents, 89 placements in safe cells for suicide watch, and 26 placements in safe cells for mental health observation. Jt. Ex. 344, at ADOC0397439.[3] That month, among prisoners in Residential Treatment Units (RTUs), there were 14 placements in safe cells for suicide watch and 12 placements in safe cells for mental health observation. *Id*. at ADOC0397440. And among prisoners in Stabilization Units (SUs), there were 4 placements in safe cells for suicide watch, 1 placement in a safe cell for mental health observation, and 10 placements in safe cells for precautionary watch. *Id*. at ADOC0397441.[4]

Defendants know that prisoners who are acutely suicidal or at risk of becoming acutely suicidal are in ADOC custody and, under current practices, face an imminent risk of serious injury or death. The Alabama Department of Corrections purports to be:

> dedicated to preventing inmate suicides through staff training in the identification and referral of inmates potentially at risk for suicidal behavior, immediate intervention and monitoring when an inmate is identified as potentially suicidal, and mental health evaluation and treatment.

[2] Under the NCCHC's definitions, prisoners who are at risk of becoming acutely suicidal include those who are "non-acutely suicidal." Ex. 1, NCCHC Essential Standard MH-G-04, at 5.
[3] September 2016 is the most recent month for which Plaintiffs have data.
[4] ADOC Admin. Reg. 630 defines "suicide watch" as "a standardized watch with designated periods of observation and inmate monitoring" and "precautionary watch" as "a watch with

Jt. Ex. 132, ADOC Admin. Reg. 629.

suicidal and the risk of irreparable harm these failures create. On December 20, 2016, ADOC Associate Commissioner Ruth Naglich, a Defendant, testified that,

Ms. Naglich testified that prisoners on suicide watch placed in shift offices could harm themselves. Dec. 20, 2016, Tr. Test. of Ruth Naglich.

As early as 2011, Defendants and ADOC have been on notice of failures in its provision of mental health care to acutely suicidal prisoners and prisoners at risk of becoming acutely suicidal. For example, in ADOC's 2011 Contract Compliance Review Report, ADOC noted that suicide watch cells at Fountain were not safe or "conducive to housing suicidal or acutely mentally ill inmates" and that the Fountain suicide watch cells were "used to manage the needs of over 1,200 Fountain inmates and hundreds of inmates housed at surrounding camps." Pls. Tr. Ex. 11n-5.23605(,)1.66153(1)3.3.66153(1)3.3.66153(1)3.3.61 [(F)-0.616744(o 23.66153(2792(

mintues intervals. This is not acceptable, as checks are to occur at random intervals not longer than 15 minutes." *Id*. The Report recommended "[t]raining for correctional officers completing 15-minute observation of patients on suicide watch" and stated, "Rounds should be staggered and documented in real-time, not using prefilled forms." Pls. Tr. Ex. 115 at 12. At trial, Ms. Naglich testified that she understood the importance of completing staggered 15-minute observations was to prevent prisoners from being able to plan suicide attempts and that the risk of failing to complete these staggered observations is death. Dec. 20, 2016 Tr. Test. of Ruth Naglich.

Also in the February 2016 Clinical Contract Compliance Review Report, ADOC noted:

> It was reported that discharges from suicide watch and mental health observation require a psychiatric order, and at times psychiatric staff

Ms. Naglich also testified that because ADOC's failure to provide constant watch with regard to acutely suicidal prisoners puts their lives at risk, the failure should be rectified immediately. *Id*

Records (filed under seal) at ADOC0399818.[5] He had been discharged from suicide watch two days prior. ***Id.*** at ADOC0399840.

Mr. Wallace testified in the trial in this matter on December 5, 2016. After testifying in the trial, Mr. Wallace was transported to Bullock Correctional Facility. *Id*. at ADOC0399819. Mr. Wallace was placed in the stabilization unit at Bullock. *Id*. at ADOC0399822. On December 10, 2016, MHM Chief Psychiatrist Dr. Hunter ordered that Mr. Wallace be placed on suicide watch after Mr. Wallace expressed suicidal ideations. *Id*. at ADOC0399807, 0399808, 0399841, 0399852. He remained on suicide watch until December 13, 2016. *Id*. at at ADOC0399840.

