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

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

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 minimal, constitutionally mandated care. In the past year, 12 prisoners in the Alabama Department of Corrections have committed suicide. Many others are at substantial risk of profoundly irreparable harm due to Defendants' failures to protect suicidal prisoners. Pursuant to Fed. R. Civ. P. 65, Plaintiffs respectfully move this Court for a temporary restraining order or preliminary injunction to prevent further

irreparable injury, including but not limited to, serious physical injury and death, to class members. Plaintiffs are substantially likely to succeed on the merits of their claims that Defendants have been and continue to be deliberately indifferent to a substantial risk of serious harm to suicidal prisoners. The obviously irreparable harm threatened to Plaintiffs and class members by Defendants' failures far outweighs the detriment that such an injunction or order may cause Defendants. The requested order or injunction will secure a measure of basic compliance with Plaintiffs' constitutional rights, will help protect against immediate threat to human life, and thus is in the public interest.

FACTUAL BACKGROUND

I. Defendants Know that Acutely Suicidal Prisoners and Prisoners at Risk of Becoming Acutely Suicidal Currently Face an Imminent Risk of Irreparable Harm and Suicide.

Over the last two years, the number of suicides within the ADOC has risen. Dec. 7, 2016, Tr. Test. of Dr. Robert Hunter; Dec. 20, 2016, Tr. Test. of Ruth Naglich. To date, 12 prisoners in ADOC custody have committed suicide in 2016. Dec. 21, 2016 Tr. Test. of Ruth Naglich.[1]

The number of prisoners in ADOC custody who are acutely suicidal, experiencing potential or inactive suicidality, or at risk of becoming acutely

[1] In her trial testimony, Associate Commissioner Naglich was unsure whether the twelve suicides took place in the calendar year 2016 or in the fiscal year that ended on September 30, 2016.

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.

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[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 varying observation and monitoring guidelines utilized only on the Intensive Psychiatric Stabilization Units (SU's) and requiring the order of a psychiatrist."

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

ADOC "is responsible, through the services of MHM, for the provision of inmate mental health care that meets constitutional standards[.]" Jt. Ex. 185, ADOC-MHM 2013 Contract, at ADOC000327. The National Commission on Correctional Health Care (NCCHC), whose policies MHM is contractually bound to follow per its contract with ADOC, defines "acutely suicidal inmates" as "those who engage in self-injurious behavior or threaten suicide with a specific plan." Ex. 1, 2015 NCCHC Essential Standard MH-G-04, at 5; Jt. Ex. 185 at ADOC000397, 000403, 000419, 000420, 000449; Dec. 20, 2016 Tr. Test. of Ruth Naglich. The NCCHC "essential standard" further states, "These inmates should be placed on constant observation." The essential standard further defines "non-acutely suicidal" as:

> those who express current suicidal ideation, expressing a wish to die without a specific threat or plan, and/or have a recent prior history of self-destructive behavior. In addition, inmates who deny suicidal ideation or do not threaten suicide but demonstrate other concerning behaviors through actions, current circumstances, or recent history, indicating the potential for self-injury should be placed on suicide precautions and observed at staggered intervals not to exceed every 15 minutes.

Id.

Defendants are on notice of system-wide failures in the mental health care it provides to prisoners who are acutely suicidal or at risk of becoming acutely

suicidal and the risk of irreparable harm these failures create. On December 20, 2016, ADOC Associate Commissioner Ruth Naglich, a Defendant, testified that, per NCCHC standards, acutely suicidal prisoners must be placed on constant observation. She then testified that within the ADOC not every acutely suicidal prisoner is placed on constant observation. Dec. 20, 2016 Tr. Test. of Ruth Naglich. She testified that as a result of a lack of correctional staff to provide constant watch, someone could die. *Id*. Ms. Naglich also testified that the NCCHC essential standard requires follow-up treatment for prisoners who have been on suicide watch in order to prevent relapse. *Id*.

