EXHIBIT B

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Zavala v. City of Baton Rouge/Parish East Baton Rouge, et al.

Preliminary Report

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I. Overview

In 2015, the Warden of the East Baton Rouge Parish Prison ("EBR"), the Sheriff of East Baton Rouge and the Sheriff's attorney addressed the City of Baton Rouge/Parish of East Baton Rouge Metropolitan Council ("Council") and testified that EBR was an old facility in very poor condition and that in particular, it could not safely incarcerate mental health inmates. The Chief Administrative Officer for the Parish and City concurred and told the Council that the situation was an emergency and, prophetically, that increased funding for EBR was a life and death matter for mentally ill inmates there.

The Council hired a health services consulting firm to do a comprehensive analysis of the healthcare and mental health care facilities and operations at EBR. That consulting group, Health Management Associates ("HMA") presented a detailed report to the Council in mid 2016 that corroborated the earlier public testimony about EBR. The report specifically found that EBR facilities, services and operations were inadequate or inappropriate for mental health inmates. Parish officials, EBR managers and HMA were in agreement that the largest barrier at EBR to housing mental health inmates safely was the lack of a dedicated mental health housing unit and inadequate staffing. Rather than take steps to implement HMA's recommendations, the Parish and EBR did nothing more substantial than to privatize the provision of health care services and marginally increase the budget in response to these warnings and continued to incarcerate mentally ill inmates, including the severely mentally ill, at EBR, essentially under the same conditions.

Jonathon Fano was a small, slight Hispanic male with a history of serious mental illness. On October 30, 2016, he was arrested in downtown Baton Rouge, Louisiana partially naked, hallucinating and delusional and taken to EBR. There, his history and condition were ignored at intake and he was put in general population where he attempted suicide within hours. Rather than providing treatment for Mr. Fano, EBR sentenced him to 20 days punitive segregation for his suicide attempt and then left him in segregation housing, largely without treatment, programs or review for three months, until his suicide. Inmates complained to the segregation staff and to the medical/mental health staff that Mr. Fano was acutely mentally ill and that he was constantly asking for a razor so that he could kill himself.

In late January, 2017, Jonathon Fano tried to commit suicide by hanging but the literature broke and he fell with a loud noise, alerting other inmates to his suicide attempt. They again notified staff that he needed help but the case record provides no indication of any staff response. A few days later, on February 2, 2017 Mr. Fano successfully committed suicide by hanging himself in his cell. His tragic death was predictable and almost certainly preventable.

Mr. Fano's history at EBR prior to his suicide is more than disturbing. He was kept in segregation housing for all but two days of his more than three months at EBR. This alone was a major violation of accepted correctional standards. He was allowed out of the cell for 15 minutes a day, four days a week and 30 minutes a day, three days a week. He had no access to programs. After his initial phone call home immediately after his arrest, he was unable to successfully place a call to his loving and supportive family until Christmas Day, 2016. In spite of inmate warnings, neither security staff nor medical/mental health staff noticed when Mr. Fano did not come out of his cell for his hall times, when he was actively hallucinating or, most importantly, when he was asking for a razor to kill himself, nor did they act when fellow inmates informed them of these behaviors. EBR's psychiatrist saw Mr. Fano once after his initial suicide attempt and did not see him again until January 18, 2017, when he decided Mr. Fano wasn't seriously mentally ill and ordered his antipsychotic medication be stopped in a week's time. A few days after his medication was discontinued, Mr. Fano committed suicide.

II. Introduction and Background

My name is Jeffrey A. Schwartz, Ph.D., and my office is at 1610 La Pradera Drive in Campbell, California. I am the president of Law Enforcement Training and Research Associates, Inc. (LETRA), a criminal justice training and consulting organization that has had offices in the San Francisco Bay area since its incorporation in June, 1972. I have worked full time with law enforcement and correctional agencies across the United States and Canada for over 35 years, both as LETRA's president and as a private consultant. The largest proportion of my work for the last 20 years has been working with prisons and jails, assisting them in applying national corrections standards to their operations for, among other things, preventing foreseeable suicides in those facilities. I have worked with more than 40 of the 50 state departments of corrections and with small, medium and large jails and local departments of corrections. During my career I have worked with and toured literally hundreds of prisons and jails. Particularly in my work conducting operational reviews of jails and prisons, I have reviewed inmate access to health care and related issues, such as the inmate grievance system and the nature of medical staff-inmate interactions, on many occasions. I have also specifically reviewed the training of correctional staff on medical issues and the medical staff compliance with contract issues, both in my expert witness work and my consulting activities.

I have served as an expert witness for both Plaintiffs and Defendants on more than 15 inmate suicide cases. I have written or co-written chapters in training texts for correctional staff on suicide and suicide prevention in jails and prisons. I have spent hundreds of hours training and certifying correctional staff as instructors for the suicide prevention training that I developed. Additionally, analyses of suicide prevention policies, practices and facility "hardening" against suicide, have been a major component of many of the operational reviews of jails and prisons I have conducted.

I am currently a Federal Court Monitor of a consent decree on conditions in the Los Angeles Jails. I am also a Federal Court Monitor for a consent decree in the San Bernardino, CA jails. I was also a Federal Court appointed security expert in a U.S. Virgin Islands Jail consent decree. I have

frequently conducted operational reviews of jails and prisons for the National Institute of Corrections (NIC) a branch of the U.S. Department of Justice. Over the past 35 years, I have co-authored three book length monographs published under NIC auspices. A copy of my resume is attached to this report as Appendix A.

I have served as an expert on law enforcement and corrections issues for more than 15 years. In the last few years, expert work has constituted approximately 15% to 40% of my total professional time. I charge $325 per hour for consultation, document review and other preparation activities and $425 per hour for actual testimony at trial or in deposition. My compensation will not be affected by the outcome of this case. A copy of cases I have worked on as an expert is attached to this report as Appendix B. A copy of my fee schedule is attached as Appendix C. Also, my recent publications are also attached to this report as Appendix D.

I was retained as an expert in this action by David Utter, Esq. of The Claiborne Firm. P.C., of Savannah, Georgia, in November, 2017. Mr. Utter represents the Plaintiff in this case, and he requested a written report of my professional opinions about this case.

A list of documents I reviewed for this case is presented as Appendix E to this report.

In addition to the documents listed in Appendix E, I also reviewed the American Correctional Association Jail Standards, "Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, June, 2004; the National Commission on Correctional Health Care standards, "Standards for Health Care Services in Jails", 2014, and the State of Louisiana Jail Standards.

I am not a medical expert and I have not been asked nor have I attempted to form opinions about medical treatment issues in this case. As an expert on law enforcement and corrections issues for more than 25 years, however, I understand well the critical importance of health care and corrections staff coordinating and communicating to work together to protect inmates in their care, custody, and control.

I requested a tour of the areas of EBR relevant to this case and that tour was scheduled but then cancelled at the last moment and it is my understanding there is a motion in front of the Court requiring that EBR accommodate my request to tour/inspect. I believe such a tour will assist me to further develop opinions in this case, which is why this is a preliminary report.[1]

This case is one of three suicide cases filed against the City of Baton Rouge and other Defendants by Mr. Utter and the Claiborne Firm, representing the various Plaintiffs in these cases. I have been retained as an expert in all of these cases. For obvious reasons, these three lawsuits are not independent of each other. EBR, the EBR policies, the EBR management, and some other factors are either the same or similar in all three of these cases.

I reserve the right to add to or change the opinions in this report if and when additional relevant information becomes available to me after the date of this report.

A note about abbreviations and references may be helpful. Throughout this report, I have referred to the East Baton Rouge Parish Prison as "EBR." When the reference is to the East Baton Rouge

[1] On April 24, 2018, I toured EBR for Plaintiff in the *Lewis v. City of Baton Rouge, et al.* matter, another suicide case. While the focus of that matter was the Q8 dorm and a different segregation unit, M01, I was able to walk down the N01 line. I did not physically tour the N02 line because I was told that the conditions and layout on N02 are identical to N01.

Sheriff, that term is spelled out. I have referred to the various living areas of EBR as "units," as in "the N02 Unit," although most of the inmates and the some of the staff refer to the various housing areas as "lines," because of the linear nature of many of the housing areas. "Housing Unit" is common and generic while "line" is local and colloquial. With regard to time, if I have not specified a particular time in a discussion, then the reference is to the late October, 2016 to early February, 2017 time frame when Jonathan Fano was incarcerated in EBR.

All of my opinions in this report are to a reasonable degree of professional certainty.

III. Method

A. The crux of this case is Plaintiff's contention that Defendants had a duty to protect inmates in EBR from the known threat of harm, including harm from known medical and mental health conditions and harm from suicide by providing medical and mental health care commensurate with accepted community standards of care, and by providing comprehensive suicide prevention policies and practices consistent with contemporary correctional practices across the United States. Defendants knew that if they failed to fulfill that duty it was reasonably predictable that one or more inmates would suffer serious harm up to and including death; that Defendants did in fact fail in their duty to protect the inmates in EBR from medical distress and failed specifically with Mr. Fano; and that his death was a direct result of Defendants' failure to protect him from the known threat of suicide. Defendants argue that they fulfilled their duties to protect Mr. Fano.

B. Within contemporary American corrections there is well-established methodology for addressing the kinds of questions raised in this case. The first step is to determine the applicable duties, looking to relevant law and regulations, to departmental policies and procedures, to professional standards and to widely accepted correctional standards and practices. The second step is to determine whether the various duties identified have been complied with or have been breached by examining the documents and other information available in the case as well as facts from other sources that might illuminate the defendants' compliance or lack of compliance with the various duties identified. An additional step in this analysis is to examine the existing policies, procedures and practices to determine whether they are wrongly formulated or insufficient. That is most often accomplished by comparing them to legal and regulatory requirements and/or to comparable policies, procedures and practices in use in other correctional agencies. An additional important step in this method is to, where possible; review the results of the policies, procedures and practices in question to determine whether they have been effective at accomplishing their objectives.

C. The method summarized above is not exclusive to expert analysis of prisoner tort cases alleging failure to protect. It is also the general method used for auditing correctional institutions for accreditation, whether by the American Correctional Association (ACA) or by the National Commission on Correctional Health Care (NCCHC). It is also used as a major component in critical incident reviews (also called "after-action reports") following major crises or emergencies in jails or prisons. This consultant has used this method for critical incident reviews following a number of very high profile crises in correctional institutions and I have also used this methodology as the central approach on the occasions when I have been commissioned to evaluate the emergency readiness of a particular correctional agency or correctional facility.

D. In addition to the method discussed above, the analysis of the record in this case must also reach the questions of whether it was reasonably predictable that the harm that occurred to Mr. Fano would occur if the various identified duties of the Defendants were not fulfilled, and whether the harm that befell Mr. Fano in this case was a direct result of the breach of those duties by the Defendants.

E. The second method has to do with situations in which there are fundamental disagreements about what factually transpired. The first step in this procedure is to identify each action, behavioral procedure or other occurrence according to each side in the factual dispute (and it is possible that there are more than two sides). Then, each of these disputed steps, behaviors, actions, decisions, or the like must be analyzed against prevailing practices in the facility, specific agency policies and generally accepted correctional practices. They must also be analyzed for internal consistency. That is, from the standpoint of correctional policies, procedures and practices in the facility, as well as generally accepted correctional practices, are the various occurrences, decisions and behaviors described by the Plaintiff consistent with each other? Put another way, does the Plaintiff's story make sense, not because of the credibility or lack of credibility of the Plaintiff, but because of what is known about prison policies, procedures and practices. Then the same analysis must also be performed with regard to the Defendants' story.

IV. The Duty to Protect

A. There is no question that County/Parish jails have an obligation to protect inmates from known threats of harm, including self-harm. In general, when individuals are incarcerated there are a number of ways in which they cannot protect themselves. That protection becomes the responsibility of the incarcerating authority. The classic example is that in a fire, inmates locked in their cells are as helpless to protect themselves as horses locked in a barn. Likewise, the duty of jails and of jail staff to protect inmates from harm is long-standing, basic and consensually accepted throughout U.S. corrections. This duty includes the duty to protect inmates from violence from other inmates, the duty to protect them from excessive staff uses of force, and the duty to protect them from the known risk of self-harm.

B. Moreover, a person in the community can take themselves to a hospital emergency room or other emergency clinic if seriously and acutely ill, while an incarcerated individual is dependent on the correctional facility to provide access to medical and mental health care. Without access to medical care, the seriously ill person may suffer permanent harm or even death.

C. A second problem is that the medical care in a correctional facility must be adequate. If it is substantially sub-standard compared to care in the community, then serious harm or even death may result.

D. There has been a strong trend over the last thirty years for jail and prison systems to contract with third parties for inmate medical services, and often inmate mental health services as well, with private providers that specialize in providing such services to correctional facilities. It is important to note that contracting for these services does not in any way diminish a jail's duty to provide medical and mental health services that are not deliberately indifferent to the serious needs of the jail population. A jail cannot "contract away" its Constitutional duty to provide adequate medical and mental health care to inmates.

E. The specific duty of jails and jail staff to protect inmates from medical disorders by providing comprehensive medical and mental health services while in jail is well established and found in state and federal case law, in state statutes and/or state jail standards, in national jail standards and in policies in almost all jail systems.

F. The duty to provide medical and mental health services to jail inmates is not esoteric. It has received a great deal of attention nationally over the last thirty years within the field of corrections and is a central concept in jail management.

G. Defendants do not dispute their general duty to protect inmates from known risk of harm nor do they dispute their specific obligation to provide medical and mental health services, including suicide prevention services, to inmates at a level that is consistent with the standard of care in the community.

V. Analysis and Opinions

A. The General Condition and Operation of EBR

1. Before reviewing the specific issues that affected Jonathan Fano prior to his suicide at EBR in early February 2017, it is important to look at the context within which that suicide occurred. That is, what kind of a jail was EBR? The answer is clear: EBR was a very bad jail. It was not the worst jail in the United States, but it would have been at home in that competition. Every aspect of the jail, from staff use of force to inmate-on-inmate violence, to policies and procedures, to staff professionalism, and much more, ranged from inadequate to deplorable. This case record provided information on many aspects of EBR and none of that information was positive or encouraging.

2. There is no single criteria or set of criteria that is consensually accepted as measuring the quality of a jail. However, one measure that is something of a "bottom line," is death rates within the facility. In 2012, the death rate per hundred thousand prisoners in the United States was 129 but at EBR, that same year, the mortality rate was 532, or more than four times the national average. In 2013, the mortality rate for EBR prisoners was 34% higher than the national average. In 2014, the mortality rate at EBR had risen to 90% higher than the national average (US DOJ, Bureau of Justice Statistics, "Mortality in Local Jails 2000-2014"; Farris, S. and Armstrong, A., Dying in East Baton Rouge Parish Prison; July 2018). Death rates at EBR declined somewhat in 2015 but were still substantially above the national average and then in 2016 approximated 300% higher than the national average. In January, 2017, the Council changed from medical and mental health services at EBR operated by the Parish (Prison Medical Services, or "PMS") to a private, for-profit, health services company, CorrectHealth. That change might have been predicted to decrease the extraordinary mortality rates at EBR but instead the mortality rate, in the two and a half years after CorrectHealth assumed responsibility, reflected a 36% increase when compared to the already extremely high death rate for previous the five years at EBR. Put another way, the 17 deaths in the two and one-half years after CorrectHealth took over at EBR is more than three times the national average (140 per 100,000) for deaths in jails (Walter Smith deposition, Exhibit 2).

3. It is not the intent of this report to attempt an analysis of all facets of the EBR operation. Still, a surprisingly informative sense of the nature of EBR can be found in the experience

of two former inmates. Daniel Hinton was an inmate at EBR and was housed on N02 at the same time that Jonathan Fano was there. Mr. Hinton had been at EBR before and testified that sometimes a new inmate would not see a medical person at intake (Hinton deposition, pgs. 18-19, lines 15-3), an allegation confirmed by an assessment of EBR's health care system performed in 2016 by HMA. He said there were always problems at EBR because people there simply did not do their jobs (Hinton deposition, pgs. 20-21, lines 14-15). He said that he had been misclassified and filed a grievance, but nothing was done about that (Hinton deposition, pgs. 21-22, lines 16-6). He said that this time he was initially placed on Unit F5 for a few hours but that inmates there jumped him and would have killed him except that the staff happened to call for mealtime. The beating left him with fractured ribs and a broken ear drum (Hinton deposition, pgs. 23-24, lines 9-18). Mr. Hinton said that even if you had a medical emergency, you wait. "They see you when they see you." That was true even when he experienced chest pain (Hinton deposition, pgs. 30-31, lines 5-15). Mr., Hinton also said that the medical staff were rude and not professional (Hinton deposition, pgs. 66-67, lines 16-6). With regard to the serious beating Mr. Hinton suffered at the hands of other inmates, he was asked at his deposition about his experience in other jails and Mr. Hinton noted that he had been in several other jails but getting beaten by other inmates was "mostly an EBR thing." (Hinton deposition, pg. 123, lines 9-17).

4. Frank Brooks had been incarcerated for six days at EBR in 2011 and then was back at EBR beginning on January 18, 2017. He was initially placed on Unit F3 but was assaulted by other inmates there and was then placed on suicide watch for approximately five days. He got no medical attention for his bloody nose and bloody lip that he received during the fight on F3 (Brooks deposition, pgs. 14-15, lines 15-4). Mr. Brooks testified that he was put on suicide watch in spite of the fact that he had not threatened suicide and was not suicidal. He said that he was placed on suicide watch by Deputies who were angry at him because he would not inform on the inmates who had been in a fight with him (Brooks deposition, pg. 18, lines 1-20). Mr. Brooks testified that no nurses were called after the fight or to his suicide cell after that, and that when he was taken off suicide watch, his nose was still bleeding on the inside and he wanted medical attention. When the nurses would come past his cell during medication pass, he said that the deputies would tell them to leave him alone and they would not give him any medical attention (Brooks deposition, pgs. 21-22, lines 10-4). Mr. Brooks described a situation in which he did directly tell nurse Granger that he needed medical attention, but she looked at the deputy who was accompanying her and asked whether she should respond to Mr. Brooks, and the Deputy said that she should not (Brooks deposition, pg. 22, lines 5-25). Mr. Brooks also testified that on the one occasion on which he saw the social worker, Ms. Eichelberger, he told her that he needed medical attention, but she did nothing about it (Brooks deposition, pgs. 23-24, lines 23-2).

