

**SYMPOSIUM:
CRUEL AND UNUSUAL PUNISHMENT:
LITIGATING UNDER THE EIGHTH AMENDMENT**

**PRISON HEALTH CARE, POLITICAL CHOICE, AND THE
ACCIDENTAL DEATH PENALTY**

*Elizabeth Alexander**

In *Hadix v. Caruso*, I represent a class of prisoners in a decades-long case challenging conditions of confinement, including medical care, at various Michigan prison facilities.¹ Since August 2006, I have been haunted by the death of one of those prisoners because, in retrospect, his death appears to be the inevitable by-product of a prison system swollen beyond any historical precedents, or its ability to manage such a huge number of people safely. Prisons are in fact extraordinarily difficult to operate safely and humanely, and the United States will continue to fail to do so absent a fundamental change in criminal justice policy. This Article seeks to trace some connections between a dysfunctional criminal justice policy and the death of one man.

Prison systems like Michigan's have been allowed to operate unsafe prisons because the federal courts have failed to provide an effective form of oversight, and no other form of serious oversight exists in the United States. In a series of decisions, the Supreme Court has preserved the form of Eighth Amendment challenges to conditions of confinement, but little of the substance, by allowing severely

* Elizabeth Alexander is the Director of the National Prison Project of the American Civil Liberties Union Foundation. She would like to thank Patricia Streeter, who has served as an extraordinary co-counsel in *Hadix v. Caruso (Hadix III)*, 465 F. Supp. 2d 776 (W.D. Mich. 2006). I am also grateful for the assistance of Susan Pourciau, a third-year law student at Duke University School of Law, and Darcy Hirsh, a third-year law student at Benjamin N. Cardozo School of Law.

¹ See, e.g., *Hadix v. Caruso (Hadix III)*, 465 F. Supp. 2d 776, 778–79 (W.D. Mich. 2006) (detailing the history of the litigation), *vacated*, 248 F. App'x 678 (6th Cir. 2007) (per curiam). Until recent years, the case was known as *Hadix v. Johnson*, and generated a large number of judicial opinions. See, e.g., *Hadix v. Johnson (Hadix I)*, 367 F.3d 513 (6th Cir. 2004) (remanding finding of a constitutional violation regarding fire safety).

overcrowded prisons,² suggesting that considerations of cost can defeat an Eighth Amendment claim,³ and allowing Eighth Amendment claims to be defeated even when prison conditions are objectively intolerable and deny prisoners basic human needs, including health care.⁴ Unfortunately, Michigan may ultimately illustrate that the only real restraint on prison growth is its cost, not the Constitution.

I. THE LONESOME DEATH OF TIMOTHY SOUDERS

Timothy Souders arrived at the Southern Michigan Correctional Facility in March 2006 with medical problems that included a thyroid disorder and cardiac risk factors.⁵ He also had been diagnosed with bipolar disorder and depression, and had attempted suicide multiple times.⁶ It was duly noted in his medical record that, because of his medications and medical problems, he was at very high risk of injury if exposed to excessive heat.⁷

In March 2006, the prison psychiatrist changed Mr. Souders's medications, prescribed lithium for his bipolar disorder, and subsequently increased his lithium. There are no records of laboratory monitoring of the level of lithium in his blood for the relevant period,⁸ although elevated lithium levels are toxic and can cause symptoms ranging from mental confusion to life-threatening side effects such as kidney failure.⁹ Monitoring lithium levels in the blood is considered absolutely necessary when lithium is prescribed, and high lithium levels are particularly dangerous in someone who is dehydrated.¹⁰

² See *Rhodes v. Chapman*, 452 U.S. 337, 348–49 (1981) (explaining that when overcrowding has not been shown to inflict wanton pain or lead to deprivation of basic necessities, such as food, it does not violate the Eighth Amendment).

³ *Wilson v. Seiter*, 501 U.S. 294, 301–02 (1991) (noting and not rejecting the argument that requiring a showing that prison officials are deliberately indifferent in order for prison conditions to violate the Eighth Amendment would allow prison officials to prevail by showing fiscal constraints and stating that interpretation of the Eighth Amendment is controlled by its language, not by policy considerations).

