TESTIMONY

of

Stuart M. Andrews, Jr.

on behalf of:

Joy C. Jay, Guardian *ad Litem* for
T.R., P.R., K.W., and A.M. on behalf
of themselves and others similarly situated;
and Protection and Advocacy for People
with Disabilities, Inc.

on

Reassessing Solitary Confinement:
The Human Rights, Fiscal, and Public Safety Consequences

before the
Subcommittee on the Constitution, Civil Rights and Human Rights
Committee on the Judiciary
United States Senate

JUNE 19, 2012

Chairman Durbin, Ranking Member Graham, and Honorable Committee Members,

Thank you for your interest in these issues of enormous significance to men and women incarcerated in prisons and jails throughout our nation. I am grateful for the opportunity to provide the Subcommittee with information concerning the use of solitary confinement in South Carolina prisons, particularly the use to which inmates diagnosed with mental illness are exposed.

Nelson Mullins law firm represents a class of inmates with serious mental illness in South Carolina prisons, many of whom have spent significant time in solitary confinement. I am appearing today on behalf of that class and its guardian *ad litem*, Joy C. Jay, as well as on behalf of Protection and Advocacy for People with Disabilities, Inc. (P&A), a South Carolina nonprofit organization charged by federal and state law to protect and advocate for the rights of people with disabilities.

After years of investigations, reports, and negotiations, the inmate class and P&A filed suit in South Carolina state court in June 2005 against the South Carolina Department of Corrections, alleging violations of the South Carolina Constitution's prohibition against cruel and unusual punishment and seeking injunctive relief to require the provision of adequate mental health services. After more than six years of litigation, a bench trial was held in February and March of 2012. No ruling has been entered to date.

A major issue in the trial was the extensive reliance by the Department of Corrections on solitary confinement as a means of managing inmate conduct, particularly inmates with mental illness. During their imprisonment, half of the nearly 3,000 men and women with mental

illnesses on the Department's caseload have been held in solitary confinement for periods averaging almost two years.

The effects of conditions in solitary confinement in South Carolina's prisons can be harmful for anyone, but they particularly expose individuals with mental illness to substantial risks of serious future harm – the applicable Eighth Amendment standard. To illustrate some of what we have learned about the operation of solitary confinement in South Carolina prisons, I would like to call to your attention three individuals who are, or in one case was, a member of the class of inmates we represent.

A. Theodore Robinson

Theodore Robinson is a 50-year old man with paranoid schizophrenia serving a life sentence in the South Carolina Department of Corrections. Mr. Robinson's speech is highly disorganized and he has a history of bizarre behavior, such as drinking his urine. Like many people with schizophrenia, he suffers from hallucinations and delusions. For example, he believes that at night while he sleeps doctors secretly enter his cell and perform surgery on him.

From 1993–2005, a period of twelve consecutive years, Mr. Robinson was kept in solitary confinement. Fifteen days after our lawsuit was filed, the Department removed Mr. Robinson from solitary and placed him in its psychiatric residential program. Ex. 1.

B. Overrepresentation of Mentally Ill Inmates in Solitary Confinement

Other inmates with serious mental illness have not been so lucky. In South Carolina mentally ill inmates are twice as likely to be in solitary confinement as inmates without mental illness (15.81% v. 7.85%); two and a half times as likely to receive a sentence in solitary that exceeds their release date from prison (4.65% v. 1.86%); and over three times as likely to be assigned to an indefinite period of time in solitary (8.66% v. 2.78%). Ex. 2.

Mentally ill inmates placed in solitary confinement in South Carolina prisons are not limited to those with mild mental disorders. Like Theodore Robinson, many are diagnosed with schizophrenia or other serious mental illnesses, such as bipolar disorder, schizoaffective disorder, or major depression. A Department of Corrections psychiatrist at Lee Correctional Institution, for example, estimated that 40-50 percent of her patients in solitary confinement were "actively psychotic." Ex. 4.

C. Conditions and Access to Mental Health Services in Solitary Confinement Units

Testimony at our recent trial confirmed that inmates in solitary are confined to their cell 23-24 hours a day. They are not allowed to hold a prison job or to attend educational classes, religious groups, or any structured therapeutic activities. Phone calls and visitation often are suspended for years at a time. Sessions with psychiatrists and mental health counselors are rarely held in confidential settings, but instead in the presence or hearing of correctional officers and other inmates.