5. While Mr. Brooks was on N02, he was allowed out of his cell for 30 minutes a day, 3 days a week and for fifteen minutes a day on the other four days a week (Brooks deposition, pg. 30, lines 4-23). That out of cell time included time for the inmate to shower. Inmates were not taken to a recreation area and were limited to walking up and down the corridor when they were allowed out of their cells. Mr. Brooks was asked whether any of the CorrectHealth medical staff had ever used racial slurs towards any of the inmates on N02. Mr. Brooks said that he had asked for something for a headache and that the nurse, Ms. Granger, had then

called him and the inmate housed next to him, Daniel Hinton, "niggers"[2] (Brooks deposition, pgs. 54-55, lines 20-23). Mr. Brooks was next asked whether he had submitted a request for sick call and he explained that they could not do that on N02. He said they do not allow pens or pencils or anything to write with and that the deputies do not give you a slip for sick call. There were other references in the case record to the fact that inmates on the lockup units often did not have access to sick call requests, a serious failing also corroborated by the HMA report as a facility wide issue regarding barriers to accessing health care. Mr. Brooks said that even if there was a medical emergency, other inmates would have to make noise to get staff attention and that can take a while (Brooks deposition, pg. 56, lines 14-20). When Mr. Brooks was asked whether any of the security staff had used racial slurs towards him or any of the other inmates, his answer was, "Deputy Noorwood, Lieutenant Lamant, Deputy King, Lieutenant McFarland, and Sargeant Roof." He added that they were the only individuals he could think of at that time who had used racial slurs (Brooks deposition, pgs. 57-58, lines 6-10). Mr. Brooks was asked how often the Deputies walked up and down N02 ("rounds", which was required every thirty minutes). Mr. Brooks testified, "maybe once every three to four hours, maybe" (Brooks deposition, pg. 58, lines 20-22). He added that the deputies rarely used the catwalk to walk and up and down the line and said, "maybe once a day, maybe," and explained that you can hear the gate open and close and from his cell he could see who was coming and going on the catwalk when the gate opened or closed because he was at the front of the cell line.

6. The picture painted of EBR in the depositions of Mr. Brooks and Mr. Hinton is not dissimilar from the picture that emerges from the record of Jonathan Fano in this case. Inmates are kept on N01 or N02 for long periods of time and even though they may be mental health inmates or protective custody inmates, they are treated as if they were on disciplinary segregation. They do not have access to programs and most services are not afforded to them. Staff do not supervise the area appropriately and even when an emergency occurs, inmates must figure out how to let staff know and get staff to respond. The situation experienced by inmates on N01 and N02 is substantially worse than what was described to the Council by public officials when they stated it was an emergency.

7. Some of the important aspects of a jail's operation are not considered in this report because they are not central to what happened to Jonathon Fano, even though they are defining for those incarcerated. One of the most obvious of those issues is staff use of force. Multiple inmates complained that staff beatings were not uncommon. One inmate described how staff would put an inmate in lockdown after he was beaten, so that he would have no visits until his wounds had healed. Lest these allegations be dismissed out of hand as inmate inventions or exaggerations, it is worthwhile to consider Sgt. Cage's deposition testimony. When asked about one of her several disciplinary suspensions, she explained that she had sprayed an inmate with OC because she was angry with him. He had been masturbating but was no longer doing that when she sprayed him because what he had been doing was "nasty". She then didn't report her use of force. Either using force so clearly as corporal punishment or failing to report a use of force would lead to termination, or close, in most well- run jails. Instead, Sgt. Cage got a short suspension and no demotion, and her several disciplinary incidents did not deter her promotions.

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[2] Throughout Mr. Brooks' deposition, both he and the questioners use the "n-word" to describe this racial slur. I chose to use the actual word because of how jarring it is to hear it in this day and age, and to convey how offensively EBR staff address the inmates.

8. Other staff corroborated in their own sworn testimony, some of the most telling intimate criticisms of the EBR. Deputy Monroe, in his deposition, admitted to logging inaccurate information (Monroe deposition, pg.43, lines 8-14). He also acknowledged that deputies sometimes ran out of sick call slips (Monroe deposition, pgs. 48-49, lines 8-13), that he had used excessive force and filed a false report (Monroe deposition, pgs.64-65, lines 5-10). Sgt. Cage described deputies cursing, causing a disturbance and then fighting with inmates (Cage deposition, pgs. 35-36, lines 24-17).

B. Jonathan Fano was Severely Mentally Ill

1. On October 30, 2016, Jonathan Fano took a bus trip from Miami to join his family at their home in Southern California. According to his family, Jonathan was hallucinating, and more specifically hearing voices, during the bus trip. As a result of the voices in his head, he decided to get off the bus at a stop in Baton Rouge, LA. There, on Oct 31, Jonathan was arrested by the Baton Rouge police. He had been creating a disturbance in the downtown area of Baton Rouge and when the police found him, he was running around naked except for a shirt, swinging his penis and explaining that he and his friend, Titianna, were both cross-dressers and that they were looking for some kind of show where they could make money. Titianna was an imaginary friend. Mr. Fano was arrested and charged with disturbing the peace, obscenity, resisting arrest, and battery on a police officer, among other charges. He was taken to EBR. He should have been taken to a psychiatric emergency facility in the community instead.

2. At the time of his arrest Mr. Fano was 27 years old. He was a small and slight (5'7", 130lb) Hispanic male. He had been diagnosed as seriously mentally ill and on anti-psychotic medication since at least 2013.

C. EBR was Ill-Equipped to Manage Mentally Ill Inmates

1. EBR had inadequate facilities, mental health services, staff training and other severe deficits that prevented reasonable treatment of mentally ill inmates. This is not just my conclusion as a result of reviewing the record in this case. It is also the conclusion of the EBR jail administrators, the East Baton Rouge Sheriff and East Baton Rouge Parish officials. Further, that conclusion was corroborated by a detailed and comprehensive independent study specifically commissioned by the Parish to evaluate the prison. The long-time Warden of EBR, Dennis Grimes, testified at his deposition, "The design of the prison proposes a risk for everybody because of the way it's designed." (Grimes deposition, pg. 38, Lines 5-17). When Warden Grimes was asked about a Metro Council meeting in January 2015, at which William Daniel described the situation at EBR as it related to mentally ill inmates as "dire", Warden Grimes testified that he would say that the situation was "urgent" rather than dire (Grimes deposition, pg. 41-42, Lines 25-3). Warden Grimes went on to detail that EBR needed a mental health unit and more and better housing (Grimes deposition, pg. 43, lines 3-11); that he knew that the bars and sprinklers could be anchors for ligatures and suicides (Grimes deposition, pg. 33, lines 1-21); that because the facility is old there were plumbing and security issues, and that inmates could "pop the gates", jimmy or block the locks, etc.; and that there were mental health inmates all over the prison. Warden Grimes went on to testify, "mental health people should not come to the prison because there are not enough staff to accommodate those people. It is not designed or equipped to handle those individuals" (Grimes deposition, pg. 35, lines 9-16). That is a candid and blunt admission

that what happened to Jonathon Fano was inexcusable because the EBR management knew that he never should have been there.

2. The Warden was not alone in his assessment. The Sheriff told the Council that the physical condition of the prison was "deplorable" and the Warden agreed with that assessment (Grimes deposition, pgs. 107-108, lines 21-5). The Sheriff also told the Metro Council that he had a safety concerns for both staff and inmates, and more specifically that EBR did not have adequate medical and mental health care for inmates, and Warden Grimes agreed with both of those statements (Grimes deposition, pg. 108-109, lines 6-2). Warden Grimes also testified, "medical, the infirmary, not capable of having the thing we need for the inmates' mental health needs as far as a place to put those individuals so they can be monitored by medical" (Grimes Deposition, pg. 109, lines 4-8). These statements remove any doubt that the Sheriff, the Warden and the Council knew full well that a seriously mentally ill inmate such as Jonathon Fano did not belong at EBR and would be in predictable jeopardy if placed there.

3. For almost all of his stay at EBR until his suicide, Jonathan Fano was on the N01 Unit and the N02 Unit. Warden Grimes admitted in his testimony that M and N units would have been shut down if Federal officials had come in and inspected the facility (Grimes deposition, pgs. 114-115, lines 20-7). The Sheriff also told the Council that EBR did not have "adequate medical and mental health care for inmates", to which Warden Grimes agreed (Grimes Deposition, pgs. 108-109, lines 13-2). At a January 14, 2016, meeting of the Council, the Sheriff's attorney, Mary Erlingson, told the Council, on behalf of the Sheriff, that there was no room to segregate mental health inmates and that "this is an emergency." Warden Grimes agreed that there was no appropriate place in EBR for mental health inmates and that was still the situation at the time of his deposition (Grimes deposition, pgs. 106-107, lines 20-3).

4. The testimony and opinions reviewed above are extraordinary. They paint a picture of a jail that was in very poor condition overall and which specifically could not safely incarcerate or manage mental health inmates. These are not opinions presented by inmate advocacy groups or attorneys for plaintiffs, but rather they are the opinions of the Warden of the jail, the Sheriff of the Parish and the Parish Administrator. The long accepted and well-established standard for health care and mental health care in jails and prisons across the U.S. is that those services for inmates must be equivalent to the medical and mental health services available in the community. EBR and the Sheriff cannot argue that they were not on notice that mental health facilities and services at EBR were dramatically below acceptable standards or that those facilities and services did not pose a serious risk of permanent harm or even death to mentally ill inmates, because it is the Sheriff, the Warden and the head of the Parish who were making those arguments publicly to the Council.

5. In the face of that situation, there were two acceptable paths for EBR and the Parish. They could either fix the conditions at EBR with regard to mentally ill inmates or they could stop incarcerating mentally ill inmates at EBR. That latter solution is not as impossible as it sounds because EBR was seriously overcrowded at the time and was already sending hundreds of East Baton Rouge inmates to other facilities. The Parish could have made the decision to not accept mentally ill inmates and to send those that had to be incarcerated to other facilities. Tragically, EBR and the Parish took neither of those courses of action and Jonathan Fano's suicide was a direct and predictable result.

D. The HMA Study

1. In 2016, the East Baton Rouge Parish contracted with an independent consulting group with expertise in medical and mental health procedures and services in correctional facilities. That group, HMA agreed to do an in-depth assessment of clinical operations at EBR. The scope of the study included staffing, pharmacy, medication, administration, quality improvement and performance, records, utilization of specialty services, treatment of communicable diseases and chronic care, suicide prevention, and mortality reviews. Each of those areas was compared and contrasted with the Louisiana state standards and with national correctional standards as reflected in the ACA standards and the NCCHC standards. Data collection and interview trips for the HMA study were primarily conducted in early 2016 and a final report was presented to the Council in early June, 2016.

2. A complete review of the HMA findings is beyond the scope of this report. However, some of the HMA findings are clearly relevant to this case. HMA found that inmate access to healthcare was found to be seriously deficient for several reasons, including that sick call request slips had to be requested from a correctional officer and that medical and mental health staffing patterns were woefully inadequate (the Warden testified at his deposition that prior to his job at EBR, he had worked at state prisons and that he was used to having six social workers for an inmate population the size of EBR, and that EBR had one social worker (Grimes Deposition, pg. 97, lines 10-20)). HMA found that the health and mental health budget for EBR was five million dollars annually and that adequate staffing for medical and mental health positions would require an annual budget of 10 million dollars. HMA noted that there were 30% nurse vacancies and that the authorized full-time nursing positions were inadequate. The result of that situation was that medical and mental health staff were commonly working beyond their credentialed practice, that physician hours authorized were approximately one-third of those required and that psychiatrist hours were similarly about 40% of what was required. In response to what should have been an alarming report corroborating the testimony of the Warden, the Sheriff and its Acting Administrative Officer, and highlighting many other serious problems, the Parish and EBR did little except to change from medical and mental health services operated by the Parish to contracting for those services with a private, for profit organization, CorrectHealth.

E. Jonathan Fano's Intake at EBR

1. Some of the mistakes that were made by EBR with regard to Jonathan Fano are so serious that they are difficult to comprehend. On the Prisoner Transport Record (EBR 1760), the Deputy transporting Mr. Fano to the EBR has to answer the question, "have you observed any mental health problems?" His written response is, "No." How is it possible that someone who was arrested on the streets running around naked and talking about his imaginary friend is not exhibiting any signs of mental illness? When a new prisoner is brought to a Jail, the individual is processed, usually referred to as "Booking and Intake." In most jails, that involves intake policies, a number of forms, and a substantial procedure. There are good reasons for all that. Is the new inmate who he or she says they are? Is the person wanted in some other jurisdiction for serious crimes? Is the individual on medication which will be life-threatening if discontinued? Is the inmate currently suicidal? There are, of course, many other important questions.

2. In most jails, a new inmate is first screened by a correctional officer or deputy and one of the key questions that must be answered first is, "should this person be admitted to the jail or does this person have injuries or medical or mental health problems that require the jail to refuse admission and direct the police officer to take the individual to a community hospital for treatment and or for clearance that they can be safely be admitted to the jail?" At EBR, Deputy Breeding testified that he had worked in intake the majority of his time employed by EBR and had never rejected a new prisoner for mental health reasons (Breeding Deposition, pgs. 36-37, lines 26-3). Then, if the person does not have immediate and possibly emergent medical or mental health issues, they are fingerprinted and go through other steps in the booking process. That includes an initial screening for medical, mental health, and suicide issues. The next step is typically a more in-depth medical screening by a medical staff member.

3. In Mr. Fano's case, it appears that much of the usual booking and screening process was ignored. There are some admitting records, but they are minimal. It does not appear that Mr. Fano received any thorough services and the minimal medical or mental health screening he did receive made recommendations that were not followed for months. That is not a complete surprise since HMA documented in their report that they estimated that somewhere over 10% of new admissions to EBR received no medical screening at all. Included in Mr. Fano's admitting document package is a form that says, "admitting deputy must read to inmate: by signing below…" That form documents that the inmate has been told about mail regulations, that he or she has received a copy of the inmate rules and the inmate disciplinary regulations, and that the Deputy has discussed the grievance procedures with him or her. In Mr. Fano's case, the document is blank. His signature is not on the document and neither is the signature of the Deputy or the Deputy's supervisor on the document. It would appear that Mr. Fano did not get a copy of the rules and disciplinary regulations nor did he have the grievance procedures explained to him. Perhaps he did not know that there was an inmate grievance procedure that he could have used when his requests for medical services were ignored. Even the fingerprinting of Mr. Fano was somehow missed, with the arresting officer claiming the booking Deputy should have done it and Deputy Breeding claiming that Officer Bennett should have done it.

4. The screening from that is in the case record for Mr. Fano includes questions about mental health history and about prior care from a mental health provider and about psychiatric medications. The form lists a "No" answer from Mr. Fano to each of those questions. That is difficult to reconcile with Mr. Fano talking openly about his delusions with the police and about his suicidal thoughts with inmates, mental health staff and family. It is noteworthy that the HMA study reported inconsistent screening practices and intake staff sometimes skipping portions of the intake interview. Booking staff at any jail have access to a new inmate's arrest charges and the nature of Mr. Fano's arrest would have indicated to almost anyone that he likely had a serious mental health history.

5. The PREA screening checklist (001761) is filled out for Mr. Fano. The purpose of that checklist is to identify, at intake, inmates who may be predatory and to also identify those inmates who are likely to be victimized. Once so identified, those inmates can then be classified and or housed in such a way as to minimize the risk that has been identified. On that checklist, question number four asks whether the individual is of small physical stature, which is defined as under 140 pounds. The classification officer at intake, Corporal J. Freeman, has written "no" although Mr. Fano is 130 pounds. The next question, number

five, asks whether the individual has developmental disabilities or mental health issues. The staff member has not answered that question and has simply drawn a diagonal line where the "yes" or "no" would typically go. Another question asks whether the individual is homosexual/Bi, LGBTI, and/or gender nonconforming. The classification staff member has answered "yes." The form specifies that if two or more questions are answered "yes" then the staff member is directed to enter a code for "potential victim." In Jonathan Fano's case, there should have been three questions answered "yes" but since one of those was incorrectly answered "no," and another was not answered, Mr. Fano was not given the "potential victim" code which might have led him to be housed in a more appropriate area. Instead, with no medical or mental health screening, and an incorrect identification as unlikely to be victimized and no awareness of his serious and extensive mental health history and current mental health problems, Mr. Fano was sent to a small dormitory of general population inmates where, within hours, he attempted suicide by cutting a wrist.

F. EBR Reaction to Jonathan Fano's Suicide Attempts

1. When Mr. Fano's suicide attempt was discovered, he was taken to a local hospital, treated and then returned to EBR. He was placed on suicide watch and given a November 2nd appointment with a social worker "for suicide precautions." That appointment was marked "highest priority." The appointment was not kept. Although it strains credulity, the emergency medical request form that was filled out at the time of the suicide request says "no mental health history" even though the narrative states that Mr. Fano was hearing voices and had made a suicidal cut to his wrist. Beyond that, no one had attempted to ascertain any of his history, mental health or otherwise. His placement on suicide watch noted depressed mood and bizarre thoughts and behavior. On November 3, 2016, two days after suicide watch, Mr. Fano was seen by the prison psychiatrist, Dr. Blanche, who discontinued the suicide watch. Photos of Mr. Fano's suicide watch cell on unit N02 show it to be filthy and foreboding with open bars across the cell front that made it remarkably inappropriate for a suicide watch cell. That is, the open bar design offered a multitude of quick and easy places to anchor a ligature during a suicide attempt.