⁴ *Farmer v. Brennan*, 511 U.S. 825, 837–38 (1994) (defining the deliberate indifference standard required to show an Eighth Amendment violation in prison conditions in a manner parallel to the recklessness standard in the criminal law).

⁵ *Hadix v. Caruso (Hadix II)*, 461 F. Supp. 2d 574, 577, 579 (W.D. Mich. 2006).

⁶ *Id.* at 578.

⁷ Transcript of Hearing on October 11–13, 2006, at 265–66, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591) [hereinafter Hearing]; Plaintiffs' Exhibit 114, at 152158, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591) (providing Timothy Souders's medical record).

⁸ Plaintiffs' Exhibit 114 at 152157, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591).

⁹ Hearing, *supra* note 7, at 134–35; see also *Hadix II*, 461 F. Supp. 2d at 579.

¹⁰ Hearing, *supra* note 7, at 134–35; *Hadix II*, 461 F. Supp. 2d at 579.

Near the end of May 2006, the psychiatrist went on medical leave and thereafter there was no psychiatrist on-site for the 1,400 prisoners at the prison.¹¹ In June, Mr. Souders was involved in a fight with another prisoner and was ordered to punitive detention. After thirty days, he was released but sent back to the segregation unit for taking an unauthorized shower during an August day on which the heat index was over 90.¹²

He was put in a boxcar cell—essentially, an unventilated cell with no windows and a solid metal door, rather than an open-barred cell front—on the sixth level of the prison.¹³ When staff opened the food slot in one of the solid doors, which is how staff talked to prisoners in those cells, on hot days they could feel a blast of hot air from inside the cell.¹⁴ During the next few days the heat index in the cells rose to around 100.¹⁵

On August 2, 2006, Mr. Souders damaged the metal stool in his cell and was put into standing restraints.¹⁶ When he tried to flood his sink, according to custody records, a supervisory nurse approved cutting off the water to the cell.¹⁷ That restriction was removed only because someone noticed that the whole prison was on heat alert status.¹⁸ Mr. Souders was then put on top-of-bed restraints on a concrete slab, with metal restraints on his wrists and ankles.¹⁹ Use of these types of restraint is well known to carry a risk of death from as-

¹¹ *Hadix II*, 461 F. Supp. 2d at 584; Plaintiffs' Exhibit 5H at 322346–48, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591).

¹² Prison Events Timeline, Plaintiffs' Exhibit 106A at 1, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591); Hearing, *supra* note 7, at 191–204; Investigation Records Re: Mr. Souders' Death, Plaintiffs' Exhibit 42, at 320501, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591) [hereinafter Investigation Records] (providing the segregation record). The heat index combines temperature and humidity into a measurement that more accurately reflects human perception of the apparent temperature. Heat index, rather than temperature, is routinely used to measure risk of heat injury under particular conditions. A heat index of 90, roughly speaking, "feels" like a temperature of 90°F. National Oceanic and Atmospheric Administration, Heat Index and Humidity from Temperature and Dewpoint, http://www.crh.noaa.gov/jkl/?n=heat_index_calculator (last visited Nov. 5, 2008).

¹³ See Plaintiffs' Exhibit 106B, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591) (showing Mr. Souders's cell confinement). For a description of a boxcar cell, see *United States v. Koch*, 552 F.2d 1216, 1218 (7th Cir. 1977).

¹⁴ Deposition of Francis Duffy, Plaintiffs' Exhibit 103, at 73, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591).

¹⁵ *Hadix II*, 461 F. Supp. 2d at 579.

¹⁶ *Id.* at 577; Investigation Records, *supra* note 12, at 320904, 320906.

¹⁷ Investigation Records, *supra* note 12, at 320904, 320844. The nurse subsequently denied remembering whether she authorized the restraints or not. Deposition of Betty Glaser, Plaintiffs' Exhibit 104, at 38, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591).