Mr. Wallace's serious mental illness caused him to suffer throughout his time in ADOC custody. He testified during trial that he had been placed on suicide watch **mord**

he be. Mr. Wallace was not evaluated after this Court ordered that he be. The records produced thus far show that Mr. Wallace received no counseling during the time he was housed in suicide watch from December 1

- In certain locations, especially the Donaldson SU, ADOC crisis cells do not provide clear visibility of individuals in the cells;
- Cameras that are supposed to enable correctional officers' ability to consistently monitor prisoners in the midst of mental health crises are not working or not being used;
- Numerous crisis cells, including those at Kilby and Holman, contain "tie offs" such as bars, as well as other hazards;
- Mental health staff relied on cell-front consultations with prisoners on suicide watch and did not actually take such prisoners out of their cells for confidential counseling sessions to assess their states of mind;
- ADOC's failure to ensure that there is follow up counseling with prisoners who were recently released from suicide watch poses a significant risk that such prisoners will attempt suicide or other self-harm again; and
- With regard to Plaintiff Jamie Wallace specifically, ADOC had repeatedly failed to ensure that he received minimally adequate counseling during and after multiple occasions on suicide watch.

LEGAL STANDARD

To obtain a temporary restraining order or preliminary injunction, the moving party must show: (1) a substantial likelihood of success on the merits; (2)

that it will suffer irreparable injury unless the injunction is issued; (3) that the threatened injury outweighs possible harm that the

suicide. *Waldrop v. Evans*, 871 F.2d 1030, 1036 (11th Cir. 1989); *Edwards v. Gilbert*, 867 F.2d 1271, 1274–75 (11th Cir. 1989). Prison officials violate the Eighth Amendment when they are deliberately indifferent to a substantial risk to inmate safety. *Farmer*, 511 U.S. at 834. Deliberate indifference "entails something more than mere negligence," but "the cases are also clear that it is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result." *Id.* at 835. Where officials have actual knowledge that prisoners are at substantial risk of serious harm, but "disregard[] that known risk by failing to respond to it in an (objectively) reasonable manner," they violate the Eighth Amendment. *Rodriguez v. Sec'y for Dep't of Corr.*, 508 F.3d 611, 617 (11th Cir. 2007); *see also Farmer*, 511 U.S. at 836 ("It is, indeed, fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk.")

The evidence adduced at trial, particularly the testimony of Associate Commissioner Ruth Naglich, and exhibits such as the

suicide or seriously injure themselves, but have failed to respond to this in a reaso6

As set forth above, Defendants' conduct and knowing failure to act constitutes an ongoing violation of their constitutional duty to adequately protect the safety of suicidal prisoners. An ongoing constitutional violation also constitutes irreparable harm in and of itself. *See Laube v. Haley*, 234 F. Supp. 2d 1227, 1251 (M.D. Ala. 2002) ("The existence of a continuing constitutional violation constitutes proof of an irreparable harm . . . .") (quoting *Preston v. Thompson,* 589 F.2d 300, 303 n. 3 (7th Cir.1978)).

III. The Threatened Injury to Acutely Suicidal Prisoners and Prisoners at Risk of Becoming Acutely Suicidal Significantly Outweighs the Harm of Issuing an Injunction Against Defendants.

Associate Commissioner Naglich testified that Defendants' failure to

LLC, 425 F.3d 964, 971 (11th Cir. 2005) ("[I]t is well-established that the amount of security required by the rule is a matter within the discretion of the trial court, and the court may elect to require no security at all.") (quotations and ellipses omitted); *Complete Angler, LLC v. City of Clearwater, Fla.*, 607 F. Supp. 2d 1326, 1335 (M.D. Fla. 2009) ("Waiving the bond requirement is particularly appropriate where a plaintiff alleges the infringement of a fundamental constitutional right."); *see also All States Humane Game Fowl Org., Inc. v. City of Jacksonville, Fla.*, No. 308-CV-312-J-33MCR, 2008 WL 2949442, at *13 (M.D. Fla. July 29, 2008) ("Plaintiffs bring a constitutional law complaint and allege infringement of fundamental rights. The action that they fear, permanent destruction of their roosters, is a considerable loss to face. The Court finds it appropriate to waive the bond requirement in this case.").