Sessions with psychiatrists and counselors are not only lacking in confidentiality, they are infrequent and irregular. Edward Barton is another South Carolina inmate who, like Theodore Robinson, is diagnosed with paranoid schizophrenia. Mr. Barton has spent the past eight years in solitary. He is scheduled to remain there until 2016, when he will be released from prison, straight from solitary confinement into society. Mr. Barton has visual, auditory, and tactile hallucinations. He sees dead people and floating fire; voices tell him his relatives are dead and order him to set his cell on fire; he feels flames burning his arms and the soles of his feet. By policy, Mr. Barton is supposed to see a mental health counselor every 30 days, but his medical records show that during a sixteen-month period from July 2008 to November 2010 there were:

- four occasions where over 60 days passed without a counseling session; and

- one period of 9 months without a counseling session.

Ex. 5. Mr. Barton's contact with psychiatrists while in solitary is also limited. During one eleven-month period in 2010-2011 he went four months without seeing a psychiatrist, then went another six months before seeing a psychiatrist again. Ex. 6.

D. Lengths of Stay in Solitary

Edward Barton and Theodore Robinson are not the only South Carolina inmates with mental illness who have spent years in solitary confinement. Evidence presented at trial showed that it is not uncommon for inmates with serious mental illness to be confined in solitary for five years, ten years, or longer.

In South Carolina there are two forms of punitive solitary confinement: (1) disciplinary detention (DD), in which an inmate is sentenced to a specific length of time in solitary for violation of Department rules; and (2) security detention (SD), in which an inmate is assigned to solitary for an indefinite length of time after a determination that the inmate poses a security risk. As of September 1, 2011, the length of the average cumulative DD sentences for inmates without mental illness was 383 days; for inmates with mental illness it was 657 days, almost 2 years. Ex. 7.

The Department has a policy called "Guilty But Not Accountable" or "GBNA," which in theory should reduce time served in solitary confinement for mentally ill inmates, but which in practice is meaningless. Under the policy, when a mentally ill inmate is charged with a disciplinary infraction his mental health counselor makes a recommendation to a hearing officer on whether the inmate should be held accountable for his actions. The Department's mental health counselors, however, are not qualified to make such determinations, as only thirteen percent are licensed. Ex. 8. Counselor attitudes towards inmate accountability are reflected in

the testimony of the Regional Mental Health Coordinator for one of South Carolina's four administrative regions, who testified under oath as follows:

> Q: What effect does mental illness have on an inmate's ability to. . . to comply with rules of prison?
>
> A: None.
>
> Q: None?
>
> A: None.

Ex. 9.

Given such attitudes, it is not surprising that the GBNA policy has had no effect on the solitary confinement sentences of mentally ill inmates. A review of Departmental records of 1,252 mentally ill inmates sentenced to solitary confinement from 2009-11 revealed that only 25 (2%) had been found "Guilty But Not Accountable." Moreover, for those 25 inmates the finding that they were not accountable for their actions had had absolutely no effect on the length of their sentences in solitary. Ex. 10.

E. <u>Crisis Intervention</u>

A particularly disturbing form of solitary confinement in South Carolina is the practice known as crisis intervention. Although crisis intervention is considered a clinical status for inmates who are suicidal or threatening self harm, the Department places crisis inmates naked in stripped-out solitary confinement cells located in disciplinary lockup units. Stripped-out cells consist of nothing but steel and concrete. Inmates testified that on crisis they seldom receive a blanket, are never provided a mattress, and are forced to sleep on concrete or steel bunks without any bedding material. Inmates describe crisis intervention cells as cold and filthy, with floors and walls smeared with the blood and feces of previous inhabitants.

Lengths of stay in crisis cells typically range from a few days to two weeks, but records show some inmates are kept in these conditions for months. Except for greater restrictions, inmates in crisis are treated as other inmates in solitary. Inmates testified that when on crisis they remain in their cells 24 hours a day, seldom are permitted to shower, are not allowed to participate in structured therapeutic activities, and rarely see a psychiatrist. Contact with mental health counselors is through the cell door, brief, impersonal, and not confidential.

From 2008-2010 at least one South Carolina prison, Lieber Correctional Institution, routinely placed crisis inmates naked in shower stalls, rec cages, interview booths, and holding cells for hours and even days at a time, as documented in Department logs. Ex. 11. Typically, these spaces did not have toilets and were not suicide resistant. Established to provide a therapeutic setting, crisis intervention in South Carolina prisons instead is a punitive process, in most cases wholly devoid of any therapeutic benefit.