¹⁸ Investigation Records, *supra* note 12, at 320844.

¹⁹ *Hadix II*, 461 F. Supp. 2d at 577.

phyxiation, heart attack, and dehydration.²⁰ That day the social worker who was in charge of mental health services for the prison characterized Mr. Souders as “floridly psychotic.”²¹ From August 2 through August 5, the segregation log and the video camera used in his cell document that Mr. Souders was repeatedly screaming incoherently.²² Between August 2 and August 6, Mr. Souders rarely accepted water.²³ During the first two days he was in restraints, the video camera staff used to film him fogged up and staff complained of the heat and humidity in his cell.²⁴ As the use of restraints continued, Mr. Souders was held in restraints naked.²⁵ He urinated in his restraints and he developed burn-like sores on his body from lying in his own waste.²⁶ At one point, custody records indicate that Mr. Souders was transported to the prison’s unaccredited on-site “hospital,” but the physician there declined to examine him, apparently because he urinated on the examining table.²⁷

On August 6, correctional officers walked him to the showers; the video shows him staggering. Shortly thereafter, the restraints were removed. He then fell to the floor of his cell and was unable to get up. Correctional officers returned him to the slab.²⁸ A nurse examined Mr. Souders in his cell and told him that his pulse was faint, a symptom that indicated that he had experienced a drastic fall in his cardiac output.²⁹ The nurse then left the cell without doing anything to assist him.³⁰ For the next hour there was no movement in the cell.³¹ Then staff reentered the cell because Mr. Souders did not appear to be breathing.³² He was pronounced dead shortly thereafter, at the age of 21.³³

Michigan allows “limited license psychologists” to treat prisoners absent supervision even though they are not eligible to treat people in the community without supervision by a fully-licensed psycholo-

²⁰ *Id.* at 580–81, 595.

²¹ *Id.* at 578.

²² Investigation Records, *supra* note 12, at 320951–56, 320958–62; Plaintiffs’ Exhibit 106B, *supra* note 13.

²³ Investigation Records, *supra* note 12, at 320952–62, 320964, 320966, 320969.

²⁴ Plaintiffs’ Exhibit 106B, *supra* note 13.

²⁵ *Hadix II*, 461 F. Supp. 2d at 577.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.* at 579.

²⁹ *Id.* at 579–80.

³⁰ *Id.* at 580.

³¹ Plaintiffs’ Exhibit 106B, *supra* note 13.

³² *Hadix II*, 461 F. Supp. 2d at 580.

³³ *Id.* at 577, 580.

gist.³⁴ The limited-license psychologist who last saw Mr. Souders alive had an undergraduate degree in theology and a master's degree in community counseling.³⁵ This limited-license psychologist had seen the psychologist who was officially "supervising" him once, from a distance, in the preceding year.³⁶ The person who diagnosed Mr. Souders as floridly psychotic was a psychiatric social worker and also was not licensed to practice in the community without formal supervision.³⁷ Aside from the prison system's employment of staff who are not fully licensed, the staff demonstrated a pervasive indifference to community standards of care, as illustrated by the psychiatrist's failure to perform routine tests for toxic levels of lithium that any psychiatrist in the community would have required.³⁸

Staff resources were severely stressed. The Director of Nursing at the prison where Mr. Souders died testified that the prison complex needed about eleven more registered nurses to deliver health care. Almost a third of the registered nursing positions were filled by licensed practical nurses.³⁹ Even today, despite Mr. Souders's death, the Department has no policy that requires large prisons with segregation units, which are typically full of mentally ill prisoners, to have on-site psychiatrists.⁴⁰

³⁴ Psychology Supervision Update and Doctoral Education Limited Licenses, http://www.michigan.gov/documents/mdch/mdch_psyssuperrequ11_09_06_177860_7.pdf (last visited Nov. 5, 2008).

