

**Responses of Gustavus Adolphus Puryear IV
Nominee to the U.S. District Court for Middle District of Tennessee
To the Written Questions of Chairman Patrick Leahy**

- 1. In July 2004, while you served as Executive Vice President and General Counsel of Corrections Corporation of America, Estelle Richardson, a female inmate at the company's Metro Detention Facility in Nashville, Tennessee, was beaten to death. She was in a solitary confinement cell when she was found unresponsive; an autopsy revealed a skull fracture, four broken ribs and liver damage. Tennessee's Chief Medical Examiner, Dr. Bruce Levy, ruled her death a homicide, saying her injuries were consistent with blunt force trauma and could not have been self-inflicted.**

When asked about Ms. Richardson's death at your confirmation hearing, you testified "[T]here were a range of alternative explanations [for Ms. Richardson's death], many of which would not have involved a beating death that could have explained what happened." You testified that Ms. Richardson's rib fractures and the liver injury, in particular, could also have been consistent with CPR being performed, which you said "does commonly happen."

In a February 21, 2008, letter, Dr. Levy, who performed the autopsy on Ms. Richardson disputes your testimony that the cause of death could not be determined, citing his ruling that the case of Ms. Richardson's death was "Blunt force injuries of the head: and the manner of death was "Homicide." Both rulings are reflected in Ms. Richardson's autopsy report and death certificate.

In his letter, Dr. Levy's letter describes your testimony regarding CPR as a possible cause of the injuries as "misleading at best" and writes, "While CPR has been reported to cause minor injuries in some patients, both the location and severity of Ms. Richardson's injuries were not consistent with attempted resuscitation. Mr. Puryear's claim makes even less sense when taken in context with the more serious fatal head injuries, which line up with the rib fractures perfectly. There is no doubt in my mind that both the fatal head injuries and the rib fractures/liver damage were inflicted on Ms. Richardson while in custody and not the result of CPR." In addition, none of the publicly available pleadings in the civil lawsuit settled by CCA reference CPR as a possible cause of Ms. Richardson's injuries.

I am attaching Dr. Levy's letter and the autopsy and investigation reports he sent to the Committee. How do you explain the inconsistency between your testimony and Dr. Levy's autopsy report and ruling?

Response: The inconsistency between the autopsy report and my testimony arises from the inconsistency of the autopsy with the medical evidence developed by both the Richardson family and CCA over a two year period. Below, I will detail the process through which CCA and the Richardson family's investigations arrived at a conclusion at odds with the medical examiner.

At the outset, I want to make clear that the death of Estelle Richardson was profoundly distressing to me personally and professionally. The circumstances surrounding the initial report of her death were truly disturbing: a female inmate in solitary confinement dies of apparent head injuries mere hours after she had to be extracted from her cell by four corrections officers (a cell extraction is categorized as a "use of force" incident in corrections). Her death led to both federal and local criminal investigations of CCA and its employees, as well as civil litigation.

At my direction, CCA fully cooperated with all law enforcement authorities. Throughout the process, the four corrections officers who were under suspicion in connection with Ms. Richardson's death were placed on administrative leave and were not in the facility.

The four corrections officers who were indicted for homicide in connection with the Richardson death steadfastly maintained their innocence. Meanwhile, in the course of preparing for the civil litigation, both CCA's medical expert (a specialist in traumatic brain injuries who serves as the Deputy Chief Medical Examiner of the State of Tennessee) and the Richardson family's medical experts (a neurosurgery expert from Stanford University Medical School and a former Chief Medical Examiner of the Commonwealth of Kentucky) concluded that Ms. Richardson's death did not result from a brain injury within 24 hours of her death, and thus could not have been caused by the four officers who performed the cell extraction hours before her death.

I understand that the Committee has been provided a transcript of the settlement hearing in the federal civil case, which is now publicly available. In that hearing, the Richardson family's lawyer, David Randolph Smith, disputed the medical evidence underlying the criminal prosecution and noted that Ms. Richardson had a seizure disorder. He also opined that the homicide cases would likely "fall apart," as indeed they did. In a separate letter to this Committee dated February 25, 2008, Mr. Smith further stated:

[T]he circumstances and cause of Ms. Richardson's tragic death were complex and debated. Dr. Levy, the Tennessee medical examiner, attributed the cause of death to a recent traumatic brain injury (skull fracture). That opinion was contested vigorously by the defense and our own experts attributed the death to a seizure and concluded that the skull fracture was not caused by the four

guards who had been indicted. ... There were also issues on whether CPR may have caused the liver and rib injuries.

(Emphasis added.)