2. On November 4, Mr. Fano was given an appointment to return to the clinic and see a psychiatrist after one month. That appointment also was not kept. It is noteworthy that Mr. Fano came in to the jail after having been arrested in a floridly psychotic state, running through a downtown area naked and talking about an imaginary friend. In spite of the hallucinations and delusions, he was not identified as mentally ill at intake and appears to have received no thorough medical screening. After a clear suicide attempt within hours of his assignment to general population housing, Mr. Fano was sent to an emergency room with a notation that said "no mental health history." When he returned to the jail from the hospital, there was no follow-up with hospital medical or mental staff or any attention to follow up care. His highest priority appointment with a social worker the day after he returned from the hospital was ignored, as was his return visit with a psychiatrist scheduled for him a month later. When Mr. Fano was removed from suicide watch by Dr. Blanche, it was not the result of a comprehensive suicide risk assessment; instead, Dr. Blanche used his common procedure of evaluating Mr. Fano at his cell front, through the bars. The logs produced documenting Dr. Blanche's clinical meetings with inmates demonstrate that he usually spent two to six minutes talking with or seeing a particular inmate and then moved on to see the next inmate at a cell front, through the bars. It was unusual to find entries indicating Dr. Blanche had spent a substantial amount of time with a particular inmate. It is

also a matter of concern that for convenience Dr. Blanche talked with inmates at their cell front, where it is not possible to have any privacy for the clinical contact. That can be a particular problem for an inmate new to the jail, such as Jonathan Fano.

G. Mr. Fano is Disciplined for His Suicide Attempt

1. Rather than conducting a thorough medical and mental health work-up of Mr. Fano because of his suicide attempt, and rather than providing him with any kind of intensive mental health treatment or programming, EBR gave Mr. Fano a "disciplinary write-up" for "self-mutilation" and the disciplinary board (actually a lieutenant and one other staff) sent Mr. Fano to disciplinary segregation ("the hole") for a 20 day sentence with several days credited for time served. Mr. Fano was transferred to unit N02. His segregation time meant he was not allowed visitors or family phone calls.

2. When the Warden was asked at his deposition about the appropriateness of imposing discipline on a seriously mentally ill inmate, the Warden explained that the disciplinary board would refer the incident and the inmate to mental health and that the mental health staff would then evaluate whether the inmate should be accountable for the incident by way of sanctions. That did not happen in Mr. Fano's case. When the audio recording of the disciplinary board was played for Lisa Burns, the EBR Social Worker through 2016, she reacted strongly to the recording, saying she found it "very disturbing" (Burns deposition, pgs. 48-49, lines 22-13). The reason she found it so disturbing was that she heard the board members say they were going to refer Mr. Fano to her but she knew they did not do that and that he subsequently committed suicide (Burns deposition, pgs. 49-50, lines 24-20).

3. The central issue here is that responding to an inmate suicide attempt with discipline instead of treatment is contrary to everything that is known about suicide or inmates and it is also barbaric. If an inmate is distraught and or seriously depressed, isolation will increase – not decrease – the risk of future suicide attempts. Some inmates like Jonathan Fano are in jail without family or friends on the outside, either because of their history of criminal behavior or their mentally disturbed behavior, or both. Jonathan Fano was very fortunate in that he had family members who had not given up on him, who cared deeply and who were in touch while he was in jail. It does not take a genius to figure out that if an inmate is depressed, distraught and suicidal, one of the last things that should be done would be to prevent family visits and family phone calls, separating the inmate from one of his few areas of strength and positive relationships.

H. Mr. Fano's Additional and Unreported Suicide Attempt

1. In his sworn statement, former inmate Emanuel Jones said that Jonathan Fano, "tried to hang himself a few days before he was successful. I actually saw it from the reflection in the catwalk's glass – either the knot or the clothe broke, but he definitely tried and failed to kill himself. I told Dep. Monroe about it, and told Monroe that he needed to get Fano help and move him to a cell closer to the cage so guards could watch him." That is not some eccentric story that is found only in Mr. Jones' statement. Evidently, when Mr. Fano tried to hang himself a few days before his actual suicide, the ligature broke and he fell with enough noise that other inmates realized what happened or were able to piece it together. At his deposition, Mr. Hinton said that he and other inmates knew that Mr. Fano had tried and

failed to commit suicide when the ligature broke (Hinton deposition, pgs. 72-73, lines 21-15).

2. This is the most egregious aspect of this case. There is no reasonable basis to doubt the sworn testimony of multiple inmates that Mr. Fano attempted suicide a few days before February 2, and that he failed. Mr. Jones is clear that he told a specific staff person, Deputy Monroe, and advised him that Mr. Fano should be moved to a location next to the cage where he could be observed. That advice was correct and it should not have been incumbent upon an inmate to point out to the staff that Mr. Fano's cell location exacerbated the risk that he would commit suicide. When the security staff were told that Mr. Fano had attempted suicide, they should have immediately placed Mr. Fano back on suicide watch and notified mental health to do an immediate evaluation of him. Those steps needed to be taken whether staff had doubts about the credibility of the inmate stories or not, because the rule of thumb in dealing with inmate suicide risk is to err in the direction of safety. Beyond that, if the mental health staff were making daily checks on the inmates on N01 and N02, they would have heard from other inmates about Mr. Fano's suicide attempt and they would have been able to talk with Mr. Fano and evaluate his condition even if the deputy who heard about Mr. Fano from other inmates had not reported anything.

I. Units N01, N02, M and the Lack of a Mental Health Unit at EBR

1. As noted earlier in this report, the Sheriff, Warden Grimes, and the HMA consulting group all spoke strongly about the lack of a mental health unit at EBR. Both the Sheriff and Warden Grimes took the position that since it was not possible to have a mental health unit in the current facilities, EBR had no choice but to scatter mental health inmates throughout the jail while placing most of the seriously ill individuals on M, N01 and N02. Those assumptions are simply wrong. There is no good correctional reason that EBR could not have converted one of its large dormitories into a mental health unit, with both security and mental health staffing. Certainly, the most acutely disturbed and or violent mentally ill offenders would not be appropriate for a dormitory setting and would need to be housed in cells. However, that would not apply to the vast majority of mental health inmates and it would not have applied to Jonathan Fano. There is a large and growing body of evidence that restrictive housing, isolation and solitary confinement are antithetical to therapeutic objectives with mental health inmates and lead to increasing decompensation and increased suicide risk. It has been established for some years that even double celling inmates with some suicide risk or suicide history is generally safer than single celling. In short, more contact is generally better than less contact for depressed and or suicidal inmates and a social atmosphere can be helpful even if it is not a well-designed and well-staffed therapeutic community, although that is certainly possible and should be the objective in jail mental health units.

2. Beyond the positive aspects of increased interaction with other individuals for the depressed inmate, there is also a built-in check against suicidal behavior. Inmates do not want to see another inmate kill himself or herself, any more than inmates want to watch as an inmate dies because of lack of medical care. Even with an inmate who may be difficult or obnoxious to other inmates because of mental illness, if that inmate is seen starting to hang himself or herself, other inmates will almost always start to yell and alert security staff that there is a hanging in progress.

3. It must be emphasized that a dormitory converted to some form of mental health unit is not the only option that was and remains open to EBR. For some reason that is baffling, perhaps historical accident, EBR uses N01 and N02 for a combination of protective custody inmates, administrative segregation inmates, mental health inmates, suicide watch inmates, and disciplinary segregation inmates. Each of those five categories of inmates is distinct and different from the others. Each should have its own rules, regulations, privileges, restrictions and programming. At EBR, that is not done and everyone on N01 and N02 is treated very similarly. Most obviously, all of the inmates are on lock down 23 ½ or 23 ¾ hours per day (with the exception of the occasional inmate worker on the unit). Thus, protective custody inmates and mental health inmates are essentially punished by being kept with, and primarily treated as, disciplinary segregation inmates. Administrative segregation inmates, which technically includes protective custody inmates, are housed apart from general population as a convenience to the facility or for security reasons, but not as punishment. Thus, they should be entitled to all of the rights, privileges, programs, and services that are available to the general population, as long as security is not impaired. Thus, if general population inmates have access to educational programs, vocational training and religious services, the correctional facility is obliged to make best efforts to deliver those programs and services to the housing units holding the mentally ill, protective custody, and administrative segregation inmates, even if that means education programs, for example, must be delivered on a one-on-one basis at the cell front. That is not an uncommon arrangement. None of that occurs at EBR. At his deposition, Warden Grimes was asked about 18 different programs that are available to inmates in EBR and the question was, which of those 18 programs were available to inmates on M and N units. His answer was that none of them were (Grimes deposition, pgs. 124-126, lines 12-5).

4. In reality, if the lack of programs and services on N01 and N02 were the extent of the problems there, it would be a blessing. Inmates largely regard N01 and N02 as a "hell hole," even within a jail that is generally very poor. In his deposition, inmate Hinton said that inmates generally refer to N and M units as "lock down" or "solitary" (Hinton deposition, pgs. 137-138, line 24-14). Inmate Hinton was initially placed in population on unit F5 for a few hours but inmates there "jumped him" and he is convinced they would have killed him except that the staff announced mealtime (Hinton deposition, pgs. 23-24, lines 9-11). As a result of the attack, Mr. Hinton suffered fractured ribs and a broken ear drum (Hinton deposition, pg. 24, lines 12-18), and was then sent to N02 for his protection. He was a "hall man" (inmate porter, or worker) and that allowed him to be out of his cell and around various locations on the unit for long periods of time. He was in a position to know the unit operations well. He said that the medical staff were rude and unprofessional (Hinton deposition, pgs. 66-67, lines 16-6), and when he was asked whether staff used racial slurs, he said that it was "racial all the time" (Hinton deposition, pg. 66, lines 7-15).

5. A number of deposed inmates provided sworn declarations in the Lamar Johnson case and some of these inmates provided testimony about the M and N units at EBR. Marcus Williams' declaration describes M01 as the "crazy line." The louder an inmate gets, the further back in the row of cells they put you. The staff don't want to deal with the inmates and the worst cases are the furthest away from the staff. He also provided testimony that the deputies do not do their required rounds (cell checks) and that drugs were commonly available on the units. Corey Pitman's declaration also included testimony that the deputies frequently skip required rounds. Byron Maxon's declaration included a statement that there was generally a great deal of violence in the jail and that there were frequent assaults on

inmates by deputies. Mr. Pitman's declaration also spoke to inappropriate force by deputies against inmates. Turner Jackson, in his declaration said that there were frequent beatings of inmates by staff and that the inmates would be put in lock down until their wounds healed. He also said there were no calls or visits in lockdown so that it was not possible to show the results of the staff beatings. He described inmates throwing feces, urine and semen on other inmates on the M1 unit where he had been housed. Travis Anderson's declaration described staff putting inmates in the shower for punishment and forcing them to stay sitting there until morning. He also said that inmate beatings take place off camera. Broderick Samuel also provided a declaration and said that deputies talk to inmates as if the inmates are dogs. He described watching deputies beat Lamar Johnson while he was handcuffed. Mr. Samuel further stated that the staff do not clean the cells on the M and N units. Both Michael Lacour's and Christopher Haney's declarations included statements that the deputies do not do rounds, as did Josh Boxie's declaration and Lorenzo McCutcheon's declarations.

6. If, for some reason, EBR had not believed it would be possible to create a dormitory mental health unit, or if they believed that would not be beneficial, there was and there remains an easier and more obvious alternative. That is, N01, N02 or M could be converted to an entirely mental health unit, or perhaps two of those units could be converted, depending on the mental health population to be accommodated. Most inmates could be double celled, which would be preferable where possible but for those inmates too disturbed or inappropriate for double celling for some other reason, they would simply be single celled. The mental health unit could then have staffing 24/7 with a deputy assigned within the unit on the corridor(s) nights and weekends and both mental health/program staff and security staff on the unit days and evenings, and could be operated in an interdisciplinary manner. Then those inmates on suicide watch could be placed in cells adjacent to the staff and station or staff desk on the unit. That would provide far more frequent observation than is the case with the current structure. That would also mean that inmates on suicide watch would have direct access to staff at most times.

J. Mr. Fano's Stay on N01 and N02

1. The chronology of Jonathan Fano's stay on N until his suicide is so disturbing that parts of it are difficult to believe. He was put on N to do the disciplinary time that he received for his suicide attempt. It would be easy to assume that when Mr. Fano had completed his 20 day sentence in disciplinary segregation he would have been moved off that unit to some other part of the jail since he was no longer serving his sentence. That did not happen. Instead, Mr. Fano was left on N for the next three months until he killed himself. Warden Grimes was asked why, after the 20 days had elapsed, was Mr. Fano held in segregation. He answered that it was a disciplinary detention issue (Grimes deposition, pg. 121, lines 7-13). That is contradicted by the lockdown review of Mr. Fano on January 3, 2017, which states that he is on lockdown for "medical/suicide" and that he should remain. That review was inaccurate because Mr. Fano was taken off suicide watch on November 4 by Dr. Blanche and not placed back on suicide watch at any point prior to his suicide. The lockdown review is one of two review procedures described by Warden Grimes as safeguards against inmates remaining on lockdown status for too long or without good reason but one review was never given to Mr. Fano and the other was only done once in over three months and was superficial, ineffective, and had information that was simply wrong.

2. On November 25, 2016, Mr. Fano filled out a medical request form and was scheduled for an appointment to be seen on December 15th. He had been scheduled to see a social worker on November 3rd but that did not happen and he should have been seen for his one month, return to clinic visit, on approximately December 4th, but that did not happen either. Then his appointment to be seen on December 15th in response to his medical request form was also ignored. It should be noted that even if that had been kept, it would not have been safe to wait three weeks after a seriously mentally ill inmate with a recent suicide attempt had completed a medical request form, before he was seen. When Mr. Fano's December 15th appointment was not kept, he filled out another medical request form on December 18th stating that he had "really bad anxiety and depression" and that he was "having really bad thoughts of my time here." Mr. Fano was moved from N01 to N02 on the 20th of December and he had still not seen a clinician.

3. On January 3rd, Mr. Fano was finally seen by a correctional health staff member who noted anxiety, depression and that he was hearing voices. On January 11th, Vincent Bradley of CorrectHealth, saw Mr. Fano because he was not taking his medications and he was not eating. That same day he was seen by Cathy Schley, who noted that she suspected Mr. Fano was faking or exaggerating his condition and that he "presents as stable overall." One week later, on January 18th, Dr. Blanche evaluated Mr. Fano on the basis of a "through the bars" interview at cell front and noted that he (Dr. Blanche), "doubts serious mental illness" and reduced Mr. Fano's anti-psychotic medications for the next week, after which he ordered them discontinued altogether. A week after Dr. Blanche had discontinued Jonathan Fano's anti-psychotic medication, Mr. Fano committed suicide.

4. The evaluation by Cathy Schley on January 11th, in which she decided that Mr. Fano was faking or exaggerating his mental health problems was made without any recent contact with Mr. Fano that would give Ms. Schley a baseline for her observations. Similarly, at the time Dr. Blanche decided that Mr. Fano was not seriously mentally ill and discontinued his anti-psychotic medication, Dr. Blanche had not seen him for 2 ½ months and Mr. Fano had no clinical contacts from November 4, 2016 until early January, 2017.

5. For two months, Mr. Fano – who had just made a suicidal attempt – was locked down in isolation and ignored. Here again, it is not that EBR and the two health providers did not know better or were not on notice. The HMA report earlier in 2016 included an analysis of EBR practices against NCCHC standards and that analysis starkly stated (at p.10, Plaintiff's 000404) that inmates in segregation should be monitored by mental health professionals once per week and by medical staff up to daily, with monitoring documented. That section ends with a warning, emphasized in italics, "inmates who are SMI should not be confined under conditions of extreme isolation." EBR, PMS and CorrectHealth all violated these standards. In fact, CorrectHealth began at EBR on January 1, 2017 but there are only four clinical contacts documented in all of January for Jonathan Fano. The CorrectHealth policy itself for segregated inmates requires a visit from medical and mental health staff at minimum on a daily basis if the inmate is in extreme isolation and three times a week if the inmate is in limited isolation. That policy required 32 contacts by CorrectHealth medical/mental health staff because Mr. Fano's isolation was extreme. Instead of 32 clinical contacts from January 1 through February 1, Mr. Fano received four.

6. None of these CorrectHealth assessments bore any relationship to the views of Mr. Fano by people who were talking with him repeatedly and at length or who were housed near him

and saw him on a daily basis. Mr. Fano's family talked with him from Southern California a number of times and had a visit. After Mr. Fano's death, his phone call records were transcribed. EBR has the kind of phone system that is used in most prisons and jails, and all inmate calls with the exception of legal calls are recorded and can be listened to in real time or at a later time, at the convenience of the facility. If either the security staff or the mental health staff at EBR had been sufficiently concerned about assessing Mr. Fano's condition, they could have easily listened to portions of a few of his phone calls with family. They would have found that he was distraught, hearing voices, and suffering from being kept in isolation. They would have also found that he frequently said, "I can't do this," a reference to suicide intent.

7. The phone records demonstrate the degree to which he does not understand his surroundings in the jail. On the 28th of January the recording of his phone call with family include, "I can't stay here. I am going crazy." That same recording, on pg. 5, at lines 4-6; "I'm not eating... I can't sleep... I can't do anything." On the same recording at pg. 9, line 8-10; "...I'm in bad shape. I'm hearing voices..." It is important to note that this last phone call is 10 days after Dr. Blanche noted that Mr. Fano was likely not suffering from serious mental illness and only a few days after Dr. Blanche had stopped his anti-psychotic medications.

8. These phone recordings demonstrate that Mr. Fano's family was deeply concerned for him, supportive and trying to help him in the best ways they could. His father, Carlos Fano, spoke with him by phone, apparently on Christmas Day, 2016. Also on Christmas, Mr. Fano was able to call his mother and speak with her and his sister Vanessa. Vanessa was also able to identify family letters to and from Mr. Fano while he was in EBR. Mr. Fano's family was quite religious, and so was he. On the January 28 phone call, the family's last contact with Mr. Fano before his death, a family member – likely his mother – tells him, "try to participate in church services," to which Mr. Fano replies, "There aren't services here."[3] There is reference to a chaplain at EBR visiting N01 and N02 once a week, but if a chaplain had visited Mr. Fano, even occasionally, it seems likely he would have mentioned to his family in this kind of conversation, and he did not. There is no record at EBR of a chaplain ever talking with Mr. Fano.