³⁵ Deposition of Allan Small, Plaintiffs' Exhibit 105, at 5–6, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591). This psychologist was involved in another patient death case during the same period. *Hadix II*, 461 F. Supp. 2d at 581–82. He thought that the second patient might have been suffering paranoid delusions, but did not refer the patient to a psychiatrist because the patient was refusing treatment. *Id.* at 582. Over a year after the patient was known to suffer from toxic levels of thyroid hormone, the staff finally petitioned for the appointment of a guardian to authorize medical treatment, but the patient died before treatment could be authorized. *Id.* at 582–83. The court found numerous other instances of inadequate psychological and psychiatric treatment of prisoners, some of whom committed suicide. *Id.* at 583–84.

³⁶ *Hadix II*, 461 F. Supp. 2d at 585.

³⁷ *Id.*

³⁸ *See id.* at 579 n.2 (describing Mr. Souders's treatment as "not clinically appropriate").

³⁹ Deposition of Debbie Roth, Plaintiffs' Exhibit 107, at 50–54, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591); *see also Hadix III*, 465 F. Supp. 2d 776, 792–93 (W.D. Mich. 2006) (noting testimony that nursing staff levels were inadequate), *vacated*, 248 F. App'x 678 (6th Cir. 2007) (per curiam).

⁴⁰ The psychiatrists in the system are employed by the Department of Community Health and are part of out-patient mental health teams. DEP'T OF CMTY. HEALTH, PERFORMANCE AUDIT OF THE CORRECTIONAL MENTAL HEALTH PROGRAM (1998), *available at* <http://audgen.michigan.gov/comprpt/docs/r3965097.pdf>. Many of the high security prisons in the system do not have an out-patient team. Defendants' Status Report Regarding Transfer Grid, at Ex. A, *Hadix v. Caruso*, No. 4:92-CV-110 (W.D. Mich. March 15,

The medical staff operate in a culture of deference to custody that interferes with care. That culture explains the behavior of the nurse who told custody that there was no reason why Mr. Souders could not be placed on a water restriction despite his medical problems and the conditions within his boxcar cell.⁴¹ It similarly explains the conduct of the doctor who knew of Mr. Souders's urine burns, but neither treated him nor objected to the use of restraints by custody.⁴² That culture also explains how a registered nurse could fail to initiate treatment when he learned that Mr. Souders had developed a weak pulse.⁴³ All of these individual failures took place in a context in which no medical or mental health staff perceived a need to intervene. Nor did any medical staff question why custody made the decision to put a mentally ill man into restraints. Nor did anyone question leaving a man in restraints within a boxcar cell where staff could not readily observe him. As the medical director for the Michigan prison system admitted, there was ample opportunity for medical, mental health, and custodial staff to intervene, but it never happened.⁴⁴

The autopsy determined that the cause of death was hyperthermia, with dehydration as a secondary cause, but it characterized the death as an "accident."⁴⁵ While no one has asserted that any staff member actively desired the death of Mr. Souders, I cannot accept the claim that the death was an accident. Rather, the death of Mr. Souders and other victims followed inevitably from the decision of the State of Michigan to imprison almost 50,000 people but fail to provide the resources necessary to provide them with minimally adequate health care, combined with a staff culture of willful blindness to the risks that this lack of care entailed.

2007) (identifying a number of high security prisons, including Baraga Maximum Security Facility, as not having any on-site psychiatric coverage); *see also* Michigan Department of Corrections, Baraga Maximum Correctional Facility (AMF), http://www.michigan.gov/corrections/1,1607,7-119-1381_1388-5325-,00.html (last visited Nov. 5, 2008) (noting that Baraga Maximum Correctional Facility confines prisoners with the highest security classification (Level V), with four out of seven housing units designated as segregation units). For purposes of clarity, I will not cite unpublished *Hadix* filings to any of the published *Hadix* cases.

41 *See supra* note 18 and accompanying text.

42 *See supra* note 27 and accompanying text.

43 *See supra* note 30 and accompanying text.

44 *Hadix II*, 461 F. Supp. 2d at 580.

45 Plaintiffs' Exhibit A to Stipulation at 1, *Hadix II*, 461 F. Supp. 2d 574 (No. 06-2591) (providing the Timothy Souders Autopsy Report).