Further, Ms. Naglich testified that MHM informed her repeatedly of the inadequate numbers of suicide watch cells and other problems with suicide watch cells. She testified that hanging is the most common method of committing suicide in prison and, for that reason, ensuring that there are not tie-off points or items in suicide watch cells that could be used by a prisoner to hang himself is very important. Dec. 20, 2016 Tr. Test. of Ruth Naglich. Ms. Naglich also testified to critical physical inadequacies with the crisis cell doors that limit visibility into the cell, specifically at Donaldson. Dec. 16, 2016, Tr. Test. of Ruth Naglich.

Ms. Naglich testified that she was aware that there is an insufficient number of crisis cells at some ADOC facilities and that sometimes prisoners are placed in inappropriate locations, such as correctional officer shift offices, for suicide watch.

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. 1190 at MHM030875. In 2012, ADOC's Contract Compliance Review Report noted that staff reported concerns about the safety of crisis cells at Ventress. Pls. Tr. Ex. 1191 at MHM030906.

As recently as February 2016, ADOC reported, "The cells used to house inmates in crisis at Holman CF appeared to be unsafe. There are open bars on the front of the cells and their location does not facilitate easy observation of the patients housed there. At the Staton Complex, the presence of a single crisis cell for over 4,000 inmates from 4 facilities is inadequate to meet the needs of the population." Pls. Tr. Ex. 115 at MHM040600. The February 2016 report further noted, "While not formally reviewed, it was noted that the suicide watch forms completed by correction staff are often 'prefilled' to include rounds at exact 15-

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 are not on-site to provide an assessment. On-call services are used in these instances, although discharging patients from crisis cells without a face-to-face assessment is not advised.

Pls. Tr. Ex. 115 at 11. Furthermore, ADOC observed, "Whenever possible, discharge decisions related to suicide watch and mental health observations should be made after a face-to-face assessment." *Id*. at 12. Ms. Naglich testified on December 20, 2016 that discharging a prisoner from suicide watch without a face-to-face evaluation by a psychiatrist would put a prisoner at risk. Dec. 20, 2016, Tr. Test. of Ruth Naglich.

Defendants have likewise been on notice of other problems related to suicide watch and crisis cell placement, including: having to transport prisoners long distances due to lack of sufficient safe cells in their home facilities; failure to raise the mental health codes of prisoners experiencing mental health crises (one mechanism for ensuring that such prisoners receive appropriate follow-up care after being discharged from suicide watch); and the availability of contraband in suicide watch cells; and the use of stabilization unit cells to house prisoners in segregation rather than prisoners in crisis. *See, e.g.,* Pls. Tr. Ex. 714, Apr. 22, 2015 CQI Meeting Minutes, at MHM029592; Pls. Tr. Ex. 1219, Email from Dr. Robert Hunter, MHM055163 Email from T. Houser to R. Naglich, et al., re Holman Corcerns with Crisis Cells, Segregation, Step Down, May 8, 2015.

II. Defendants Have Systematically Failed to Respond to the Substantial Risk of Serious Harm in an Objectively Reasonable Manner.

Though they have been on notice of the systemic failures to provide adequate mental health care to acutely suicidal prisoners and prisoners at risk of becoming acutely suicidal, Defendants have failed to respond in an objectively reasonable manner to this risk. Associate Commissioner Naglich testified she has never taken MHM to task for failing to meet the NCCHC standard regarding constant watch for acutely suicidal prisoners and that ADOC had never taken express efforts to comply with the standard. Dec. 20, 2016, Tr. Test. of Ruth Naglich.

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.* Though Plaintiffs and Defendants have recently discussed the implementation of constant watch for acutely suicidal prisoners and ensuring the appropriate assessment of prisoners on suicide watch, Defendants represented to the Court on December 21, 2016 that any such agreement reached is, at this point, unenforceable and "indefinite" in length. Plaintiffs and Defendants also continue to disagree as to the necessity of additional measures to ensure adequate care of suicidal prisoners, such as whether psychiatrists or psychologists determining whether to release prisoners from suicide watch must consult with such prisoners in person before making their determinations.