9. It is also apparent that the family considered the best alternatives for Mr. Fano with regard to his release options. They found out that they could bail him out somewhat sooner than his scheduled release date but rejected that option because they thought it would place him in an impossible situation in which he would have to fly back from Southern California to Baton Rouge for various court appearances and that he would likely be overcome with the same kind of anxiety that led him to get off the bus in Baton Rouge in the first place, and that the end result would be a warrant for his arrest for failure to appear. One member of his family can be heard explaining that to him in the earlier phone call (118721402-3480, pg. 4, lines 12-20), "can't bail you out because you'd have to keep flying out here and going through the whole anxiety thing," … and that "they'll put out a warrant for you." In light of Jonathan Fano's severe mental health history and the fact that he was in bad shape and actively hallucinating at the time, their reasoning was realistic. In his condition, it would have been unlikely for him to successfully navigate cross country trips to return to court. A missed

[3] It should be noted when inmates cannot be taken to a congregate area such as a chapel for religious services, that is standard correctional practice to have chaplains provide religious counseling or services at cell fronts.

court appearance would equate to a bench warrant for failure to appear. There was also the chance that Mr. Fano would attempt to travel and would have another episode similar to what happened in downtown Baton Rouge, or perhaps he would have been taken off an airplane under arrest. Any incident of that kind, or perhaps a bench warrant, could have resulted in additional charges against Mr. Fano and further entangled him in the criminal justice system. Thus, weighing the alternative of bail and further required court appearances against leaving this situation and waiting for Mr. Fano to reach his release date, the family chose the latter course of action as being in Jonathan Fano's best interest. Importantly, the family was also following the advice of Jonathon Fano's attorney, from the Public Defender's Office, who counseled the family not to bail him out, for the same reasons explained above. Hindsight is 20/20 and after Mr. Fano's suicide, it is easy to criticize the family for not deciding to make bail and get Mr. Fano out of EBR. However, while the family knew that Mr. Fano was not doing well and was complaining about isolation and lack of medication, they were being assured -falsely, it turns out- that EBR was providing appropriate mental health treatment and they had no way to know of EBR's almost total abdication of their responsibility for Mr. Fano's welfare and safety.

10. If EBR staff did not want to take the time or trouble to review some sample of Mr. Fano's family phone calls in order to help determine his condition, they had other obvious avenues to find out what was happening with Mr. Fano. The security staff charged with making the rounds on N01 and N02 could have and should have noticed that Mr. Fano was not communicative, looked upset and with some frequency did not take his medication. If a security staff member had tried to talk with Mr. Fano, one of two things would have happened. Either he would not have responded and been uncommunicative with them, or he would have responded and talked to them more like he talked with his family, acknowledging that he was hearing voices and distraught. In either case, the security staff member would have known that there was a serious problem and that he needed attention from the mental health staff. EBR also should have known about Mr. Fano's condition, in some detail, from mental health staff. After all, this was an inmate who had been sent to a local hospital in November after attempting suicide and it had been documented that he was hearing voices and distraught.

11. Courtney Eichelberger was the CorrectHealth social worker assigned to do rounds on M and N units and she testified that she felt like she did those rounds every day. She added that it felt like she was there a lot. She also testified that those rounds meant that she went completely up and down the tiers (Eichelberger deposition, pgs. 40-41, lines 18-10). Ms. Eichelberger also testified that when she was doing the rounds on those units, she was checking on the wellbeing, needs and concerns of the inmates and that if they were on suicide watch or mental health observations she would be stopping to see and visit with them (Eichelberger deposition, pg. 41, lines 12-19). From the time Ms. Eichelberger began working for CorrectHealth at EBR on January 23, 2017, until his suicide, was ten days. From Ms. Eichelberger's testimony, it would appear that she would have made the rounds N-02 on a daily or almost daily basis and checked on Jonathan Fano's condition and even stopped and visited with Jonathan Fano. That is not what happened. Based on EBR log books, from Jan. 23 to Feb. 2, 2017, Ms. Eichelberger visited N unit a total of one time, on 1/26 (EBRSO 001250). There is no documentation of any contact between Ms. Eichelberger and Mr. Fano prior to his suicide and she testified that she never heard of Mr. Fano until after his suicide (Eichelberger deposition, pg. 27-28, lines 19-1). Ms. Eichelberger also testified that she did not know if she had received the CorrectHealth policies when she was hired or whether she

ever had read them (Eichelberger deposition, pgs. 59-60, lines 19-4). In spite of Ms. Eichelberger's incorrect assertion of daily or almost daily rounds on M and N units that she testified to, she said that she did not know about any programs on those units and that she did no group sessions and no extensive counseling for inmates on those units (Eichelberger depo, pg. 38, lines 10-22).

12. In reality, EBR was on notice that Jonathan Fano was an acute and imminent suicide risk. EBR knew that because the inmates on N-02 were well aware that Mr. Fano was severely mentally ill and was actively wanting to kill himself, and some of those inmates told staff. In January and the beginning of February, Mr. Fano was housed in a cell at the far end of the N02 unit, next to the shower. Thus, every inmate who was released from his cell to shower had to walk past the front of Mr. Fano's cell. It was common knowledge among the inmates on N02 that when inmates walked past Mr. Fano's cell front he would ask them for a razor in order to kill himself. At his depo, Mr. Hinton testified that he was housed on N02 and that he was a "hall man" (inmate worker, or trustee, charged with cleaning the public areas of the unit). Mr. Hinton said there were several mental health inmates who were out of their minds and should not have been on N-02 (Hinton deposition, pg. 42, lines 10-23). He further said that Mr. Fano was one of those mental health inmates and that he and a few other inmates told deputies about Mr. Fano and told the deputies that Mr. Fano should have been moved (Hinton deposition, pgs. 46-47, lines 13-4). Mr. Hinton testified that Jonathan Fano asked for a razor in order to kill himself and that Mr. Hinton told deputies, including Deputy Monroe and, he believed, Deputy Brown as well (Hinton deposition, pg. 48-50, lines 13-5). Later in his deposition, Mr. Hinton had remembered that he had told Deputy Brown and Deputy Monroe about Mr. Fano wanting to kill himself (Hinton deposition, pgs. 132-133, lines 13-1). Mr. Hinton said that the inmates on N-02 knew that Mr. Fano had tried and failed to commit suicide when the ligature broke (Hinton depo, pgs. 72-73, lines 21-15). Mr. Hinton testified that inmates also told medical staff about Mr. Fano being suicidal (Hinton deposition, pg. 71 lines 1-17), and that he personally heard inmates tell nurses about Mr. Fano at least twice (Hinton deposition, pg. 133, lines 14-23). He also said that other inmates also knew that Mr. Fano was asking inmates for a razor and that he said he "couldn't take it" (Hinton deposition, pg. 75 lines 1-4).

13. Former inmate Frank Brooks was housed on N02 at EBR from somewhere between January 24 and January 27 until well after Mr. Fano's suicide. At his deposition, Mr. Brooks testified that a Spanish inmate in a cell at the end of N-02 asked him for razors and that he told the deputies and also told one of the medical staff, Ms. Granger (Brooks deposition, pgs. 33-34, lines 12-12). Mr. Brooks also testified that, in addition to the razors, he remembered "the Spanish guy" having what Mr. Brooks referred to as "mental complications" because "his conversation wasn't normal" and he was talking to himself and also talking as if he was conversing with Mr. Brooks and a few other people at the same time (Brooks deposition, pg. 36-37, lines 6-14). In Mr. Brooks sworn statement, he was more specific, stating that Mr. Fano was, "asking for a razor blade every time I saw him", and that Mr. Fano was, "Talking to himself, saying things out loud to no one … like he was hearing and talking to voices in his head."

14. Inmate McNeely, in cell 22, and the inmate in cell 23, Bobby Earl, described Jonathon Fano as crying often and said so to the Sheriff's investigator, Sgt. Henning, in the aftermath of the suicide. Many inmates on N02 knew Mr. Fano was seriously mentally ill and asking for a razor in order to kill himself.

15. After Jonathon Fano's suicide, notes were found in his cell indicating he may have been targeted by other inmates for food and for sex. It is not known when those incidents occurred and there was no follow-up by the Sheriff's investigators. The relationship between his victimization and his suicide will likely never be determined but the victimization likely could have been prevented had EBR followed the PREA requirements correctly at his intake. Also, had even one thorough cell search been completed in the three months Mr. Fano was on N01 and N02, the notes would have been discovered and staff could have worked with any ongoing threats or remaining fears. None of that happened.

K. Required Cell Checks Might Have Saved Jonathan Fano's Life

1. Cell checks are one of the primary defenses against inmate suicides in prisons and jails. That is, cell checks (also called security rounds, welfare checks and other less frequent names; at EBR they are most frequently referred to just as "rounds" but are called "cell checks" throughout this report) are standard in correctional facilities. They serve two crucial and co-equal but quite different purposes. One of the purposes is security. When an officer looks into a cell, he or she is looking for any evidence of a security problem. Is there a weapon in sight, or homebrew, or evidence of tampering with the cell or with the bars? The other equally important purpose of the cell check is inmate welfare. Is the inmate obviously injured? Is there blood on the floor, or vomit? Does the inmate appear to be hallucinating? Is there a suicide attempt in progress?

2. It is not possible to satisfy these two objectives by walking past a cell at a slow trot. It is necessary to go to the cell front and stop and look in the window in the cell door (unless it is an open barred cell front) and spend perhaps three to five seconds or more making sure that everything in the cell appears to be normal. Many agencies teach staff that the key three-word mantra for cell checks is, "flesh and movement". That is, if you cannot see flesh, then you may have to wake the inmate so that you can be sure that the lump under the covers is not a dummy covering up an escape attempt. Similarly, if you cannot see movement you must stay at the cell front until you see indications of breathing.

3. Cell checks have been documented to prevent suicides. Although it is not directly related to Mr. Fano, LPN Danielle Thomas provides an excellent and typical example in her deposition in this case of how a cell check can save a life during a suicide attempt. Ms. Thomas described coming across a female inmate who had tied a towel or blanket to the cell bars and was hanging until Ms. Thomas held her up with her weight off her neck until staff cut the woman down (Thomas deposition, pgs. 40-41, lines 18-12). Cell checks are best conducted on a staggered schedule so that if they are required every thirty minutes, then it is usual to sometimes do twenty-two minutes and perhaps the next time twenty-nine minutes and continue to keep the schedule somewhat varied so that inmates are not able to time the officers' rounds. In general population areas cell checks are typically required every thirty minutes to every sixty minutes. For segregation housing and other specialty units, fifteen minutes to thirty minutes is typical and suicide watch is usually in the ten to twenty-minute range with fifteen minutes most common.

4. An additional advantage of cell checks with regard to suicide prevention is that they guarantee frequent opportunities for inmates to talk to staff, make requests, or let staff know if they are in distress. Since inmates know staff will come to their cell door approximately

every thirty minutes (or fifteen if on suicide watch) an inmate can use that opportunity to talk to staff without alerting the entire unit.

5. Warden Grimes testified that cell checks were required every fifteen to thirty minutes, on a staggered schedule. That does not make sense. Since N01 and N02 combined segregation inmates with suicide watch inmates, thirty-minute intervals would be inadequate for the suicide watch inmates. A fifteen-minute interval would be very difficult for all of M, N01 and N02 (Sgt. Cage testified that it required 30 minutes to complete one round of cell checks on N01 and N02). It would have made better sense, even if just for the purposes of cell checks, to have the suicide watch inmates in one area where they could be monitored on a fifteen-minute staggered schedule.

6. The biggest problem with cell checks on N01 and N02 was that the staff too often did not conduct them. That is not an unusual problem. When staff walk through a living unit, conducting cell checks, and find time after time that nothing is amiss, particularly at night, staff are tempted to become complacent and make a log entry but simply not do the required cell checks.

7. In earlier times, the only safeguard against that kind of staff negligence was for supervisors or managers to visit the living units and check the unit logs and also see if the staff assigned to the unit were engaged in doing cell checks. That could be difficult, because in some facilities the frontline staff would send signals to each other indicating that a manager or supervisor was coming around. That made it difficult to determine if staff were documenting cell checks in the logbook but not actually conducting them. That has changed dramatically with the widespread use of security cameras. Today, a supervisor can look at the logbook and the documentation of cell checks and then look at the video footage from the security camera or cameras showing the living unit corridor. Either the Deputy is visible walking down the corridor when he or she has documented the cell check on the logbook, or there is no staff member walking the corridor at that time and the log book entries are false. The security camera footage also allows supervisors and managers to make sure that the staff members doing cell checks are actually stopping at cell fronts long enough to realistically notice a problem if one exists. At EBR, there is compelling evidence that Deputies frequently failed to conduct the required cell checks on N01 and N02. Numerous inmates testified to that in deposition or provided declarations under oath to that effect. One of the several disciplinary actions taken against Sergeant Cage stated that one of her subordinates had failed to make required cell checks continuously for a period of six hours, and that she had not recognized the problem.

8. There should be no argument about whether staff regularly performed cell checks or not because the case record provides direct physical evidence. That evidence is consistent with inmate accounts of deputies failing to perform cell checks, sometimes for extended periods of time. The physical evidence consists of video footage from the security camera provided by EBR and showing the N02 corridor the evening prior to Mr. Fano's suicide and then showing that same corridor on February 2, 2017, the day of his suicide. In general, the video begins at 8:40 PM on February 1 and then continues until after the suicide on February 2. There are some relatively short gaps where video was not provided and there are some other times when there was video but it did not show enough of the area in question to be conclusive. In most cases the time stamp on the video could be matched against logbook

entries where staff had entered documentation purporting to show that they had completed cell checks.

9. From 8:40 PM the night before the suicide until 5:27 PM on February 2, shortly before Mr. Fano was discovered hanging in his cell, there were 34 log entries that could be compared to video footage of the N02 corridor. On 16 of those 34 log entries, or just one short of half of them, staff have recorded cell checks being completed but the video footage shows no staff member walking the N02 corridor, or even on the N02 corridor, during the timeframe covered by the log entry. That would suggest that approximately half of the log entries during this 18- or 19-hour period did not occur. The actual situation is likely somewhat worse than that, however, for of the 18 occasions on which there was a log entry and one or more deputies visible on the video on the N02 corridor, five of those 18 occasions were deputies accompanying a nurse on medication pass and seven of those occasions were at mealtime and the deputies were on the unit because they were distributing food trays to the inmates. If those 12 occasions are taken out of the equation, then there were 22 remaining times where there was a log entry of cell checks being completed and video showing the corridor during that same time frame. The video only showed deputies on the corridor for six of those twenty two occasions, or approximately 30% of the times required to conduct cell checks.

10. It could be argued that the time stamp on the video footage may be inaccurate, accounting for the lack of congruity between the logs and the video footage. However, the time stamp on the video footage matches the various reports at the time Mr. Fano was found hanging in his cell, eliminating that possibility. A second potential concern would be that the deputies were conducting the required cell checks but that they were doing so on the catwalks behind the cells, which would not be visible on the video. There are a number of reasons to reject that possibility, including that the catwalks were dirty and awkward to navigate and that the windows from the catwalks into the back of the cells were badly scratched or otherwise damaged in a number of cases so that a staff member could not easily see into the cell and, in any case, would not have a view of the entire cell. All of that is perhaps less than relevant because Warden Grimes, at his deposition, testified that he had issued an order that cell checks were not to be done on the catwalks, and if staff ever did conduct cell checks from the catwalks, they were obligated to note that fact when documenting the cell checks. Finally, it may also be tempting to hypothesize that the limited timeframe that was examined, an 18 or 19 hour duration over two days, might have involved only one or two deputies who logged cell checks that did not appear on the video footage. That was not the case. The sixteen occasions in which there is a log entry but no video evidence of any cell checks, included two deputies, two corporals, a sergeant, and a lieutenant.

11. Former inmate Emanuel Jones overlapped with Mr. Fano on N02 and his sworn statement includes a succinct summary of this issue. Mr. Jones wrote, "the day Fano hanged himself, Dep. Brown did not do his count until 5:30. I do not know what he wrote in the log, but if he had done his roll call at 5 like he was supposed to, Fano would not have been able to hang himself when he did."

L. EBR Failed to Administer Prescribed Medications

1. When Mr. Fano was arrested and taken to EBR, he had been prescribed anti-psychotic medication for three or four years. Dr. Blanche initially prescribed an anti-psychotic for him

but then tapered it off and discontinued it entirely just prior to Mr. Fano's suicide. However, even when the prescription was in force, Mr. Fano missed his medications 57 times. Of those 57 occasions, there was documentation as to why his medications were missed on only six of those times. The other 51 occasions are unexplained.

2. Once again, this is not a new problem at EBR or one for which EBR had had no notice or warning. The HMA study had found that medications were missed on 22% of scheduled occasions. Then, rather than correcting the situation, some six months later Mr. Fano is in EBR and his medications are missed over 30% of the time.

M. The EBR Suicide Prevention Policy and Procedure

1. One of the most crucial issues in any jail is suicide prevention because it has been well known for some time that suicide is the single leading cause of death for jail inmates. Thus, most jails have detailed and comprehensive suicide prevention policies and procedures.

2. In 2016 and in 2017, the EBR suicide prevention policy and procedure (EBRSO 000579) was a total of one page and was hopelessly inadequate. The policy states that an inmate on suicide watch will be placed in a single cell, in itself contrary to safest practices with suicidal inmates, on M or N units. It does not say which of those three living units will be used, so that suicide watch inmates were scattered. That makes staff observation and staff awareness more difficult for no good reason. The policy does not specify how frequently observation must be made and does not require suicide watch logs. Those are consensually accepted standards throughout corrections. The policy specifies that phone use for the inmate will be dictated by the location of the cell the inmate is placed in, rather than determined by some standard for all suicide watch inmates or by clinical decision. The policy does not specify who can release an inmate from suicide watch. It does not require or discuss any follow-up once an inmate is removed from suicide watch. There is no mention of the frequency of clinical visits or assessments for those inmates on suicide watch. That is just a sample of the crucial missing elements in this policy. Importantly, even as minimal as the policy was, it was not followed. The policy requires that when the medical department believes an inmate may be suicidal, the medical department will email a suicide watch notification to classification, to the disciplinary board, to the chief of security, and to the security shifts. When Mr. Fano was placed on suicide watch, that did not happen.