I stated at my hearing that I had been advised that the broken ribs and liver injury could have been caused by the cardiopulmonary resuscitation (“CPR”) that was performed on Ms. Richardson when she was found non-responsive in her cell. This was based on my recollection of an oral report made by CCA’s medical expert, Dr. McCormick. In addition to Mr. Smith’s letter, which notes that this was an issue, the Committee also has a letter from Dr. McCormick to one of CCA’s lawyers expressing in writing his view that these injuries are “almost certainly” attributable to CPR, though he cannot make a definitive conclusion because the medical examiner neither performed a microscopic examination of the injured tissue nor retained tissue samples that could be used to determine the precise timing of the injuries. Dr. McCormick also opines that such injuries commonly occur with CPR, and cites extensive medical literature to that effect.

It is unlikely that anyone will ever know the definitive cause of Ms. Richardson’s rib and liver injuries. It is known, however, that CCA cooperated fully with all law enforcement investigations into the death, and that CCA cooperated fully with the Richardson family in the civil litigation. It is known that the Richardson family voluntarily dismissed its civil actions against the four corrections officers who were under indictment. It is known that the Richardson family and CCA settled the dispute over the exact causes of the death and CCA’s liability, if any, in connection with those possible causes. It is known that the District Attorney General met with both CCA’s and the family’s medical experts. Last, it is known that the District Attorney General, who had access to Dr. Levy’s opinions and all of the police investigatory materials relating to this matter, then dismissed the charges against the four corrections officers.

Unfortunately, the medical findings by both the family’s and CCA’s experts do not permit a definitive conclusion as to how Ms. Richardson died. In my testimony to the Committee, I relied in good faith on these opinions. My opinion that there is substantial uncertainty regarding the cause of Ms. Richardson’s death was also shared by the lead lawyer for the Richardson family as expressed in his letter to the Committee. In sum, the inconsistency between my testimony and the autopsy is merely derivative of an inconsistency between the autopsy and the conclusions of the other medical experts retained by CCA and the Richardson family.

2. **Ms. Richardson’s death occurred in 2004 while she was an inmate under your company’s care, yet in your testimony nearly 4 years later you raise a wide variety of possible explanations, all inconsistent with the Medical Examiner’s autopsy and report. You testified: “There is a possibility—well,**

there are any number of possible explanations, including fights with other inmates, a fight with unknown correctional officers, self-inflicted wounds, medication issues. She had a history of seizures. I do not know what happened, Senator.”

A. What investigation did you or CCA undertake upon learning of Ms. Richardson’s death? Did your investigation determine or rule out any cause of death? Why or why not?

Response: First, CCA fully cooperated with law enforcement investigations into her death, and CCA believed that these investigations would determine the cause of her death, and who, if anyone, was responsible for it. Based on the initial reports surrounding Ms. Richardson’s death, CCA believed that this investigation would conclude rapidly; however, state and federal investigations continued for more than two years.

In addition, CCA’s outside lawyers investigated the possible causes of death through examination of records, interviews of cooperative witnesses, depositions taken during the civil case, and consultations with medical experts; this process also involved more than two years’ work.

CCA’s medical expert consulted directly with one of the Richardson family experts, Dr. Nichols (the former Chief Medical Examiner of the Commonwealth of Kentucky) to help determine a cause of death in a cooperative manner. Their shared conclusions are discussed above, in response to Question 1. In sum, the only “cause of death” that could be ruled out by CCA and the Richardson family was the one that was being used to prosecute the four corrections officers, namely that Ms. Richardson allegedly died from a head injury that could have occurred within 24 hours of her death. The experts consulted by the Richardson family and CCA agreed that the head injury was at least three days old, and there were still substantial issues surrounding what role, if any, that injury played in her death.

I agree with the view that David Randolph Smith, the lead lawyer for the Richardson family, expressed in his February 25, 2008 letter to this Committee: “In a nutshell our extensive investigation and expert analysis ... indicated that the circumstances and cause of Ms. Richardson’s tragic death were complex and debated.” After extensive law enforcement investigations, investigations by the Richardson family’s lawyers and CCA’s lawyers, and protracted and cooperative discovery efforts by the Richardson family and CCA, the exact cause of Ms. Richardson’s head injury and the precise role that injury played in her death are not known.

B. When did you first learn that Ms. Richardson had died? What steps did you take to determine what happened?

Response: As I testified at my hearing, the time and place of my learning of her death is seared into my memory. It was the morning of July 5, 2004, at around 9:00 a.m. I was told that detectives from the police department had been on the scene for some time. CCA cooperated fully and allowed these detectives access to any information, so that they might determine what happened. Additional steps relating to the criminal investigations and our efforts to understand what happened are detailed in response to Questions 1 and 2A.