When asked by the Court whether an assessment of the physical adequacy of crisis cells and windows had been done throughout the ADOC system, Ms. Naglich stated that she did not know and that she had not personally done anything to ensure that cell doors were physically adequate. Dec. 16, 2016 Tr. Test. of Ruth Naglich. Later, when asked by the Court if anything had been done to fix the problems specifically with the Donaldson crisis cell doors, reported as early as late spring 2013, Ms. Naglich stated that she did not know. *Id.*; Pls. Tr. Ex. 689 at ADOC045465. Although she has been made aware of specific hazards in suicide

watch cells, and has informed Defendant Commissioner Jefferson Dunn and others within the ADOC of such hazards, Ms. Naglich does not, as of the date of her testimony, know if such hazards have been rectified. Dec. 21, 2016 Tr. Test. of Ruth Naglich.

Throughout the four days of her testimony, Ms. Naglich made clear that she has done little to nothing to rectify the problems with the provision of mental health care to acutely suicidal prisoners and prisoners at risk of becoming acutely suicidal. Likewise, the evidence already presented in this case makes clear that Commissioner Jefferson Dunn has also done little to nothing to rectify the problems.

III. Plaintiff Jamie Wallace's Death Exemplifies Defendants' Systemic Failures and the Imminent Risk of Serious Harm.

Defendants have known of individual instances of serious injury and death that have already occurred as a result of their failures to provide adequate mental health care to acutely suicidal prisoners and prisoners at risk of becoming acutely suicidal and yet continue to fail to respond to the imminent risk posed. For example, on December 15, 2016, Named Plaintiff Jamie Wallace was found hanging in his cell at Bullock Correctional Facility. Ex. 2, Jamie Wallace Med.

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 **more than 60 times** during the approximately five years he was in ADOC custody. As recently as October 26, 2016, psychologist Brandon Dearen recommended that he be evaluated at Taylor Hardin, the State's psychiatric hospital. *Id*. at ADOC0399938. The same day, MHM Certified Nurse Practitioner Dorothy Coogan recommended the same thing. *Id.* at ADOC0399878. And during his testimony in this matter, the Court ordered that Mr. Wallace be evaluated. Mr. Wallace was not evaluated at Taylor Hardin after Nurse Coogan recommended that

[5] Plaintiffs note that, to date, they have not received any records, other than Defendants' public statements, indicating how and when Mr. Wallace's body was discovered or suggesting how he might have died.

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 10, 2016 to December 13, 2016. *See generally* Ex. 2. They also show that Mr. Wallace received no counseling after he was discharged from suicide watch on December 13, 2016. *See generally* Ex. 2. Rather, Mr. Wallace's care providers at Bullock indicated that they believed he was malingering. *See, e.g.*, Ex. 2 at ADOC0399861. The records produced thus far also reflect that he was left unattended most of the day of his death. *See* Ex. 2 at ADOC0399818.

IV. Plaintiffs' Expert Has Testified That Numerous Practices by Defendants Put the Lives of Acutely Suicidal Prisoners at Risk.

Plaintiffs' expert Dr. Kathryn Burns testified to numerous, obvious instances in which Defendants' practices in dealing with suicidal prisoners pose a substantial risk that those prisoners will commit suicide or engage in other serious self-harm. Among other things, Dr. Burns testified that:

- ADOC does not maintain constant watch over suicidal prisoners in crisis cells;
- ADOC monitors suicidal prisoners at regular 15 to 30 minute intervals, thereby providing those prisoners with predictable intervals during which they can harm themselves;

- 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 injunction may cause the opposing party; and (4) that the injunction would not disserve the public interest. *GeorgiaCarry.Org, Inc. v. U.S. Army Corps of Engineers*, 788 F.3d 1318, 1322 (11th Cir. 2015). If a temporary restraining order is sought, the moving party must also show that immediate and irreparable injury will result before the adverse party can be heard in opposition. *See* Fed. R. Civ. P. 65(b)(1)(A).[6]

ARGUMENT

I. Plaintiffs Are Likely to Succeed on the Merits of Their Claim that Defendants Are Deliberately Indifferent to Serious Risks of Prisoner Suicide and Self-Harm Resulting from Defendants' Failure to Provide Adequate Mental Health Care.