RELIEF REQUEST

Specifically, Plaintiffs seek an order restraining and enjoining Defendane2,hause9(D)2

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1. Ensure that all prisoners undergo a risk assessment by a psychiatrist or licensed psychologist within 24 hours of being placed on suicide watch in the Alabama Department of Corrections to determine if they are "acutely suicidal" or "nonacutely suicidal"[8];
2. Ensure that all risk assessments ardenlrdrdtsroo d

7. Ensure that individual ADOC prisoners are discharged from suicide watch only by a licensed psychiatrist or licensed psychologist who has conducted an in-person[9], out-of-cell, confidential evaluation to determine the prisoner's level of suicidality and the appropriate follow-up treatment plan;
8. Ensure that both constant watch and close watch monitoring are contemporaneously documented at staggered intervals not to exceed 15 minutes on a record maintained on each individual cell door;
9. Ensure that crisis cells, suicide watch cells, safe cells, semi-closed and closed residential treatment unit (RTU) cells, and intensive stabilization unit (SU) cells are used exclusively to house prisoners in need of mental health treatment and are free from prisoners who are being detained in segregation;
10. (a) Conduct in-person, confidential, out-of-cell treatment team meetings (including, at least, the psychiatrist as well as either a licensed psychologist or licensed mental health professional) to assess and revise the operative treatment plan as prisoners approach 72 hours on suicide watch and, (b) after 72 hours on watch, either transfer the prisoner to the SU or convening in-person, out-of-cell, confidential treatment team meetings (including, at least, the psychiatrist as well as either a licensed psychologist or licensed mental

[9] As the evidence in this case has shown, evaluations are sometimes conducted through telepsychiatry over a video monitor. As used in this motion, "in-person" requires the mental health staff to be on site for a face-to-face meeting with the patient, rather conduct the meeting through the use of audiovisual equipment.

14. Conduct in-person, confidential, out-of-cell evaluations of all prisoners on the mental health caseload to identify those at risk of becoming acutely suicidal at least monthly for any prisoner housed in segregation for more than 30 days;

15. Ensure that mental health rounds of segregation and death row, including assessments to identify those at risk of becoming acutely suicidal, are conducted at least five times each week by ADOC psychologists or psychological associates, including Segregation Board Review Rounds, as required by Admin. Reg. 624 (Jt. Tr. Ex. 126);

16. Ensure that mental health staff conducting mental health rounds in segregation (including staff assessing those at risk of becoming acutely suicidal) contemporaneously document their rounds on each individual cell door;

17. Ensure that any prisoner housed in segregation that is found to be psychotic, acutely depressed, or at risk of becoming acutely suicidal is provided with a clinical contact in an in-person, out-of-cell, confidential clinical contact with a psychiatrist, nurse practitioner, psychologist, or mental health professional and is transferred to a bed in a RTU, SU, or crisis cell immediately;

18. Ensure that an independent expert, agreed to by the parties or appointed by the Court, provides an evaluation and assessment of the policies, practices,

and procedures related to suicide watch currently in place in ADOC (including but not limited to the risk assessment tool used by ADOC and Admin. Regs. 629, 630, 632, and 632-1), and recommended remedies to the parties and the Court within the next forty-five (45) days;

19. Ensure that a plan for implementing the recommended remedies of the independent expert regarding the policies, practices, and procedures related to suicide watch is in place within the next seventy-five (75) days;

20. Ensure that an independent expert, chosen by the parties or appointed by the Court, provide an evaluation and assessment of the policies, practices, and procedures of the SU and closed- or semi-closed RTU

23. Ensure that any ADOC prisoner housed in a cell with an identified tie-off point or other suicide hazard is kept under constant watch, regardless of the level of suicidality, until the suicide hazards have been resolved;

24. Remedy all tie-off points and other suicide hazards in all ADOC suicide cells, crisis cells, or safe cells and segregation cells within the next sixty (60) days;

25. Provide weekly updates to the Court and Plaintiffs' counsel detailing the

Dated: December 22, 2016

Respectfully Submitted,

__/s/ Maria V. Morris_____
Maria V. Morris (ASB-2198-R64M)
SOUTHERN POVERTY LAW CENTER
400 Washington Avenue
Montgomery, AL 36104

Rhonda Brownstein (ASB-3193-O64R)
Maria V. Morris (ASB-2198-R64M)
Ebony G. Howard (ASB-7247-O76H)
Latasha L. McCrary (ASB-1935-L75M)
Brooke Menschel (ASB-7675-Z61K)
Jaqueline Aranda Osorno (ASB-3296-A17H)
Natalie Lyons (ASB-1108-D63Y)
SOUTHERN POVERTY LAW CENTER
400 Washington Avenue
Montgomery, AL 36104
Telephone: (334) 956-8200
Facsimile: (334) 956-8481
rhonda.brownstein@splcenter.org
maria.morris@splcenter.org
ebony.howard@splcenter.org
latasha.mccrary@splcenter.org
brooke.menschel@splcenter.org
jaqueline.aranda@splcenter.org
natalie.lyons@splcenter.org