J. Solitary Confinement and Isolation Housing

1. In 2016, the U.S. Department of Justice issued its final report on the use of restrictive housing in correctional facilities, in response to a Presidential request for a review of the overuse of solitary confinement. Based on an extensive review, the report states that as a matter of policy the Justice Department believes strongly that segregating inmates from the general population is a practice that should be used rarely, applied fairly, and subjected to reasonable constraints. The Justice Department goes on to state that best practices include housing inmates in the least restrictive settings necessary to ensure their own safety as well as the safety of others and that restrictions on an inmate's housing serve a specific penological purpose and are imposed for no longer than necessary.

2. The report notes that when an inmate must be segregated from the general population, the inmate should be housed in safe and humane conditions. In the report, solitary confinement

or restrictive housing is defined as involving removal from general population, placement in a locked room or cell with inability to leave that room or cell for 22 hours or more a day. Jonathan Fano's incarceration on N01 and N02 met and substantially exceeded those criteria as he was unable to leave his cell for more than 23 and a half hours per day. It is clear from even the overview in the US Department of Justice report that EBR was far from compliant with these guidelines in the case of Jonathan Fano. His segregation conditions were not humane and he was not kept in segregation for the minimum time necessary. In fact, Mr. Fano was at EBR for approximately 90 days until his suicide and for all but two of those days, he was in isolation under extremely punitive conditions. Warden Grimes testified at his deposition that inmates sentenced to disciplinary segregation are limited to 20 days per month in isolation and even then there is a requirement that after 10 days in isolation they must be taken out of isolation for a day before they can be placed back for an additional 10 days. It makes no sense to limit isolation to 10 days at a time and 20 days per month, at a maximum as a sanction for inmates committing serious infractions, but then place no limit on the amount of consecutive days in isolation for inmates with serious mental illness. It is that latter group of inmates, those with serious mental illness and or suicidal tendencies, that will predictably suffer more serious effects from isolation than most general population inmates who have been sent to isolation as their punishment.

3. Warden Grimes testified that everyone in administrative segregation for mental health issues comes in front of an interdisciplinary board on a monthly basis that includes the Warden, the top staff, the EBR psychiatrist, and other health and mental health staff in order to reassess each individual, and that that procedure had started before CorrectHealth began at EBR and that Warden Grimes had initiated that review board (Grimes deposition, pgs. 47,-48, lines 10-6). That may have been a theory or a plan but it was not what was done with Mr. Fano. He was not seen by that board in November although he was in segregation housing for most of that month. He was not seen by the board in December although he was in segregation housing for all of that month. In January, Mr. Fano was again not seen by that board. In fact, he was never seen by that board although it was supposed to operate as a major safeguard against leaving an individual in administrative segregation for too long. The Warden also testified there was a second safeguard against an individual inmate getting "lost" on the segregation units, the "lockdown board," which also reviewed all lockdown inmates on a monthly basis. Mr. Fano was not seen by that board in November or in December, however. He was finally reviewed by that Board in January and there is nothing to document that review except a notation that he was to "remain," but without explanation except that he was categorized as "medical/suicide"(EBRSO 02149). In reality, at the time of that review, Mr. Fano had been off suicide watch for two months. Considering both boards, Mr. Fano should have been reviewed six times during the time that he was locked up on N01 and N02 but these safeguards did not operate for Mr. Fano.

4. Based on prior medical records and the deposition of Dr. Gregory Doane, when Mr. Fano was arrested and taken to EBR, he had been prescribed anti-psychotic medication for three or four years. Dr. Blanche initially prescribed an anti-psychotic for him but then tapered it off and discontinued it entirely just prior to Mr. Fano's suicide. However, even when the prescription was in force, Mr. Fano missed his medications 57 times. Of those 57 occasions, there was documentation as to why his medications were missed on only six of those times. The other 51 occasions are unexplained. Once again, this is not a new problem at EBR or one for which EBR had had no notice or warning. The HMA study had found that medications were missed on 22% of scheduled occasions. Then, rather than correcting the

situation, some six months later Mr. Fano is in EBR and his medications are missed over 30% of the time.

K. Violations of State and National Correctional Standards

1. The HMA study included a detailed analysis of various health and mental health standards promulgated by the NCCHC. As HMA made clear in their report, there were numerous areas where EBR was in substantial violation of those NCCHC standards.

2. Similarly, there have been a number of issues discussed in this report in which I have opined that the practices of EBR in general and the specific performance of EBR and its staff with regard to Mr. Fano, failed to meet national correctional standards. The EBR method of housing mentally ill and suicidal inmates is an excellent and obvious example.

3. There are only two currently promulgated and maintained sets of written national standards for correctional facilities. The first of these is published by the ACA and covers jails and prisons very broadly with standards ranging from sanitation to security to inmate programs to suicide preventing, and much more. The second set of written national standards are the NCCHC standards, referred to above. Those standards are substantially more detailed than the ACA standards but cover health and mental health issues exclusively (including pharmacy, dentistry, etc.). Neither set of written national standards is binding upon counties or states unless a particular jurisdiction has chosen to adopt that set of standards. Thus, for most counties and most states, they do not have force of law but are influential, particularly in the case of the NCCHC standards.

4. The situation with state jail standards is different. Most states have state jail standards specific to that state, although some states do not. In Louisiana, the state jail standards are found in Title 22, Part 3, Subpart 3, and are called "Minimum Jail Standards." Those standards have been adopted by the state Legislature, signed by the Governor and do have force of law.

5. Section 2705G of Louisiana State Jail Standards requires that the method and frequency of supervisory review of staff must be specified and documented. There is nothing in the documents produced by defendants in this case that would appear to meet that state requirement.

6. Section 2909E states, "inmates shall have continuous access to emergency healthcare by trained personnel and professional medical attention whenever required." Mr. Fano did not have continuous access to emergency healthcare during the two months following his first suicide attempt at EBR and had no access to either emergency healthcare or professional medical attention after his second suicide attempt.

7. Section 2909H requires that new inmates be asked during booking about the state of their health, medications taken and any health problems, with immediate referral to a physician where indicated. There was no serious inquiry about Mr. Fano's health history or his medication history when he was booked into EBR.

8. Section 31111A requires active outdoor recreation for all inmates for one hour per day, three times a week, where possible. Mr. Fano spent more than three months at EBR and it appears

that he never had so much as one hour of outdoor recreation in three months. Further, it is standard practice in correctional facilities that when a particular jail has no outside recreation yard or has no outside recreation area that would be secure for certain inmates, then inmates are given some recreation time indoors, whether in a gymnasium or some other large area where they can move about, perhaps with windows or sky lights open, etc. The important point is when this standard cannot be met, some reasonable alternatives must be arraigned and then maintained. That was simply ignored at EBR for N01 and N02 inmates, who were out of their cells for fifteen minutes or thirty minutes a day, and that time included shower time. Their "recreation" was limited to walking up and down the corridor. That generally accepted correctional practice is embodied in section 3111B, "inmates shall be provided with some form of indoor recreation activity on a daily basis." EBR made no attempt to comply with this state regulation. Walking to a shower and back is not "recreation".

9. Section 3305E states, "inmates may be involuntarily confined in their cells a maximum of 12 hours in any 24 hour period except as required for security reasons." There was no good security reason why Jonathan Fano had to be confined in his cell for 23.5 or 23.75 hours per day. He was not a danger to other inmates and he was not a danger to staff. He was not classified as on suicide watch so that he was not an imminent danger to himself. He was not classed as a potential victim so he did not need to be kept away from other inmates. Although both of these determinations by EBR are incorrect (that is, his PREA classification should have been "potential victim," and he should have been seen as an ongoing suicide risk), based on his classification by EBR, they were in constant violation of this standard with him.

10. Section 3307A requires that inmates have continuous access to communication from their housing areas to a staffed control station. Newer jails and prisons are typically built as modular or podular facilities and in those designs, staff can see all or almost all of the cells from a control area. In jails and prisons that use direct supervision, staff members are stationed full time inside the living units with the inmates. In older, linear facilities such as EBR, it is common to have a buzzer system or an intercom system or something similar, so that an inmate in distress or otherwise needing immediate staff attention, can immediately communicate with a control room or other staff station. EBR had none of that for the inmates on N01 and N02. Inmates talked about having to "rack the bars" in order to get staff attention when there was an urgent or emergency matter in that housing area. "Rack the bars" means that the inmates shake the cell doors to make enough noise that staff will hear them. Yelling and kicking the cell doors are also often used by inmates in those situations, but that does not substitute for a communication method providing continuous access, as required by the Louisiana state standard.

11. Section 3307C provides that protective custody inmates shall have equivalent conditions to the general population. That issue was discussed in this report and it should be clear that EBR makes no attempt to meet this state standard. Inmates on protective custody are housed with disciplinary segregation and, in general, are subject to the conditions governing those inmates in disciplinary segregation.

12. Section 3305C requires that inmates be logged into and out of the institution when entering or leaving for any reason. That is closely related to section 2705D which requires, "a log shall be kept of all persons entering or leaving the jail." While these two requirements do not apply to Jonathan Fano, they do serve as examples of how badly EBR was and is

operated. For a jail, these requirements are little more than common sense. Yet, when Lamar Johnson died in his cell at EBR, EBR was surprised because they did not have him listed as part of the population at the jail and thought he had already been discharged.

VI. Summary and Conclusions

A. EBR, the Parish, CorrectHealth and the prior medical/mental health provider were all on notice that EBR could not safely house mentally ill inmates. They were on notice because EBR officials and Parish officials testified to that effect, at length and in detail in 2015, at one point describing the situation as "an emergency", and for mentally ill inmates, "life or death".

B. In mid 2016, a comprehensive report from an independent consulting company provided a lengthy analysis of the medical and mental health facilities, services, and operations at EBR. That independent analysis confirmed that EBR needed to develop or build a mental health unit and could not safely manage mental health inmates in the current state of EBR. Both medical/mental health providers (pre Jan.1, 2017 and post Jan.1, 2017) had access to that report as did Parish officials.

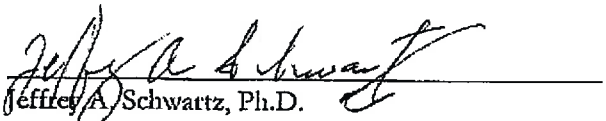
C. EBR, the Parish and the medical/ mental health providers knew the EBR could not come close to providing the quality of metal health care that was available in the community, and that it was dangerous to continue to house the seriously mentally ill at EBR, and to do so would predictably lead directly to long-term harm and even death for those inmates.

D. EBR, the Parish and the medical/mental health providers made no substantial attempts to eliminate or even mitigate the predictable harm to seriously mentally ill inmates at EBR and were callously unconcerned about those risks. Jonathan Fano's suicide death was a direct and proximate result and his family is left to cope with what was almost certainly a preventable tragedy.

E. When CorrectHealth took over health and mental health service at EBR on Jan. 1, 2017 they might have saved Jonathon Fano's life had they advocated to EBR security for medically appropriate ways to deal with the mentally ill. Instead, they continued with the discredited and dangerous practices that had been in place at EBR. That included placing individuals with mental illness in solitary confinement, minimal clinical contacts with the inmates in solitary confinement on N01 and N02, no meaningful reviews of those individuals, no programs for them and no movement toward establishing a functional mental health unit. In spite of a Jan. 3 report that Mr. Fano was hearing voices and suffering from anxiety and depression, and more recent information that he was not eating or sleeping, CorrectHealth staff member Cathy Schley saw Mr. Fano on Jan. 11 and decided he was likely faking or exaggerating. His family knew better and most of the inmates on N02 knew better but CorrectHealth also failed to respond to any of that information and their failures ultimately doomed Jonathon Fano's young life.

Jeffrey A. Schwartz, Ph.D.
January 9, 2020
At Campbell, CA

End-



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-End-

APPENDIX A

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SUMMARY

Thirty years experience in criminal justice management coupled with a psychology Ph.D. in research methodology. Detailed, hands-on experience with police, prisons, jails, community corrections; adult and juvenile; local, state, federal and foreign correction agencies. Development of innovative training programs and new approaches to training methodology. Planning for "turnaround management" and culture change in troubled institutions and agencies.

PROFESSIONAL EXPERIENCE

LETRA, Inc., Campbell, CA (1972 - present), A non-profit training and research organization, serving criminal justice and other governmental agencies, business and industry.

Founder and Chief Executive Officer:
All phases of corporate and fiscal management, supervision of professional staff, consultants. Policy development and procedures for emergency preparedness, use of force and conflict resolution. Design of new training programs and training of trainers.

RICHMOND POLICE DEPARTMENT, Richmond, CA (1968-1976)

Administrative Consultant to the Chief of Police:
Organizational development, research, program evaluation, new training programs and grants. Developed first generalist police crisis intervention training program in the U.S.. Planned and organized innovative department-wide juvenile diversion project, used as state model. National research on female and minority employment in policing.

PALO ALTO VETERAN'S HOSPITAL, Palo Alto, CA (1969-1971)

Chief of Program Evaluation Unit:
Founded, organized and managed new applied research unit in large medical/psychiatric teaching hospital. Developed research and statistical strategies for evaluating effectiveness of clinical programs. Served on Hospital Director's Executive staff.

EDUCATION

1960-1964	Western Reserve University	B.A. Chemistry and English Literature.
1964-1965	Toledo University	Graduate work: Psychology
1965-1968	Denver University	M.A. & Ph.D. Experimental Psychology (Research Methods, Learning, Statistics)
1968-1969	Palo Alto Veteran's Hospital	Internship: Clinical and Community Psychology

CORRECTIONS EXPERIENCE (representative sample)

National Institute of Corrections: Thirty years experience working with NIC. Conducted two large national management training programs over three years. Developed original curriculum, innovative training methodology, trained 500 managers from all areas of corrections from all 50 states in a residential 7-day, intense corrections-specific management skills training program. Administrated all aspects of these projects. Project Director for more than 10 major NIC grants / cooperative agreements; technical expert on more than 25 NIC technical assistance projects from all four NIC operating Divisions; authored 3 book length NIC publications. Helped plan new NIC courses and evaluated NIC operating procedures.

Shelby County, TN (Memphis) Jail: Comprehensive operational review of deeply troubled large jail system after Federal Court found the county in contempt of all five major elements of consent decree (2000). Developed plan to cure contempt findings, drafted response to Civil Rights Division of US DOJ to avoid second1983 suit, worked on transformation of jail to direct supervision and on population management, use of force, inmate grievance system, management training and practices. Achieved discharge from Federal Court supervision in 2005 and from DOJ supervision in 2009.

California Youth Authority (CYA): The development of Conflict Management and Crisis Intervention procedures in all Youth Authority institutions; training and procedures for the management of hostage situations; training of trainers. LETRA's Crisis Intervention training program has been required by policy of all CYA institutional staff and in use for over 15 years, and LETRA's Emergency Preparedness course was in use state-wide for over ten years.

Montana Department of Corrections (DOC): After the maximum security unit riot and hostage situation at the Montana State Prison in Deer Lodge, in 1991, selected by NIC to head the seven person Administrative Inquiry Team commissioned to investigate the events leading to and surrounding the riot. Coordinated the writing of the Inquiry Team Final Report ("Riot at Max") and managed extensive media contacts for the Inquiry Team.

Michigan DOC, Hawaii DOC, Alaska DOC: Initiated state-wide training programs in each state on institutional crisis intervention. All three State DOC's continued to provide this training to all or almost all institution staff for many years.

Pennsylvania DOC: After Camp Hill riots, conducted assessment of Department's emergency response capacity, developed plan to increase preparedness including recommendations for specialized equipment, staff, etc. Conducted administrative policy seminar, tailored emergency training curriculum to department's needs, trained cadre of mid-managers to deliver emergency preparedness training at all 16 institutions to both management and line/supervisory staff and developed format for new institutional emergency plans.

Nebraska, Iowa, Wyoming, Oregon, Kentucky, North Carolina, Missouri, Kansas, Florida, Delaware, North Dakota, Hawaii, Nevada, Arkansas, Vermont and New Hampshire DOC's, the Omaha, Jacksonville, Greenville and Boise jail systems: Emergency Preparedness. Typically began with security analysis and evaluation of existing emergency plans and procedures, review of emergency policies, leading to adaptation of LETRA's detailed, comprehensive and generic ("all risk") emergency system. Provided Emergency Preparedness training for all staff at all institutions on new emergency system by training and certifying department instructors.

Hawaii DOC: Created new Use of Force policy, then developed curriculum to train all staff to new policy. Prepared Department staff as instructors so Department would be self-sufficient. Achieved substantial reduction in allegations of improper use of force. Similarly adapted LETRA's model use of force policy and training for state DOC's in Oregon, New Mexico, Shelby Co. Jail.

Correctional Services of Canada: Crisis Intervention and Conflict Resolution work at Stony Mountain Penitentiary following riot and murder of two staff members. Developed Conflict Resolution program (in English and French) for all Regions of Penitentiary Service. Revised and expanded emergency policies governing crisis management at all Federal institutions in Canada.

POLICE CONSULTATION EXPERIENCE (representative sample)

FBI National Academy, Quantico, Virginia: Presented two seminars on Domestic Crisis Intervention to police executives from largest 50 police departments in U.S. LETRA was the first outside group (non-FBI) to be invited to present an entire course at the FBI Academy.

Richmond, California, Police Department: Developed new 40-hour training program for generalist patrol officers on child and juvenile issues. Course ranged from gangs to drug abuse to battered and neglected children. All uniformed officers and detective trained within one calendar year.

Sacramento, California, Police Department and Sheriff's Office: Long-term project to train trainers in Crisis Intervention. Over 1500 patrol officers trained in LETRA's Domestic Crisis Intervention during an 18 month period. Evaluation showed 40% reduction of officer injuries, reduction in time spent on disputes. Similar projects in Rochester, NY; San Jose, CA; and other police agencies.

COLLEGE/UNIVERSITY TEACHING EXPERIENCE

Denver University, San Francisco State University, San Jose City College, University of California at Santa Cruz, Guest Lecturer at Stanford Law School. Psychology courses taught: Learning, Theory of Measurement, Educational Psychology, Introductory Statistics. Criminal justice courses: Correctional Management, Police Supervisory Training, Training for Trainers, etc.