The Eighth Amendment requires that prison officials adequately meet the serious mental health needs of prisoners. *See Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986). It also requires that officials "take reasonable measures to guarantee the safety of the inmates." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (internal quotations omitted). Officials violate the Eighth Amendment when they are deliberately indifferent to prisoners' risk of self-inflicted injuries, including

[6] Fed. R. Civ. P. 65(b)(1)(B), the attorney for the movant seeking a temporary restraining order must "certif[y] in writing any efforts made to give notice and the reasons why it should not be required." Yesterday, Plaintiffs filed a motion to file certain exhibits under seal, putting Defendants on notice of this upcoming filing. Given that the parties are in the midst of trial and have been actively discussing the issues presented by this Motion in and out of court, Defendants have received ample advance notice of the substance and fact of this filing.

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 ADOC Contract Compliance Review Reports, Pls. Tr. Ex. 1190, 1191, 114, 115, and CQI Meeting Minutes, *e.g.* Pls. Tr. Ex. 714, as well as ADOC records setting forth details of the last days of Plaintiff Jamie Wallace's life, clearly demonstrate that Defendants have actual knowledge of the substantial risk that acutely suicidal prisoners will commit

suicide or seriously injure themselves, but have failed to respond to this in a reasonable manner. Defendants are knowingly failing to provide the basic mental health care necessary to prevent prisoner suicide and self-harm.

II. Defendants' Failure to Adequately Monitor and Treat Suicidal Prisoners Creates a Substantial Threat of Irreparable Injury.

The injury at issue in this Motion—suicide or serious self-injury— is patently imminent and irreparable. It has happened before, notably in Plaintiff Jamie Wallace's case, and will happen again without this Court's intervention. Defendants' failure to adequately monitor and treat suicidal prisoners puts those prisoners at substantial risk of suicide and serious self-harm. Associate Commissioner Naglich has testified that, by failing to adequately monitor suicidal prisoners, Defendants are endangering lives. The serious physical injury and death that is likely to result from Defendants' practices cannot be rectified by damages. *See Scott v. Roberts*, 612 F.3d 1279, 1295 (11th Cir. 2010) (injury is irreparable if it "cannot be undone through monetary remedies" (internal quotations omitted)). Although Jamie Wallace's death illustrates the gravity of the current situation, Court "need not await a tragic event" before it may act. *Helling v. McKinney*, 509 U.S. 25, 33 (1993) ("It would be odd to deny an injunction to inmates who plainly proved an unsafe, life-threatening condition in their prison on the ground that nothing yet had happened to them.").

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 provide adequate staffing—and their subsequent failure to put suicidal prisoners on constant watch—means that prisoners could die. The records of Jamie Wallace and testimony of Dr. Burns further illustrate the severe injuries that have resulted and will continue to result from Defendants' failure to provide adequate mental health care to suicidal prisoners. Weighed against any administrative difficulties Defendants may incur, this threatened harm to suicidal prisoners necessitates injunctive relief. *Laube*, 234 F. Supp. at 1252 (finding that the defendants would "suffer no harm from providing sufficient staff and adequate facilities to reduce the risk of assault and harm to women prisoners"); *see also Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 705 (11th Cir. 1985) ("Lack of funds for facilities

cannot justify an unconstitutional lack of competent medical care and treatment for inmates."). Defendants have failed their constitutional duty to adequately monitor and treat suicidal prisoners. Even in the midst of this trial, another suicide has resulted from Defendants' inaction. The Court need not await yet another before it may act.

IV. A Restraining Order or Preliminary Injunction Would Be in the Public Interest.

The public has a substantial interest in preventing the preventable deaths of prisoners and safeguarding the rights afforded under the Constitution. *Laube*, 234 F. Supp. at 1252 ("[T]here is a strong public interest in requiring that plaintiffs' constitutional rights no longer be violated, as well as in prevention of the foreseeable violence that will occur if present conditions persist."). Defendants have disregarded their constitutional obligation to adequately monitor and treat suicidal prisoners, and the public would be served by an injunction requiring them to adhere to their constitutional duty.