C. What steps did you or CCA take to ensure that what happened to Ms. Richardson would not happen to other inmates?

Response: As soon as police investigators disclosed to CCA personnel on July 5, 2004 that they believed that four corrections officers involved in a cell extraction the day before Ms. Richardson's death may have been responsible for that death, CCA immediately placed the officers on administrative leave and kept them out of the facility. CCA then cooperated fully with the investigations by various law enforcement agencies and the plaintiffs' efforts in civil discovery.

As neither CCA nor the Richardson family knows with any certainty exactly what happened to Ms. Richardson, it would be difficult to know what steps could be taken to prevent it from recurring; however, CCA did implement certain remedial measures as result of what was learned from the circumstances surrounding the death.

Examples of actions that I understand the facility properly emphasized in the wake of the Richardson death included: following CCA policy concerning special needs medical assessments, both as to timing and documentation; additional in-service training regarding use of force policy (especially as it related to approval of uses of force, reporting of such uses, and the requirement that photographs be taken of an inmate following such a use of force); additional in-service training concerning video camera procedures; a written directive to medical staff requiring signed documentation by an inmate when she refuses medical treatment; and a written directive that inmates must be seen by the facility physician on the date of a scheduled appointment.

More broadly, as a result of this incident and certain other, unrelated incidents, within two months CCA's Chief Executive Officer decided that additional resources should be committed to the Company's Quality Assurance Department (which had approximately three employees at the time). He transferred the department to the Office of General Counsel to

give it independence from the Operations Department, which supervises facility operations. Under my leadership, the Quality Assurance department was completely reorganized. I placed a former Director of the Federal Bureau of Prisons in charge of the department and instructed him to design a new audit program. The department hired two five-person teams to conduct annual audits of each facility's operations. In addition, an analysis group staffed by employees with backgrounds in statistics was created within the department to review data collected from facilities and attempt to recognize trends that could point to management issues or other concerns within a facility.

Also within two months CCA's then-Chief Operating Officer resigned. That individual did not have a background in corrections. A new position, Chief Corrections Officer, was created and was filled by Richard P. Seiter. Dr. Seiter was serving as an Associate Professor in the Department of Sociology and Criminal Justice at St. Louis University. Dr. Seiter has had a distinguished career in corrections: he served in a variety of positions with the Federal Bureau of Prisons, including Warden and Assistant Director; he served from 1983-1988 as Director of the Ohio Department of Rehabilitation and Correction; and he has authored two textbooks on corrections management. Dr. Seiter has since reorganized the operations departments at CCA, implemented unit management and direct supervision within the Company's facilities, and sought to standardize procedures throughout CCA. Virtually every policy and procedure at CCA has since been re-written, and new training programs are in place.

3. **Please describe the steps taken by CCA personnel when Ms. Richardson was found unresponsive in a solitary cell, including whether and how quickly she received medical treatment on site and from whom? How soon after being found was she transported to Southern Hills Medical Center? How quickly did CCA call the local police and what law enforcement investigation of the circumstances surrounding the fatality occurred?**

Response: While I was not at the scene when these events occurred, and thus have no first-hand knowledge of these events, I can give you my understanding based upon the facility's documentation regarding this matter. It is my understanding that breakfast was served in Pod 1 of the Segregation Unit (where Ms. Richardson was housed) around 4:35 a.m. on July 5, 2004. Ms. Richardson came to her cell door and received her breakfast tray. When the corrections officers came back to her cell a while later to pick up her breakfast tray, Ms. Richardson was laying on her bed and did not respond when officers called her name. The officers entered her cell, checked her pulse, and immediately called a medical emergency (at 5:32 a.m.). Medical personnel and other corrections officers from the facility arrived immediately thereafter. 911 was called and the facility's medical personnel and corrections officers administered CPR and placed an Automated External Defibrillator on Ms. Richardson after checking Ms.

Richardson for a pulse and breathing. Paramedics arrived at approximately 5:43 a.m. and Ms. Richardson was thereafter transported to the hospital. Police officers arrived at the facility a short time thereafter and began their investigation; they were at the facility before I learned of the event at around 9:00 a.m.

While I was not privy to the investigation conducted by law enforcement, I do know that the state investigation of Ms. Richardson's death began on the morning of July 5, 2004, and the investigation continued by state and federal investigators for more than two years. Over that period, numerous CCA employees were interviewed by investigators and gave grand jury testimony, thousands of documents were produced by CCA to investigators, and CCA cooperated fully in the investigation.

4. You testified that if confirmed you would recuse yourself from cases involving CCA during the period in which you divested your interest in the company and for an extended period thereafter.

A. Would your recusal include cases involving CCA's executives, subsidiaries and employees?

Response: Yes.