F. Death by Neglect: Jerome Laudman and Lee Supermax

Perhaps the single most deplorable solitary confinement unit in the South Carolina prison system is the cellblock at Lee Correctional Institution known as Lee Supermax. Department officials insist this is not a true maximum security unit and prefer to characterize it as the "cells with private showers." Lee Supermax cells do, in fact, have private showers controlled by security staff, but the shower drains are usually stopped up, according to inmate testimony. As a result, when the showers are turned on they flood the cells, leaving standing water up to six inches high. Inmates describe the cells as cold, vermin-infested, and filthy.

On February 18, 2008 an inmate named Jerome Laudman was found in a Lee Supermax cell, lying naked without a blanket or mattress, face down on a concrete floor in vomit and feces. He died later that day in a nearby hospital. The cause of death was a heart attack, but hospital

records also noted hypothermia, with a body temperature upon arrival at the hospital of only 80.6 degrees. Ex. 12 at 900-01, 909.

On June 8, 2008 an internal investigator for the Department of Corrections issued a report on Mr. Laudman's death. Ex. 12. That investigative report is the source for the following information.

Jerome Laudman suffered from schizophrenia, mental retardation, and a speech impediment. Ex. 12 at 908. According to his mental health counselor, Laudman had never acted in an aggressive or threatening manner. *Id.* at 909. On February 7, 2008 – eleven days before his death – Laudman was moved to Lee Supermax, purportedly for hygiene reasons, because he refused to shower, although no one admitted to ordering the move. *Id.* at 901-03. A correctional officer told the investigator that the lieutenant in charge physically threw Laudman, who was naked and handcuffed, into the Supermax cell, even though Laudman was not resisting. When the lieutenant realized he had placed Laudman in the wrong cell, he took him out and "shoved" him into another cell, where Laudman, still handcuffed, fell on the concrete bunk. *Id.* at 901. According to his mental health counselor, Laudman was not on crisis intervention, even though he was placed in Supermax without clothing, blanket, or mattress. *Id.* at 902. The mental health counselor stated he was never made aware of Laudman's transfer to Supermax. *Id.*

On February 11, one week before Laudman's death, a correctional officer saw him "stooped over like he was real weak or sick." The officer noticed styrofoam food trays piled up inside his cell door that no one had collected. He considered notifying a unit captain or administrator about Laudman's condition but his supervisor advised him against it. *Id.* at 904. Two other Supermax inmates grew concerned because Laudman was "ignored by officers" and

three or four days had passed without any noises from Laudman's cell. The inmates warned officers that Laudman was not eating or taking his medicine. *Id.* at 903-04.

On the morning of February 18, Officer Shepard saw Laudman lying on the floor of his cell in "feces and stuff." Shepard notified his supervisor, but was told "not to stress about it." Shepard noted that Laudman stayed in the same position all morning. *Id.* at 905.

That afternoon two nurses, Andrews and Thompson, were called to Laudman's cell where they observed him lying facedown covered in feces and vomit, but still alive. The styrofoam trays were still there, containing rotting, molding food. One of the nurses described the stench from the cell as the worst thing she had ever smelled. *Id.* at 905-07.

The conditions were so foul that both nurses and officers who had joined them refused to enter the cell to remove Laudman. Instead, they called for two inmate hospice workers, and waited a half hour before they arrived. After the inmate hospice workers removed Laudman from his cell he was transported to a nearby hospital, where he died later that day. *Id.* at 905-07.

The Department of Corrections never ordered a quality assurance review in the aftermath of Laudman's death. Seven months after Laudman's death, Plaintiffs' experts inspected Lee Supermax and described it as "filthy." Ex. 13. At the 2012 trial the Lee warden testified that he had never personally visited or inspected the cell where Laudman died.

G. Conclusion

In South Carolina a disproportionate number of mentally ill inmates are placed in solitary confinement. Many are actively psychotic. Conditions are atrocious, mental health services inadequate, and stays inhumanely long. Theodore Robinson was fortunate – after twelve consecutive years in solitary he was transferred to a psychiatric residential program (coincidentally, just two weeks after he sued the Department of Corrections). Jerome Laudman

was not so fortunate – after eleven days in Lee Supermax he died of neglect in a cold, filthy cell. For Edward Barton, the story is ongoing. Will he be released from prison into society as scheduled in 2016, after twelve consecutive years of solitary? Will he receive adequate treatment meanwhile to stabilize his profound schizophrenia? How well will solitary prepare him to handle the transition back into society? These questions, and their implications for the constitutional, civil, and human rights of all mentally ill inmates in South Carolina prisons, remain unanswered.