EXPERT WITNESS (Plaintiff and defense-side experience)

Use of Force (Police and Corrections); Operation of Correctional Facilities; Failure to Protect (Staff Sexual Misconduct with Offenders; Suicide; etc.); Emergency Preparedness and Emergency Response (Prisons and Jails); Crisis Intervention (Police, Probation, Parole, Jails and Prisons)

Currently a Federal Court Monitor On a Los Angeles Jails class action consent decree on use of force; also Federal Court Monitor, use of force consent decree, San Bernardino County Jails.

Class Action and related cases: Corrections expert in class action by Southern Poverty Law Center and Special Litigation Section of DOJ resulting in 2013 Consent Decree against New Orleans Jails; Corrections expert for Manhattan U.S. Attorney's Office in CRIPA investigation of adolescent conditions, Rikers Island; Invited testimony before Citizens' Commission on Jail Violence (CCJV), Los Angeles Jails; Federal Court security expert, consent decree on conditions, Virgin Islands Jails;

CRITICAL INCIDENT REVIEWS ("after-action reports")

Camp Hill (PA) riots; Hurricanes Katrina and Rita and the LA DOC; Hostage taking at Delaware Correctional Center; "Riot at Max" at Montana State Prism; Wyoming Penitentiary carbon monoxide poisonings; Southern Ohio Correctional Facility (Lucasville) riot.

AWARDS, PUBLICATIONS AND INVITED ADDRESSES

NDEA Fellow in Graduate Psychology. Presented invited addresses at ACA, APPA, AJA, CPPCA, IACP meetings, State Correctional Associations. Published numerous articles and chapters on corrections, research methodology, police science and psychology. Authored or co-authored more than 15 training texts, three book length NIC publications early NIC programmed learning course.

PROFESSIONAL ORGANIZATIONS (current and former)

American Correctional Association; American Probation and Parole Association; American Jail Association; California Probation, Parole and Corrections Association; American Psychological Association; International Association of Chiefs of Police

COMMUNITY INVOLVEMENT

Elected Trustee, West Valley-Mission Community College District, three terms. Served as President of Governing Board 1984-85 and 2005-2006. The District serves over 25,000 students, with more than 1000 employees and a budget of over $100 million dollars per year.

Member, Bd. of Directors, former President of large homeowners' association in Saratoga, CA.

Vice Chair, Board of Directors (1988 - 1995), Women's Housing Connection, which was the only homeless shelter in Santa Clara County exclusively for women and women with young children.

Co-founder and Director (1986-2009), Visa Technologies (later Momar Industries), a computer supply and flexible packaging company with over $10M in sales, annually.

Volunteer Mediator, Child Find, Inc., A national organization that attempts to locate missing children, reconcile run-away children and juveniles with their families, and prevent child abduction.

ADDITIONAL SKILLS AND EXPERIENCE

Budget and Personnel Management: As President of a College Board of Trustees, oversaw a budget in excess of $100M/year with approximately 1000 professional and support staff. Oversaw private corporate budget (Visa Technologies) in excess of $10M/year with 65 employees. Extensive experience teaching leadership development, personnel administration, budget and fiscal control and other management topics to criminal justice managers.

Media Relations and Public Speaking: Extensive media experience in community activities as well as with criminal justice work. Frequent public speaking in a wide variety of contexts.

Legislative Liaison and Policy Analysis: Substantial experience working with local legislative delegations, testifying before legislation bodies, analyzing and drafting policy and regulations.

Special Consultant to the California Assembly: (1) Investigation and hearings leading to resignation of Insurance Commissioner Charles Quackenbush. (2) Investigation and hearings on the state of California contract for Oracle software.

APPENDIX B

Jeffrey A. Schwartz, Ph.D.

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LIST OF CASES (May 28, 2019)

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Piszker v. Wackenhut Corrections and Raymond Andrews Case No. 97-16397	Court of Common Pleas Delaware County Civil Trial Division	Defense Sean Halpin @ Reed Smith Shaw & McClay 2500 One Liberty Plaza 1650 Market St. Philadelphia, PA 19103 Office: 215-851-8100	Couple sued private corporation running Delaware County Jail for injuries received from an inmate who had escaped from the jail.	Case settled.	Wrote report.
Mahar v. City of Reed City, et al. Case No. 1:98CV178	U.S. District Court Western District of Michigan, Southern Division	Plaintiffs Diane Goller Dilley, Muskowski & Goller, PLLC 1000 Trust Building 40 Pearl Street, NW Grand Rapids, MI 49503 Office: 616-4598383	Resident sued Reed City Police Department for unlawful arrest resulting in injuries. Arrest was made pursuant to a littering citation.	Case settled.	Wrote report, deposed.
Gonzalez v. New Mexico Department of Corrections, et al.	13th Judicial District Court, County of Valencia, New Mexico	Defense Timothy S. Hale Riley, Shane & Hale 4101 Indian School Rd. NE Albuquerque, NM 87110 Office: 505-883-5030	Correctional officer sued State Department of Corrections for injuries resulting from his participation in an emergency preparedness drill.	Ruling for Defense.	Wrote report.
Jeffers v. James Gomez, et al. Case No. CIV S-97-1335	U.S. District Court Eastern District	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, Ca 94109 Office: 415-561-9600	Inmate shot during disturbance at new Folsom Prison, CA DOC.	Case settled.	Wrote report.
Leitner v. Santa Clara County		Defense Doug Allen	Personnel Board disciplinary action against staff over death of mentally disturbed inmate in County Jail.	Judgment for Defense.	Reviewed records and videotapes, consulted with Defense attorneys, wrote report.

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Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
White v. City of Big Rapids, MI, et al. Case No. 1:94-CV-296	U.S. District Court Western District of Michigan, Southern Division	Plaintiffs Dianne Goller Dilley, Murkwski & Goller, PLLC 1000 Trust Building 40 Pearl St. NW Grand Rapids, MI 49503 Office: 616-459-8383	Plaintiffs sued City of Big Rapids MI, a public safety director and two police officers for unlawful arrest, excessive force and civil rights violations because of a broken arm and other injuries that plaintiff sustained pursuant to a police traffic stop.	Case settled.	Wrote report, deposed.
Sandoval v. Terhune, et al. Case No. C99-20027	U.S. District Court Northern Division	Plaintiffs Lawrence Knapp 215 Dorris Plaza Stockton, CA 95204 Office: 209-946-4440	Inmate shot by CA Department of Corrections officer during an altercation among inmates in recreation yard.	Case settled.	Review of documents.
Ford v. Terhune, et al. Case No. CIVS991234	U.S. District Court Eastern District	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Gay inmate attacked and killed by cellmate in maximum security mental health unit.	Case settled.	Reviewed documents, wrote report.
Klink v. City of Newman, et al. Case No. F-99-6360	U.S. District Court Eastern District Fresno Division	Plaintiff Jeff Klink 9976 Falcon Meadow Dr. Elk Grove, CA 95624 Office: 916-686-1488	Mentally disturbed individual, on amphetamines, shot and killed by Newman policy officer while threatening officer with a shovel.	Case settled.	Reviewed documents, wrote report.
Perez v. Terhune, et al. Case No. C99-20117	U.S. District Court Eastern District San Jose Division	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Inmate shot by correctional officer during fight with another inmate on Administrative Segregation exercise yard at Salinas Valley State Prison, CA.	Case settled.	Reviewed documents, wrote report.
Little v. Shelby County. Case No. 96-252-M1A	U.S. Federal District Court. Western District	Defense Shelby County (Memphis) Kathleen Spruill Shelby County Attorney's Office Donnie Wilson, Chief County Attorney	1983 conditions of confinement case focusing on inmate on inmate violence in county jail. Consent decree entered 1997, county found in contempt 12/00.	Defendants released from court supervision in 2005.	Hired 03/01 as consultant to assist county in improving jail conditions, meeting terms of consent decree. Testified in court as expert for county. Then served as Court expert.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Torrez v. Terhune Case No. 02AS00716	Superior Court of the State of California IN and for County of Sacramento	Plaintiff Roger Naghash 4400 Mac Arthur Blvd. Suite 900 Newport Beach, CA 92660 Office: 9499955-1000	Shooting death of inmate Torrez during a fight between Hispanic and Asian inmates at High Desert State Prison.	Case settled	Reviewed documents, wrote report.
Mack v. Oakland PD Case No. C-00-4599-CAL	U.S. District Court Northern District of California	Plaintiff Rodney Mack, et al. John Burris, Esq. 1212 Broadway Street, Suite 1200 Oakland, CA 94612 Office: 5510-839-5200	Allegations of police misconduct. Over 100 criminal defendants wrongly sentenced.	Stipulated settlement agreement approved by court.	Review documents, drafted consent decree, wrote report (Referred to as "The Riders" case.
Xavier v. San Francisco Police Department	U.S. District Court Northern District of California	Plaintiff Harriet Ross, Esq. One Sansome Street Suite 2000 San Francisco, CA	Allegations of excessive force while incarcerated in San Francisco jail.	Judgment in favor of defendant.	Wrote report, deposed, testified.
Duran v. State of California Case No. GIC 753709	California Superior Court County of San Diego	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter Suite 222 San Francisco, CA 94109 Office: 415-561-9600	Inmate stabbed in kitchen of CDC prison.	Case settled.	Reviewed documents.
Karr v. Roseville PD		Plaintiff Jeff Klink 9976 Falcon Meadow Dr. Elk Grove, CA 95624 Office: 916-686-1488	Wrongful death claim for the shooting of mentally disturbed man living in a storage unit.	Case settled.	Reviewed documents, wrote report.
Fernandez v. San Francisco Police Department		Plaintiff Andrew Schwartz Casper, Meadows & Schwartz 2121 N. California Blvd. Ste. 1020 Walnut Creek, Ca 94560 Office: 925-947-1147	Plaintiff was inmate in County jail. Deputy had sexual relationship with Plaintiff in jail.	Judgment for defense.	Reviewed documents, prepared declaration.

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Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Sheppard v. San Francisco Police Department Case No. C 01-3424-PJH	United States District Court Northern District of California	Plaintiff Harriet Ross One Embarcadero Center Ste. 500 San Francisco, CA 94111	Excessive force claim pursuant to arrest.	Judgment for Defense.	Reviewed documents, wrote report.
ILWU v. OPD Crowd Control Case		Plaintiff James Chanin 3050 Shattuck Ave. Berkeley, CA 94705 Office: 510-848-4752	Claim against Oakland PD for shooting people with multiple baton rounds, sting ball grenades, etc. during anti-war demonstration.	$4.5 million dollar settlement to Plaintiff Scott Olsen.	Assisting in preparation of model crowd control policy pursuant to seeking a consent decree.
Agredano v. County of San Bernardino SCVSS 098984	San Bernardino Superior Court	Plaintiff David Martinez, Esq. Robins, Kaplan, Miller & Ciresi, LLP 2049 Century Park E., Ste 3400 Los Angeles, CA 90067 Office: 310-552-0130 Fax: 310-229-5800	Inmate with long mental health and suicidal history hung himself from the top bunk. Inmate's family sued for failure to provide adequate medical care.	Case settled.	Reviewed documents.
Watson v. Livermore PD Case No. C-02-2830-WHA	United States District Court Northern District of California	Defense John L. Burris, Esq./State Bar #69888 Law Offices of John L. Burris 7677 Oakport St. Ste 1120 Oakland, CA 94621 Office: 510-839-5200	Claim of racial profiling by African American couple driving through Livermore.	Case settled.	Wrote curriculum for policy training regarding "minority issues with policy", per settlement agreement.
White v. Brown Case No. CIV F-02-5939 OWW SMS	United States District Court Eastern District of California	Plaintiff Stephen Horvath, Esq. 200 East Del Mar Blvd. Ste 202 Pasadena, Ca 91105	Civil rights case brought by family of inmate who died after a staff use of force against him at Corcoran State Prison in California.	Case settled.	
Adam Burke v. Garfield County Sheriff's Department, et al. Case No. 08-cv-00140	U.S. District Court District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen, PC 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Mr. Burke sued alleging that while he was in the Garfield County Jail, he was subject to excessive force including being shot in the testicles with a pepper ball gun, placed in a restraint chair and injured permanently.		Reviewed documents, wrote report.

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Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Anditon v. Priest & Lamarque Case No. C02-3703 MMC	U.S. District Court Northern District of California	Plaintiff Bill Orrick, Esq. Coblentz, Patch, Duffy & Bass 2049 1 Ferry Bldg, Ste 200 San Francisco, Ca 94111 Office: 415-752-6809 Office: 415-772-5712	Mental health inmate at California's Salinas Valley State Prison sued for excessive force after he was sprayed with OC and then injured by baton strikes from officers.	Case settled.	Reviewed documents, wrote report.
Freeman v. Alameda County Case No. C04-1698 SI	U.S. District Court Northern District of California	Plaintiff Frank S. Moore 1374 Pacific Ave San Francisco, Ca 94109 Office: 415-292-6091	Suit alleged deliberate indifferences and failure to protect after homeless, mental health inmate was beaten to death by his cellmate in the Santa Rita (Alameda Co.) CA, jail.	Case settled.	Reviewed documents and consulted.
Cingle, Guardian for Luethke v. Nebraska Case No. BC295053	District Court of Lancaster County, Nebraska	Defense Assistant Attorney General Stephanie Caldwell 2115 State Capitol Lincoln, NE 68509 Office: 402-471-2862	Inmate was beaten to death in a multiple occupancy cell at Diagnostic and Reception Facility in Nebraska.	Judgment for defense.	Wrote report, deposed; testified at trial.
Gavira v. LA County Sheriff Case No. BC2955053	LASC – Central District	Defense Timothy J. Kral Manning & Marder, Kass, Ellrod, Ramirez, LA California Office: 213-624-6900 Fax: 213-624-6999	Family members sued for negligence, deliberate indifference in the failure to provide medical/mental health treatment and for excessive force in the suicide by hanging of a jail inmate.	Settled.	Reviewed documents.
Porras & Grigsby, et al. v. Los Angeles County Case No. CV04-1229 ABC	USDC CV04-1229 RGK (RNBX)	Defense Timothy J. Kral Manning & Marder, Kass, Ellrod, Ramires 801 S. Figueroa Ste. 15 Los Angeles, Ca 90017 Office: 213-624-6900 Fax: 213-624-6999	1983 class action suit; deliberate indifference providing medical services; general failure to provide inmates access to adequate medical services and 14th and 18th amendment violations regarding health care, sanitation and access to council.	Settled.	Reviewed documents.
Ferrel v. City of Santa Rosa Case No. SCV 237557	Superior Court of the State of California	Plaintiff Eric G. Young 141 Stony Circle Ste. 202 Santa Rosa, Ca 95401 Office: 707-575-5005	Plaintiff alleges excessive and unnecessary force by Santa Rosa Police Department.	Case settled.	Reviewed documents, deposed.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Baker v. State of Nebraska Docket No. 1044 545	District Court of Douglas County, Nebraska	Defense Ms. Maureen Hannon, Ms. Stephanie A. Caldwell, Assistant Attorneys General 2115 State Capitol Lincoln, NE 68509	Couple sued state for negligence after inmate escaped and invaded their home, injured them.	Case settled in 2008.	Wrote report.
Harris v. Grams, et al. Case No. 07-CV-678	United States District Court for the Western District of Wisconsin	Plaintiff Pamela McGillivray and Carlos Pabellon Garvey, McNeil & McGillivray, S.C. 634 W. Main St. Ste 101 Madison, WI 53703 Office: 608-256-1003	Inmate sued for deliberate indifference in denying medical treatment and for retaliation.	Settled.	Reviewed documents, wrote report, deposed.
Trina S. Garcia v. Zavares, et al. Case No. 1:08-CV-02780	U.S. District Court, District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Ms. Garcia was an inmate in the CO DOC who was coerced into sex by a male staff member who was supervising her and was also having sex with at least three other female inmates.		Reviewed documents, wrote report.
David Ramirez v. County of Los Angeles, et al. Case No. CV-08-2813	U.S. District Court Central District of California, Western Division	Plaintiff Navid Sulimani & Adam J. Rottenberg Proskauer Rose, LLP 2049 Century Park East Ste. 3200 Los Angeles, CA 90067 Office: 310 284-4541	Mr. Ramirez was an inmate at Men's Central Jail and sued for injuries as a result of "serial extraction" of segregation unit.	Verdict for Defense.	Reviewed documents; wrote report; deposed; testified at trial.
Troy Short v. AJ Trujillo, et al. Case No. 08-CV-02209	U.S. District Court, District of Colorado	Plaintiff Jared B. Briant & Spencer B. Ross Faegre & Benson, LLP 1700 Lincoln St. Ste 3200 Denver, CO 80203 Office: 303-607-3500	Mr. Short was an inmate in the CO DOC and was harassed, threatened and beaten by gang related inmates. He sued for failure to protect him.	Case settled.	Reviewed documents, wrote report, deposed.
Shannon Bastedenbeck v. Zavaras, et al. Case No. 08-CV001841	U.S. District Court District of Colorado	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Ms. Bastedenbeck was an inmate in the CO DOC and was coerced into sexual relation by a Lieutenant. She sued Department Administrators and Supervisors for damages.		Reviewed documents, wrote report.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Oscar Garay, Jr., by Kelly Sue Garay v. Hamblen County Tennessee Case No. 2:11-CV-00128	U.S. District Court Eastern District of Tennessee	Plaintiff Robert Bates Law Offices of Tony Seaton 118 E. Watauga Ave. Johnson City, TN 37601 Office: 423-282-1041	Mr. Garay died as a result of a seizure while in a restraint chair in the Hamblen County Jail. His estate sued for failure to provide medication, medical treatment and for other causes.	Case settled.	Reviewed documents, wrote initial and supplemental report, deposed.
Jeffrey Marshall v. Deputy Castro, et al. Case No. S:04-1657	U.S. District Court Eastern District of California	Plaintiff Scotia J. Hicks, Yelitza V. Dunham & Craig Crockett Winston & Strawn, LLP 101 California St. San Francisco, CA 94111 Office: 415-591-1000	Mr. Marshall sued for unnecessary and excessive force on the part of Deputies in the Solano County, Ca Jail.	Case settled.	Reviewed documents, wrote initial and supplemental report, deposed.
Laura Lobozzo v. Colorado Department of Corrections, et al. Case No. 08-CV-01829	U.S. District Court Western District of Michigan, Southern Division	Plaintiff Andrea L. Blanscet Irwin & Boesen 501 S. Cherry St. Ste 500 Denver, CO 80246 Office: 303-322-2531	Laura Lobozzo was threatened and coerced into a sexual relationship by a male correctional officer while she was an inmate in the CO DOC. She sued for damages.		Reviewed documents, wrote report.
Estate of John Ketchapaw v. County of Ottawa, et al. Case No. 1:10-cv-320	U.S. District Court Western District of Michigan, Southern Division	Plaintiff Neal J. Wilensky Kaechele & Wilensky, PC 6500 Centurion, Ste 230 Lansing, MI 48917 Office: 517-853-1940	John Ketchapaw committed suicide. Plaintiff sued for damages based on Defendants alleged failure to appropriately screen Mr. Ketchapaw for suicide risk and to take appropriate preventative actions.	Case settled.	Reviewed documents, wrote report.
Don Antoine v. County of Sacramento Case No. 2:06-CV-01349	U.S. District Court Eastern District of California	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter St. Ste 222 San Francisco, CA 94109 Office: 415-561-9600	Mr. Antoine sued for damages alleging that several deputies had entered his cell, used excessive force, seriously injured him and then chained his handcuffs and leg shackles to the toilet drain grate in the cell floor and left him.	On appeal.	Wrote report; deposed; testified at trial.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Anthony Ferrel, et al. v. City of Santa Rosa, et al. Case No. SCV-237557	Superior Court State of California County of Sonoma	Plaintiff	Plaintiff and family members sued alleging that City of Santa Rosa police officers used excessive force in tasering, beating and pointing firearms at Mr. Ferrel and family members.	Case settled.	Reviewed documents, wrote report, deposed.
Krenn v. County of Santa Clara, et al. Case No. C07-2295	U.S. District Court Northern District of California	Defense David Sheuerman of Sheuerman, Martini & Tabari, PC 1033 Willow St. San Jose, CA 95125 Office: 408-288-9700	Andrew Martinez, a frequent mental health inmate in the Santa Clara County Jail, committed suicide in the jail in May 2006. His mother subsequently sued for failure to prevent the suicide.	Case settled.	Reviewed documents, wrote report.
Snyder & Santoro v. City and County of San Francisco Case No. 03-04927	U.S. District Court Northern District of California	Plaintiff John Houston Scott The Scott Law Firm 1375 Sutter St. Ste 222 San Francisco, CA 94109 Office: 415-561-9600	Mr. Snyder and Mr. Santoro alleged that they were walking out of a restaurant when two off duty SF police officers savagely beat them because they were gay. (Case referred to in SF as "Fajita – gate".)	Case settled.	Provided declaration on police Early Warning Systems, Progressive Discipline Systems, Effective Police Supervision, etc.
Daniel Duran v. State of California, et al. Case No. GIC753709	State of California San Diego Superior Court	Plaintiff Suzie Moore Law Offices of Suzie Moore 1901 First Ave. Ste 227 San Diego, CA 92101 Office: 619-231-9490	Mr. Duran sued after he was attacked and stabbed repeatedly by several other inmates at Centinela State Prison.	Case settled.	Reviewed documents, wrote report, deposed.
Lynette Frary (Carmignani) v. County of Marin (City of Novato) Case No. C-12-3928-MEJ	United States District Court Northern District of California	Plaintiff David L. Fiol, Attorney at Law Brent, Fiol, & Nolan LLP Two Embarcadero Center, 18th Floor San Francisco, CA 94111	Inmate died in custody from opiate overdose resulting from ingesting morphine pills prior to booking.	Settled	Received documents
Lawrence Carty v. John Dejongh (US Virgin Islands) Case No. 94-78	District Court of the Virgin Islands Division of St. Thomas and St. John	Appointed by Federal Court as the Court's Security Expert. The Honorable Judge Stanley S. Brotman.	Long-standing consent decree over conditions of confinement at two jails on St. Thomas, USVI.	Consent Decree ongoing	Conducted security audit, wrote report, testified on two occasions at Federal Court hearings in USVI.