In all cases, I would abide by the then-current statutes and Code of Conduct for United States Judges to ensure the absence of actual or apparent partiality and to ensure that the litigants receive due process of law. With respect to any action involving a CCA executive or employee not arising out of or related to their official activities for CCA (e.g., a personal bankruptcy appeal by a CCA employee), I would assess the facts of such a case with reference to relevant statutes and the Code of Conduct for United States Judges and make my decision accordingly. Applying these criteria, and given my personal relationship with current CCA executives, I would almost certainly recuse myself from any case involving a CCA executive in his or her entirely personal capacity for the foreseeable future due to the possible appearance of bias. After the passage of time and natural turnover in executive positions at CCA, this concern would likely dissipate.

B. Will you also recuse yourself from any cases involving the private prison industry, even if they do not directly involve CCA?

Response: I would not create an automatic recusal rule for such cases, but instead I would resolve any potential conflict of interest by complying with relevant statutes and the Code of Conduct for United States Judges. In the case presented in the question (which is exceedingly unlikely given that there are no other private prison operators conducting business in the Middle District of Tennessee), I do not believe that a typical case

involving other private prison operators would pose any actual conflict of interest, assuming I did not hold any direct financial interest in the operator. But one can envision hypothetical cases where appearance concerns might counsel in favor of recusal (e.g., a case that required interpreting a state statute that controls prison privatization generally). In the absence of concrete parties, facts and claims, I thus believe it would not be wise for me to opine definitively on this question.

C. Will you recuse yourself from lawsuits brought by prisoners, even if they do not directly involve CCA?

Response: I would not create an automatic recusal rule for lawsuits brought by a prisoner, but instead would look to the facts and circumstances of an individual case and apply the appropriate statutes and canons of the Code of Conduct for United States Judges to determine whether any recusal was necessary. I think it unlikely that recusal would be necessary, but would not want to opine on any individual case without knowing the particular parties, facts, and claims pleaded in that matter.

One way to think of this would be to consider the case of a public defender who is appointed as a district judge; a judge with such a background would likely consider the issue of recusal on a case-by case basis, rather than a blanket recusal from all criminal cases.

I think it important to know that my exposure to corrections over the past seven years has made me aware that there are, in fact, individuals in corrections who commit grievous crimes against inmates – ranging from physical abuse to sexual exploitation. Indeed, it is my personal belief that some individuals may be attracted to careers in corrections because they seek to control and exploit others, and, no matter how careful a corrections employer is in attempting to screen out such individuals, some may wind up being hired. I also know that some corrections officers become compromised by simple errors in judgment, and that those errors can have terrible consequences.

I have also seen first-hand the good that can come from corrections. I remember encountering an inmate at a facility who tied beautiful flies for fishing. The delicacy and precision of his work caught my eye, even though I had never before fly-fished. We talked about how he became interested in that hobby; how long it took him to tie various flies; and, ultimately, why he was in prison, when he hoped to get out, and what his dreams were for the future. I have likewise met former inmates who now work for CCA as counselors, who have movingly described their rehabilitation. So I have seen the humanity of those who are, and have been, incarcerated, and I understand that the hope for rehabilitation that

must be carefully nurtured in environments that are not always conducive to it.

In private practice, I saw a jury simply refuse to credit the testimony of a former inmate, who was my client, in spite of the fact that the corrections officials involved were effectively impeached and lacked credibility themselves – at least in my judgment. So I am aware that many in our society may never give an ex-inmate a fair shake.

In short, I think my experiences will make me particularly sensitive to issues raised in inmate lawsuits. And, there are other, objective actions that I believe demonstrate my personal commitment to the humane treatment of inmates:

- Volunteering to serve as an appointee of the National Prison Rape Elimination Commission;
- Defending the civil rights of an inmate in a lawsuit against a Tennessee Department of Corrections warden and other staff;
- Instituting an aggressive, new quality assurance program while at CCA to promote inmate welfare and ensure high-quality operations;
- Settling meritorious inmate lawsuits for substantial monetary awards; and
- Implementing CCA's first corporate compliance program and drafting the company's first Code of Ethics and Business Conduct, which includes standards of conduct to protect inmates and provides for anonymous reporting by employees of possible mistreatment of inmates by staff.

I close with a statement I made on the record, long prior to this nomination, when commenting on my visits to corrections facilities operated by CCA:

[T]here is a human dimension to our business, not just for our employees, but also the inmates entrusted to our care. So you're aware, every day, that this company has to conduct itself with absolute integrity, because the lives of the people we're housing depend on it, the lives of the people who work for us depend on it, the lives of those outside of our facility who depend on us to protect them depend on it. So you're acutely aware of that dimension and of the good that can come from corrections.

Greg Land, "No More Get Out of Jail Free," GC South October 2005 at 21.