V. Plaintiffs Should Not Be Required to Post Bond Under Fed. R. Civ. P. 65(c).

The Court should require no security or nominal security under Fed. R. Civ. P. 65(c), as Plaintiffs and class members are prisoners seeking compliance with their basic civil rights and injunctive relief to prevent further death and serious injury. *See BellSouth Telecomm., Inc. v. MCIMetro Access Transmission Servs.,*

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 Defendants Jefferson Dunn and Ruth Naglich, in their official capacities, and their officers, agents, servants, employees, attorneys and persons who are in active concert or participation with them from failing and/or refusing to do the following:[7]

[7] Plaintiffs have consulted with their experts, Dr. Kathryn Burns, Dr. Craig Haney, and Eldon Vail, regarding the specific details of the immediate relief they seek. All three experts are prepared to provide further testimony to the Court if necessary as to the appropriateness and necessity of the relief Plaintiffs seek.

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 are forwarded to the mental health contractor's Chief Psychiatrist (currently Dr. Robert Hunter) and ADOC's Chief Psychologist (currently Dr. David Tytell), who will review the assessments and request additional information as necessary;
3. Ensure that the contractor's Chief Psychiatrist and the ADOC's Chief Psychologist conduct monthly evaluations of completed suicide risk assessments and issue corrective actions and training based on the outcome of those evaluations;
4. Provide constant watch over ADOC prisoners who are acutely suicidal;
5. Implement a constant watch procedure that ensures one-on-one visual contact at all times, except to the extent that the physical design allows an observer to maintain an unobstructed line of sight with no more than two people on suicide watch at once;
6. Provide close watch (staggered intervals not to exceed every 15 minutes) over ADOC prisoners who are "nonacutely suicidal";

[8] "Acutely suicidal" and "nonacutely suicidal" are used as they are defined by NCCHC standard MH-G-04 (attached as "Exhibit 1")

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.

health professional) every 24 hours thereafter for the duration the prisoner's confinement in a suicide watch cell;

11. Ensure that prisoners admitted to the SU or the closed- or semi-closed RTU remain under constant watch until they are assessed through an in-person, confidential, out-of-cell evaluation with a licensed psychiatrist or licensed psychologist within 24 hours of admission, and if the person is admitted to the SU or closed- or semi-closed RTU from suicide watch, this evaluation must be distinct from the evaluation done when the person was released from suicide watch;

12. Ensure that any ADOC prisoner released from suicide watch receives evaluation and treatment following the discontinuation of suicide watch, which at minimum shall require in-person, confidential, out-of-cell evaluations by a licensed psychologist or licensed mental health professional within one, three and five days after being released from suicide watch;

13. Ensure that any ADOC prisoner released from suicide watch to segregation receives evaluation and treatment following the discontinuation of suicide watch, which at minimum shall require in-person, confidential, out-of-cell evaluations by a licensed psychologist or licensed mental health professional twice within the first 24 hours and at least daily for the next four days after being released from suicide watch;

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, and recommended remedies to the parties and the Court within the next forty-five (45) days;

21. Ensure that a plan for implementing the recommended remedies of the independent expert regarding the policies, practices, and procedures related to the SU and closed- or semi-closed RTU is in place within the next seventy-five (75) days;

22. Provide access to an independent expert, chosen by the parties or appointed by the Court, to conduct a physical inspection of all ADOC suicide cells, crisis cells, or safe cells and segregation cells for tie-offs and other recognized suicide hazards within the next thirty (30) days;

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 number of people on suicide watch delineated by "acutely suicidal" and "nonacutely suicidal," the number of people discharged from suicide watch delineated by discharge to the SU, to segregation, to the RTU, and to general population, the duration of each person's confinement on suicide watch, and any completed suicides; and

26. Allow an independent monitor, agreed to by the parties or appointed by the Court, to enter and access ADOC facilities during non-business hours for the purposes of monitoring compliance with the injunction or restraining order entered by the Court.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court enter a temporary restraining order or preliminary injunction as set forth in this Motion.

Dated: December 22, 2016

Respectfully Submitted,

__/s/ Maria V. Morris_____
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