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
LaShawn Jones, et al., v. Marlins Gusman, Sheriff, Orleans Parish, et al. Case No. 2:12-cv-00859	United States District Court Eastern District of Louisiana	Plaintiff Katie Schwartzman Director, Louisiana Office Southern Poverty Law Center 1055 St. Charles Ave., Suite 505 New Orleans, LA 70130	Class action suit over conditions of confinement in the New Orleans jails, jointly litigated by Southern Poverty Law Center and Special Litigation Section of Civil Rights Division of US DOJ.	Consent decree entered.	Conducted security audit of New Orleans jail facilities, wrote report, testified at hearing over consent decree.
Nathaniel L. Jackson v. Perry Phelps Case No. 10-919-SLR	United States District Court District of Delaware	Plaintiff Erika Caesar Young Conawa Stargatt & Taylor, LLP Rodney Square 1000 North King Street Wilmington, DE 19801	Inmate alleges cruel and unusual punishment for being placed in full restraints, left in cell for 24 hours in underpants as punishment for flooding cell.	Settled	Wrote report, deposed.
Ronald E. Johnson v. Douglas Weber Case No. CIV-12-4084	United States District Court District of South Dakota Southern Division	Plaintiff John Burke Thomas Braun Bernard & Burke, LLP 4200 Beach Drive Suite 1 Rapid City, SD 57702	Civil Rights suit by wife of Correctional Officer who was beaten to death in an escape attempt by two inmates at South Dakota state prison.	Dismissed pursuant to Defense motion.	Wrote report, deposed.
Aleshia Cyrese Henderson v. Stanley Glanz, Sheriff Case No. 12-cv-68-TCK-FHm	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Female inmate sues Sheriff for damages after she alleged rape by male inmate in medical area of jail.	Settled	Wrote report, deposed.
LaDona Poore v. Stanley Glanz, Sheriff Case No. 11-cv-797-CVE-TLW	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Former adolescent female inmate sues Sheriff alleging rape and other sexual assaults by male correctional officer.	$25,000 verdict for Plaintiff. On appeal.	Wrote report, deposed.
Linsey Dawn Shaver v. Stanley Glanz, Sheriff Case No. 12-Cv-234-CVE-PJC	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Female adolescent inmate sues Sheriff alleging sexual misconduct by male correctional officer in medical area of jail.	Pending	Wrote report.
Jeffrey Trevillion v. Stanley Glanz, Sheriff Case No. 12-CV-146-JHP-TLW	United States District Court Northern District of Oklahoma	Defense Guy Fortney, Esq. Corbin Brewster, Esq. Law Offices of Brewster & DeAngelis, P.L.L.C. 2617 East 21st Street Tulsa, OK 74114	Male inmate sues Sheriff over failure to provide wheel chair, excessive use of force and failure to provide medications.	Settled	Reviewed documents

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
CRIPA Investigation of Violence Issues Effecting Male Adolescent Inmates on Rikers Island Case No. 11-Cv-5845	United States District Court Southern District of New York	Plaintiff Emily A. Daughtry Jeffrey K. Powell Assistant United States Attorneys US Department of Justice Southern District of New York 86 Chambers St. New York, NY 10007	CRIPA investigation of staff use of force and inmate-on-inmate violence involving male adolescent inmates on Rikers Island.	Formal agreement reached under Federal Court Supervision	Reported to US Attorney's Office following assessment of condition for juveniles on Rikers. Participated in drafting/negotiating consent decree.
Marvin Hunter v. Jerome Wilen, Case No.	United States District Court Western District of Washington at Tacoma	Plaintiff Fred Diamondstone 1218 Third Ave., Suite 1000 Seattle, WA 98101	Inmate in Washington DOC has filed suits in State and Federal Court alleging he was assaulted by prison gang because Department wrongfully published information that he was a confidential informant then refused him protective custody or transfer.	Settled	Wrote report, deposed.
Michael Miceli v. Marlin Gusman, Sheriff Case No. 09-8078	United States District Court Eastern District of Louisiana	Plaintiff Mary E. Howell 316 S. Dorgenois St. New Orleans, LA 70119	Suicidal female inmate died in custody as a result of being placed in 5-point restraints on her back for 4 hours and staff using force to hold her down.	Settled	Received documents
Margaret Goetzee Nagle and John Eric Goetzee v. Marlin Gusman, Sheriff Case No. 12-1910	United States District Court Eastern District of Louisiana	Plaintiff Mary E. Howell 316 S. Dorgenois St. New Orleans, LA 70119	Widow of Coast Guard Commander sues Sheriff, Sheriff's employees, after her husband commits suicide on the tenth floor, mental health unit of the House of Detention.	Settled	Wrote report, deposed.
Jesse Goode v. County of Genesee Case No. 12-10340	United States District Court Eastern District of Michigan Southern Division	Plaintiff Neal Wilensky 6005 W. St. Joseph, Suite 303 Lansing, Michigan 48917	Inmate died as a result of opiate overdose ingested while in custody in the Genesee County Jail.	Settled	Wrote report, deposed.
Thomas Gould v. Board of County Commissioners of Major County Case No. CIV-11-290-M	United States District Court Western District of Oklahoma	Plaintiff Michael E. Grant Musser, Kouri, Bentwood & Grant 114 E. Sheridan, Suite 102 Oklahoma City, OK 73104	Wife arrested for possession when went to visit her husband in jail. Wife subsequently committed suicide by hanging in jail.	Dismissed pursuant to Defense motion.	Wrote report, deposed.

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Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Phillip Morris, Jr. v. R. A. White, et al. Case No. CV-08-02823-DOC (SSx)	United States District Court Central District of California	Plaintiff Katherine A. Rykken Latham & Watkins, LLP 355 South Grand Ave Los Angeles, CA 90071	Inmate in California Department of Corrections sued alleging excessive force by staff after inmate ran from two officers and across exercise yard.	Settled	Wrote report.
Cook County Case No. 13 CV 8752	United States District Court Northern District of Illinois	Plaintiff Sheila Bedi, Esq. David Shapiro, Esq.' McCarther Justice Center, Northwestern University Law School	A class action suit against the Cook County Jails focusing on staff use of force and inmate-on-inmate violence.	Case dismissed on motion by circuit court.	Wrote report; deposed testified at hearing.
Pickens v Management Training Corp	In The United States District Court For the Southern District of Mississippi Northern Division	Plaintiff Yancy B. Burns Burns & Associates, PLLC P.O. Box 16409 Jackson, MS 39236	Inmate lost one eye after stabbed and beaten in riot/gang war at private prison in MS.	Settled	Wrote report
Rosales v State of Nebraska Case No. CI 13-717	District Court of Lancaster County, Nebraska	Defense Bijan Koohmaraie Assistant Attorney General Nebraska Department of Justice 2115 State Capitol Lincoln, Nebraska 68509	Plaintiff suffered brain damage as result of assault by another inmate. Plaintiff sued state for failure to protect.	Verdict for Defense	Testified at trial.
Christopher Shapard v. John Attea, et al. Case No. 08-CV-6146 (CJS)	United States District Court Western District of New York	Plaintiff Luke X. Flynn-Fitzsimmons Paul, Weiss, Rifkind, Wharton & Garrison, LLP 1285 Avenue of the Americas New York, NY 10019	Plaintiff was inmate at Wende Correctional Facility in N.Y. DOC. Plaintiff alleges that three correctional officers beat him as retaliation.	Verdict for Defense	Wrote report; deposed.
Anthony Josta v. Woodbury County Case No. 13-97-0060	In The United States Disctrist Court Northern District of Iowa Western Division	Plaintiff John f. Carroll, RN, JD Attorney 2809 S. 160th Street, Suite 409 Omaha, NE 68130	Plaintiff died due to alcohol withdrawal while he was in the Woodbury County, Iowa, Jail.	Settled	Wrote report.
Anita Arrington-Bey, Administration of the Estate of Omar K. Arrington-Bey v. City of Bedford Heights, et al. Case No. 1:14-CV-02514	Court of Common Pleas Cuyahoga County, Ohio	Plaintiff Jacqueline Green Friedman & Gilbert 55 Public Square, Suite 1055 Cleveland, OH 44113	Plaintiff died in custody in the Bedford Heights, Ohio, jail following his placement in a restraint chair after he assaulted two officers in the jail.	Settled	Wrote report, deposed.
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**

Case Name & Number	Court	Retained By	Summary of Case	Disposition	Participation
Kelly Conrad Green v. Corizon Health, Inc. Case No. 42 USC 1983	United States District Court for the District of Oregon Eugene Division	Plaintiff Elden M. Rosenthal 121 S.W. Salmon St, Suite 1090 Portland, OR 97204	Plaintiff sued for failure to protect and failure to provide adequate medical services after he sustained permanent injuries.	Settled	Reviewed documents.
Farris v. Island County Case No. 15-I05352	Case settled before filing	Plaintiff Rebecca J. Roe Schroeter Goldmark Bender 810 Third Avenue, Suite 500 Seattle, WA 98104	Inmate died of dehydration and malnutrition while in custody for 11days in the Island County, WA Jail.	Settled	Reviewed documents.
Meirs v. Ottawa County Case No. 1:15-cv-00866	United States District Court Western District of Michigan	Plaintiff Steven T. Budaj Goodman & Hurwitz, PC. 1394 E. Jefferson Ave. Detroit, MI 48207	Inmate committed suicide while in custody in Ottawa County, MI, jail.	Verdict for defense	Wrote report; deposed; testified at trial.
Brian Otero v. Thomas J. Dart, Sheriff of Cook County Case No. 1:12-dv-03148	United States District Court for the Northern District of Illinois – Eastern Division	Plaintiff Jacie Zolna, Esq. Myron M. Cherry & Associates, LLC 30 North La Salle St., Suite 2300 Chicago, Illinois 60602	Class action suit alleging male prisoners in Cook County Jail held unnecessarily, endangered and treated differently than female prisoners after "not guilty" verdict.	Settled	Wrote report; deposed.
Glover v. Jayson Vest, et al. Case No. CIV-14-936-F	In the United States District Court for the Western District of Oklahoma	Plaintiff Rachel S. Fields Atkinson, Haskins, Nellis, Brittingham, Gladd & Fiasco, P.C. 525 South Main Tulsa, OK 74103	Staff sexual misconduct. Rape of female inmate in Harmon Co., OK jail by Deputy Chief of Police of Hollis, OK Police Department.	Jury award of 6.5 million dollars to Plaintiff	
Wilmer Catalan-Ramirez v. Ricardo Wong, Field Office Director, Chicago, U.S. Immigration and Customs Enforcement, et al.	District Court for the Northern District of Illinois Easter Division	Plaintiff Sheila Bedi, Esq. David Shapiro, Esq.' McCarther Justice Center, Northwestern University Law School	Handicapped Plaintiff was being transported in restraints without a seatbelt.		Testified by phone at Preliminary hearing
Donnie Ray Brown, et al. v. Conmed Healthcare Management, Inc., et al. Case No. 6:14-cv-01620-TC	United States District Court District of Oregon Eugene Division	Plaintiffs Benjamin W. Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Failure to provide medical treatment. Inmate in Coos Bay County, OR, jail died after failure to treat him for a perforated ulcer and peritonitis.	Settled	Wrote report and supplemental report.
Matthew Allen v. State of Oregon, et al., Case No. 3:11-CV-0218-PK	United States District Court District Court of Oregon Portland Division	Plaintiffs Benjamin W. Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Failure to protect (inmate-on-inmate gangs). Inmate in OR State Prison beaten by former gang after requesting protection.	Settled after state stipulated to liability on all three counts.	Reviewed documents.

Chris Blevins, et al. v. Marlin N. Gusman and Orleans Parish Sheriff's Office Case No. 2013-04979	Civil District for the Parish of Orleans State of Louisiana	Plaintiff Suzette Bagneris The Bagneris Firm, LLC 4919 Canal Street, Suite 104 New Orleans, Louisiana 70119	Failure to protect (inmate-on-inmate gangs). Male inmate stabbed to death in New Orleans Parish jails.	Settled	Reviewed documents.
Hamilton v. Correctional Health Care Management, Inc, et.al. Case No. CIV-09-544-M	In the United States District Court for the Western District of Oklahoma	Plaintiff Venessa Brentwood Durbin, Larimore & Bialick 920 N. Harvey Oklahoma City, OK 73102	Failure to provide medical treatment. Inmate died after staff use of force, lengthy time in restraint chair at the Oklahoma County Detention Center	Settled.	Wrote report; deposed.
The Estate of Joice Howard v. County of Genesee, et al. Case No. 14-12350	**Cannot find Complaint**	Plaintiff Neal Wilensky 6005 W. St. Joseph, Suite 303 Lansing, Michigan 48917	Failure to provide medical treatment. Female inmate in Genessee Co., MI, jail had high blood pressure and gran malseizures. Got no medication and died.	Settled	Wrote report.
Katka v. State of Montana, el. al. Case No. BDV-2009-1163	Montana First Judicial District Court Lewis and Clark County	Plaintiff Andree Larose Morrison, Motl & Sherwood, PLLP 401 N. Last Chance Gulch Helena, MT 59601	Juvenile held in high security at Montana State Prison. Conditions of confinement, failure to provide treatment.	Settled	Wrote report.
James Joshua Mayfield, et al. v. Orozco et al. Case No. 2:13-CV-02499-JAM-AC	United States District Court Eastern District of California, Sacramento Division	Plaintiff Josh Piovia-Scott Hadsell Stormer Renick, LLP 128 North Fair Oaks Avenue Pasadena, CA 91103	Failure to protect (suicide attempt).	Settled.	Wrote report.
James Merchant v. Woodbury County, et al. Case No. 7C16-CV-4111		Plaintiff John F. Carroll Watson & Carroll PC LLO 2809 S. 160th Street, Suite 409 Omaha, NE 68130-1755	Failure to provide medical treatment at the Woodbury Co., IA, jail. Inmate's stroke-like symptoms disregarded, inmate suffered permanent and profound impairment.	Settled	Wrote report.
Glenda Millington v. Corrections Corporation of American, et.al. Case No. 10-CIV-650-L	The United States District Court for the Western District of Oklahoma	Plaintiff Steven J. Terrill Bryan & Terrill Law, PLLC 401 S. Boston, Suite 2201 Tulsa, OK 74103	Failure to protect inmate-on-inmate gangs. Inmate at Cinnarron, private prison in Oklahoma, badly beaten in gang incident. Permanent, serious brain damage.	Settled	Wrote report and declaration; deposed.
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**
Williams v. Williams, et al.	In the United States District Court for the Central District	Plaintiff Leila Azari Latham & Watkins,	Inmate in L.A. Co. jails, at IRC, was in wheel chair and alleged	Settled.	Wrote report; deposed; retained as rebuttal witness.