Miriam Haskell* (FL. Bar No. 069033)
SOUTHERN POVERTY LAW CENTER
P.O. Box 370037
Miami, FL 33137
Telephone: (786) 347-2056
Facsimile: (786) 237-2949

miriam.haskell@splcenter.org
*admitted *pro hac vice*

Kristi L. Graunke* (GA Bar No. 305653)
Eunice Cho* (GA. Bar No. 632669)
SOUTHERN POVERTY LAW CENTER
1989 College Avenue NE
Atlanta, GA 30317
Telephone: (404) 221-5842
Facsimile: (404) 221-5857
kristi.graunke@splcenter.org
eunice.cho@splcenter.org
*admitted *pro hac vice*

William Van Der Pol, Jr. (ASB-2112-114F)
J. Patrick Hackney (ASB-6971-H51J)
Glenn N. Baxter (ASB-3825-A41G)
Alabama Disabilities Advocacy Program Box 870395
Tuscaloosa, AL 35487
Telephone: (205) 348-4928
Facsimile: (205) 348-3909
wvanderpoljr@adap.ua.edu
jphackney@adap.ua.edu
gnbaxter@adap.ua.edu
Lisa W. Borden (ASB-5673-D57L)
William G. Somerville, III (ASB-6185-E63W)
Andrew P. Walsh (ASB-3755-W77W)
Dennis Nabors
Patricia Clotfelter (ASB-0841-F43P)
Baker, Donelson, Bearman, Caldwell & Berkowitz PC
420 20th Street North, Suite 1400
Birmingham, AL 35203
Telephone: (205) 328-0480
Facsimile: (205) 322-8007
lborden@bakerdonelson.com
wsomerville@bakerdonelson.com
awalsh@bakerdonelson.com
dnabors@bakerdonelson.com
pclotfelter@bakerdonelson.com

CERTIFICATE OF SERVICE

I hereby certify that I have on this 22nd day of December, 2016, electronically filed the foregoing with the clerk of the court by using the CM/ECF system, which will send a notice of electronic filing to the following:

David R. Boyd, Esq.
John G. Smith, Esq.
John W. Naramore, Esq.
Balch & Bingham LLP
Post Office Box 78
Montgomery, AL 36101-0078
dboyd@balch.com
jgsmith@balch.com
jnaramore@balch.com

Michael L. Edwards, Esq.
Steven C. Corhern, Esq.
Jenelle R. Evans, Esq.
Balch & Bingham LLP
Post Office Box 306
Birmingham, AL 35201-0306
medwards@balch.com
scorhern@balch.com
jevans@balch.com

William R. Lunsford, Esq.
Melissa K. Marler, Esq.
Stephen C. Rogers, Esq.
Christopher S. Kuffner, Esq.
Michael P. Huff, Esq.
Maynard, Cooper & Gale, P.C.
655 Gallatin Street, SW
Huntsville, AL 35801
blunsford@maynardcooper.com
mmarler@maynardcooper.com
srogers@maynardcooper.com
ckuffner@maynardcooper.com
mhuff@maynardcooper.com

Mitesh Shah, Esq.
Mitchell D. Greggs, Esq.
Bryan A. Coleman, Esq.
Evan P. Moltz, Esq.
Luther M. Dorr, Jr., Esq.
Maynard, Cooper & Gale, P.C.
1901 6th Avenue North, Suite 2400
Birmingham, AL 35203
mshah@maynardcooper.com
mgreggs@maynardcooper.com
bcoleman@maynardcooper.com
emoltz@maynardcooper.com
rdorr@maynardcooper.com

Anne Hill, Esq.
Elizabeth A. Sees, Esq.
Joseph G. Stewart, Jr., Esq.
Alabama Department of Corrections
Legal Division
301 South Ripley Street
Montgomery, AL 36104
anne.hill@doc.alabama.gov
elizabeth.sees@doc.alabama.gov
joseph.stewart@doc.alabama.gov

Deana Johnson, Esq.
Brett T. Lane, Esq.
MHM Services, Inc.
1447 Peachtree Street, N.E., Suite 500
Atlanta, GA 30309
djohnson@mhm-services.com
btlane@mhm-services.com

___/s/ Maria V. Morris_____
One of the Attorneys for Plaintiffs