Case No. CV08-7958-JVS	of California	LLP 355 South Grand Ave Los Angeles, CA 90071	unnecessary staff use of force		
People of the State of New York v. Anthony Criscuolo Case No. 2055-2013	Supreme Court of the State of New York County of Bronx	Plaintiff Steven A. Metcalf II, Esq. The Metcalf Law Firm, PLLC 11 Broadway, Suite 615 New York, New York 10004	Motion to set aside. Guilty plea as a result of pre-trial conditions.		Took case pro bono; provided declaration.
Jon Watson v. Cumberland County, et al. Case No. 1:16-cv-06578-JHR-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report; deposed.
David Hennis v. Cumberland County, et al. Case No. 1:16-cv-04216	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report
Alissa Allen v. Cumberland County, et al. Case No. 1:15-CV-06273-JBS-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report.
Estate of Megan Moore, et al, v. Cumberland County Case No. 17-cv-2839-RBK-KMW	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Reviewed documents.
Estate of David Conroy et al, v. Cumberland County Case No. 1:17-cv-07183-RBK-AMD	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Reviewed documents.
(Johnson, Lamar) Adrienne Lewis, by and on behalf of the minor child Liya Alexandria Johnson v. East Baton Rouge Parish, et al. Case No. 16-352-JWD-RLB	United States District Court Middle District of Louisiana	Plaintiff The Claiborne Firm, P.C. David J. Utter, Esq. 410 E. Bay Street Savannah, GA 31401	Suicide in the East Baton Rouge Parish Jail	Settled	Wrote report.
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**

Jonathan Fano v. East Baton Rouge Parish, et al. Case No. 3:17-cv-00656-SDD-EWD	United States District Court Middle District of Louisiana	Plaintiff The Claiborne Firm, P.C. David J. Utter, Esq. 410 E. Bay Street Savannah, GA 31401	Suicide in the East Baton Rouge Parish Jail by mentally ill male inmate.	Pending	Reviewed documents.
Frazier, Tayo Case No. 16-cv-2364	United States District Court for the Central District of Illinois Urbana Division	Plaintiff Shayla Maatuka Dodd & Maatuka 303 S. Mattis Ave, Suite 201 Champaign, IL 61821	Failure to provide medical services to female inmate going through withdrawal in Champaign Co. Jail. Inmate died.	Pending	Wrote report; deposed.
Cordell Johnson v. Correctional Corporation of America, et al. Case No. CIV-16-1061-R	In the United States District Court for the Western District of Oklahoma	Plaintiff Bryan & Terrill Spencer Bryan Steven Terrill 9 East Fourth Street, Suite 307 Tulsa, Oklahoma 74103	Failure to protect Inmate-on-inmate gang fight/riot in Cimmaron CCA operated private prison in OK. Inmate stabbed and permanent injuries.	Settled	Wrote report
Steve Tiffee, as Special Administrator for the Estate of Kyle Tiffee v. Corrections Corporation of America, et al. Case No. CJ-2016-378	In the District Court for Payne County State of Oklahoma	Plaintiff Bryan & Terrill Spencer Bryan Steven Terrill 9 East Fourth Street, Suite 307 Tulsa, Oklahoma 74103	Failure to protect. Inmate stabbed seriously injured in riot/gang war at Cimarron CCA operated prison in OK.	Pending	Reviewed documents.
Tyson Christian v. Willamette Community Health Solutions Case No. 6:17-cv-00885-AA	United States District Court For the District of Oregon Eugene Division	Plaintiff Patrick D. Angel Angel Law PC 6960 SW Varns Street, Suite 110 Portland, OR 97223 John T. Devlin Devlin Law, P.C. 1212 SE Spokane Street Portland, OR 97202	Failure to protect alcoholic inmate found unresponsive on floor of jail cell; died.	Settled	Reviewed documents.
Jacob Parenti v. County of Monterey; Sheriff Scott Miller Case No. 5:14-cv-05481	United States District Court Northern District of California	Plaintiff Joshua Piovia-Scott, Esq. Hadsell Stormer & Renick, LLP 128 North Fair Oaks Avenue Pasadena, CA 91103	Failure to provide medical care, negligence and wrongful death	Settled	Wrote report; deposed.
Estate of Laura Semprevivo, et al, v. Cumberland County Case No. 17-cv-2839-RBK-KMW	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Conrad Benedetto Attorney at Law Law Offices of Conrad J. Benedetto 1615 S. Broad Street Philadelphia, PA 19148	Suicide in the Cumberland County, New Jersey Jail	Pending	
Case Name & Number	**Court**	**Retained By**	**Summary of Case**	**Disposition**	**Participation**

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Madaline Pitkin v. Corizon Health, Inc. Case No. 3:16-cv-02235-AA	United States District Court District of Oregon – Portland Division	Plaintiff John Coletti Paulson Coletti 1022 NW Marshal, Ste. 450 Portland, OR 97209	Failure to provide appropriate medical care to young female inmate undergoing withdrawal in the Washington County Oregon Jail	Settled for 10 million dollars.	Wrote reports.
Rocky Stewart v. Coos County Jail	Complaint not yet filed.	John T. Devlin Devlin Law, P.C. 1212 SE Spokane Street Portland, OR 97202	Failure to provide appropriate medical care		Reviewed documents
Abdiwali Musse v. William Hayes, et al. Case No. C18-1736-JCC	United States District Court Western District of Washington at Seattle	Plaintiff Jay Krulewitch 2611 N.E. 113th Street, Suite 300 Seattle, WA 98125	Inmate in King Co. Jail attacked and seriously injured while he slept in congregate cell.	Pending	
Markist Webb v. Management & Training Corporation Case No. 15-CV-029-LE-C	In the Circuit Court of Leake County, Mississippi	Plaintiff S. Todd Jeffreys, Esq. Povall & Jeffreys, P.A. P.O. Box 1199 215 North Pearman Ave. Cleveland, MS 38732	Inmate seriously injured in riot/gang war at privately run proson (Walnut Grove) in MS.	Settled	Reviewed documents.
Christopher Thomas Woolverton v. Barry Martin, et al. Case No. 2:15-cv-00314-J	United States District Court for the Northern District of Texas Amarillo Division	Plaintiff Ben Haile Attorney at Law P.O. Box 2581 Portland, OR 97208	Fatal abuse of seriously mentally ill inmate who also suffered from medical significant problems, in a Texas State Prison.	Pending	Wrote report; provided declaration.
Anthony Huff v. Garfield County Sheriff's Office		David Donchin, Esq. Durbin, Larimod & Bialick, PC Oklahoma City, Oklahoma			
Robert W. Lewis v. Cumberland County, et al. Case No. 1:16-cv-03503	In the United States District Court for the District of New Jersey Camden Vicinage	Plaintiff Law Offices of Conrad Benedetto *Conrad Benedetto* 323 East Front Street Media, Pa. 19063	Suicide in the Cumberland County New Jersey Jail	Pending	Wrote report; deposed.

APPENDIX C

Jeffrey A. Schwartz, Ph.D.
1610 La Pradera Drive
Campbell, California 95008
(408) 379-9400 ♦ FAX (408) 379-9410
jasletra@aol.com

Expert Witness Fee Schedule (9/10/18)

1. Document review and other case preparation: $325 per hour

2. Testimony at deposition or trial: $425 per hour (Minimum charge $1,700 or 4 hours)

3. Airfare, car rental, meals and incidentals on travel status, and other case expenses: Cost reimbursable

4. Retainer: Agreed to on case by case basis, typically $2,500

5. Initial case review, typically up to 4 hours: No charge if not retained or if case declined. Charged at case preparation rate if retained and case accepted.

APPENDIX D

Recent Publications
Jeffrey A. Schwartz

1. A note on "Verbal and Non-verbal Indicators to Assault"; Corrections.com; May, 2009.
2. "Planning for the Last Disaster; Correctional Facilities and Emergency Preparedness; Journal of Emergency Management; Volume 7, #1; January/February, 2009.
3. Reducing Exposure in Use of Force Litigation; Corrections Today; June, 2009.
4. "The Force Continuum: Is It Worth Keeping? Part 1; Bill Collins, Jeffrey A. Schwartz and Donald Leach; Correctional Law Reporter; December/January, 2011.
5. "The Force Continuum: Is It Worth Keeping? Part II"; Bill Collins, Jeffrey A. Schwartz and Donald Leach; Correctional Law Reporter; April/May, 2011.
6. "Come and Get Me! The Best and Worst in Cell Extractions"; American Jails; July/August, 2009.
7. Turn Around in a Good Jail; Gary Raney and Jeffrey A. Schwartz; American Jails; January/February, 2008.
8. "Fixing Use of Force Problems"; American Jails, January/February, 2010.
9. "A Guide to Preparing for and Responding to Jail Emergencies"; Jeffrey A. Schwartz, Ph.D. and Cynthia Barry, Ph.D.; a book-length monograph published by the National Institute of Corrections; 2009.
10. "A Guide to Preparing for and Responding to Prison Emergencies;" Jeffrey A. Schwartz, Ph.D. and Cynthia Barry, Ph.D.; June, 2005; a book length monograph published by the National Institute of Corrections.

APPENDIX E

List of Documents for East Baton Rouge Parish Prison Litigation Jonathan Fano

1. Retainer agreement for Jeffrey A. Schwartz from The Claiborne Firm, P.C. re: East Baton Rouge Parish Prison Litigation dated November 14, 2017. 3 pgs.
2. Complaint Case No. 3:17-cv-00656-SDD-EWD dated September 20, 2017. 38 pgs.
3. Health Management Associates Report and Recommendations Clinical Operations at East Baton Rouge Parish Prison. 28 pgs.
4. Standards for Mental Health Services in Correctional Facilities. 17 pgs.
5. Some Positive Features/Aspects of Care at EBR Prison Draft 3/6/16. 10 pgs.
6. East Baton Rouge Prison. 14 pgs.
7. Deposition of Robert Blanche, M.D. Civil Docket No. 3:17-CV-00656-JWD-EWD & Civil Docket No. 3:16-cv-352-JWD-RLB dated June 11, 2019 and Exhibits.
8. Deposition of Lisa Burns and Exhibits 1-7 Civil Docket No. 3:17-CV-00656-JWD-EWD dated October 3, 2019.
9. Exhibit 7: Policies and Procedures Sub: Disciplinary Procedures revised 01/04/16. 10 pgs.
10. Deposition of Warden Dennis Grimes Civil Docket No. 3:17-CV-00656-JWD-EWD dated July 22, 2019 and Exhibits.
11. East Baton Rouge Parish Prison Disciplinary Report of Louis Fano dated November 1, 2016. 2 pgs.
12. Exhibit 3: Lockdown Review from Lt. Bryan Simmons dated January 3, 2017. 6 pgs.
13. Deposition of Danielle Thomas Civil Docket No. 3:17-CV-00656-JWD-EWD dated June 19, 2019 and Exhibits.
14. U.S. Department of Justice Report and Recommendations Concerning the Use of Restrictive Housing Final Report dated January 2016. 7 pgs.
15. M & N Control Log Started October 10, 2016 & Ended November 19, 2016. 79 pgs.
16. N-Wing Control Log Started October 31, 2016 & Ended December 17, 2016. 153 pgs.
17. Men Control Log Started November 19, 2016 & Ended December 28, 2016. 161 pgs.
18. N-Wing Control Log Started January 9, 2017 & Ended February 2, 2017. 49 pgs.
19. M & N Control Log Started January 9, 2017 & Ended February 2, 2017. 53 pgs.
20. Clinical Services Operations Policies and Procedures. 75 pgs.
21. M & N Control Logbook dated December 28, 2016. 27 pgs.
22. N-Wing Control Logbook Started date December 17, 2016 & Ended January 9, 2017. 41 pgs.
23. 34 Videos
24. Staff Activity Report – Blanche, Robert CHEBR03295-CHEBR03322 28pgs.
25. Staff Activity Report – Burns, Lisa CHEBR03323-CHEBR03329 6pgs.
26. Deposition of Jean Llovet Civil Docket No. 3:17-CV-00656-JWD-EWD Dated September 19, 2019 and Exhibits.
27. Sworn Statement of Daniel Hinton, JR. Civil Docket No. 3:17-CV-00656-JWD-EWD 4pgs
28. Sworn Statement of Emanuel Jones 2pgs.
29. Sworn Statement of Frank Brooks 3pgs
30. Disciplinary report – Louis Fano 2 pg
31. Information Report – Frank Brooks 1pg
32. Deposition of Courtney Eichelberger Civil Docket No: 3:17-CV-00656-JWD-EWD dated November 8, 2019 and Exhibits.
33. Booking Records – Louis Fano 19pgs.
34. Transcripts of phone and visit logs – 45pgs.

35. Deposition of Daniel Hinton, Jr. Civil Action No. 3.17-CV-00656-JWD-EWD dated November 12, 2019 and Exhibits.
36. Logbook Video – Excel spreadsheet
37. Deposition of Sharon Saxton Allen dated June 19, 2019 and Exhibits.
38. Deposition and Exhibits of Dolores Alvarez Zadikian dated August 20, 2019.
39. Deposition of Miguel Alvarez dated August 20, 2019 and Exhibits.
40. Deposition of Maria Miriam Alvarez dated August 20, 2019 and Exhibits.
41. Deposition of Kimberly Khosravian dated September 12, 2019 and Exhibits.
42. Deposition of Brian Bennet dated October 4, 2019 and Exhibits.
43. Deposition of Vincent Bradley dated August 6, 2019 and Exhibits.
44. Deposition of Joseph Breeding and exhibits dated June 18, 2019.
45. Deposition of Dr. Charlie Bridges dated October 17, 2019 and Exhibits.
46. Deposition of Frank Brooks and exhibits dated October 17, 2019.
47. Deposition of Andrea Brown and exhibits dated June 18, 2019.
48. Deposition of Joyce Brown dated September 19, 2019 and Exhibits.
49. Deposition of Jasmyn Cage dated June 19, 2019 and Exhibits.
50. Deposition of Tonyala Cannon and exhibits dated September 12, 2019.
51. Deposition of William Daniel and exhibits dated October 2, 2019.
52. Deposition of Gregory Doane dated August 21, 2018 and Exhibits.
53. Deposition of Courtney Eichelberger and exhibits dated November 8, 2019.
54. Deposition of Carlos Fano dated August 9, 2019 and Exhibits.
55. Deposition of Vanessa Fano dated August 19, 2019 and Exhibits.
56. Deposition of Linda Freeman-Jones and exhibits dated August 6, 2019.
57. Deposition of Justin Freeman and exhibits dated July 16, 2019.
58. Deposition of Tamekka Green dated June 11, 2019 and Exhibits.
59. Deposition of Chad Guillot and exhibits dated October 18, 2019.
60. Deposition of Susan Hatfield dated July 22, 2019 and Exhibits.
61. Deposition of Daniel Hinton dated November 12, 2019 and Exhibits.
62. Deposition of Rudolph Hyde dated June 19, 2019 and Exhibits.
63. Deposition of Jolanda James and exhibits dated June 18, 2019.
64. Deposition of Natasha Jones and exhibits dated October 18, 2019.
65. Deposition of Jean Llovet and exhibits dated September 19, 2019.
66. Deposition of Troy McGee dated June 15, 2019 and Exhibits.
67. Deposition of Ronald Monroe dated July 15, 2019 and Exhibits.
68. Deposition of Carlo Musso dated September 30, 2019 and Exhibits.
69. Deposition of Cathy Schley and exhibits dated June 11, 2019.
70. Deposition of Johnny Scott dated July 16, 2019 and Exhibits.
71. Deposition of Bryan Simmons dated July 16, 2019 and Exhibits.
72. Deposition of Walter Smith and exhibits dated October 14, 2019.
73. Deposition of Beatrice Stines and exhibits dated October 3, 2019.
74. Deposition of Danielle Thomas dated June 19, 2019 and Exhibits.
75. Deposition of Gary Wilson and exhibits dated July 15, 2019.
76. Deposition of Maria Zavala dated August 19, 2019 and Exhibits.
77. Deposition of Rani Whitfield and exhibits dated November 11, 2019.
78. Corey Pittman declaration in Lamar Johnson case.
79. Marcus Williams declaration in Lamar Johnson case.
80. Byron Maxon declaration in Lamar Johnson case.
81. Turner Jackson declaration in Lamar Johnson case.
82. Travis Anderson declaration in Lamar Johnson case.

83. Broderick Samuel declaration in Lamar Johnson case.
84. Michael Lacour declaration in Lamar Johnson case.
85. Josh Boxie declaration in Lamar Johnson case.
86. Christopher Haney declaration in Lamar Johnson case.
87. Joseph Jones declaration in Lamar Johnson case.
88. Shawn Robinson declaration in Lamar Johnson case.
89. Lorenza McCutcheon declaration in Lamar Johnson case.
90. US DOJ, Bureau of Justice Statistics, "Mortality in Local Jails 2000-2014".
91. Farris, S. and Armstrong, A., Dying in East Baton Rouge Parish Prison; July 2018.
92. Deposition of Walter Smith, Exhibit 2.
93. HMA notes dated 2016.
94. PPt Draft 1 dated 2016.
95. Batia Notes – NCCHC Medical Standard dated April 2016.
96. Batia Notes – NCCHC Medical Standard Mental Health.
97. NCCHC Position Statement: Solitary Confinement (Isolation) dated April 2016.
98. Metro Council Meeting video, Jan. 14, 2015, Item 13P and Q Part I.
99. CorEMR-EBRP – Reports staff activity reports provided by CorrectHealth in discovery.
100. Select security logs and booking unit rosters from the Lewis litigation.
101. EBRPP lockdown board review.
102. Select security logs and booking unit rosters from the Lewis litigation, including "C.B. Inmates" Roster.