II. JUST ANOTHER BRICK IN THE WALL

As might be expected from the number and variety of deficiencies in the medical and mental health care implicated in the death of Timothy Souders, this death took place against a backdrop of systemically inadequate care. For some years, the Michigan prison system has chosen to concentrate its sickest prisoners in the *Hadix* facilities.⁴⁶ As of early 2007, at the largest *Hadix* prison, half of the prisoners suffered from at least one chronic disease requiring ongoing treatment.⁴⁷ The apparent reason for this concentration of chronically ill prisoners was the proximity of Duane Waters Hospital, run by the Department of Corrections. The hospital was required under a Consent Decree entered early in the *Hadix* litigation.⁴⁸ For a substantial period of time, the hospital was accredited by the Joint Commission on Health Care Organizations, but that accreditation has now lapsed.⁴⁹ Despite the lack of accreditation, the Department of Corrections continues to allow a surgeon who lacks admitting privileges at any hospital to perform surgeries there.⁵⁰

Thus, although the *Hadix* facilities have served as the linchpin of the Michigan prison health care system, that linchpin is malfunctioning. The *Hadix* court made findings in 2002 regarding hundreds of incidents in which prisoners received inadequate or delayed care, or no care at all.⁵¹ These findings included cases in which the medical system failed to provide timely access to prisoners with urgent and emergent serious medical problems, including failures resulting in death.⁵² Subsequent findings by the court-appointed medical monitor, Robert Cohen, M.D., described multiple medical failures, includ-

⁴⁶ Findings of Fact and Conclusions of Law at 82, *Hadix v. Johnson*, No. 4:92-CV-110 (W.D. Mich. Sept. 14, 2005); *Hadix v. Caruso*, No. 4:92-CV-110, slip op. at 2 (W.D. Mich. Mar. 6, 2007). In this Article, the term “*Hadix* prison” or “*Hadix* facility” means a prison unit confining members of the certified class in *Hadix*, and subject to the district court’s *Hadix* orders.

⁴⁷ Letter from Robert Cohen, M.D., Head of the Office of the Indep. Med. Monitor, to Hon. Richard A. Enslen at 3, *Hadix v. Caruso*, No. 4:92-CV-110 (W.D. Mich. Apr. 30, 2007) [hereinafter Cohen Letter].

⁴⁸ Consent Decree at 8, *Hadix v. Johnson*, No. 80-73581 (E.D. Mich. Feb. 13, 1985) (requiring that the new hospital meet state licensure standards).

⁴⁹ *Hadix III*, 465 F. Supp. 2d 776, 778 (W.D. Mich. 2006).

⁵⁰ E-mail from Robert Cohen to *Hadix* parties (Nov. 29, 2007, 08:49 CST) (on file with author). Robert Cohen, M.D., is the head of the Office of the Independent Medical Monitor, established by the *Hadix* court. *Hadix III*, 465 F. Supp. 2d at 779–80, 809–810.

⁵¹ Findings of Fact and Conclusions of Law 28–190, *Hadix v. Johnson*, No. 4:92-CV-110 (W.D. Mich. Oct. 29, 2002).

⁵² *Hadix III*, 465 F. Supp. 2d at 779 (summarizing the 2002 findings).

ing a prisoner who died of an untreated “staph”⁵³ infection and gastro-intestinal bleeding; an HIV patient with difficulty in swallowing who, despite a weight loss to 108 pounds, was denied the pureed diet he needed; and a diabetic who predictably died of hypoglycemia after gross failures of treatment and monitoring, accompanied by a failure to respond to his emergency needs.⁵⁴

The court medical monitor and the Director of Medical Care for the Department of Corrections, a physician, jointly reviewed six randomly selected medical records of *Hadix* class members whose specialty care appointments had been delayed. In one case, there were no apparent consequences from the delay; in a second case, the only effect may have been to force the prisoner to experience unnecessary pain. In the other four cases, the *Hadix* court concluded, the delay exposed the prisoners to the “prospect of unnecessary death and grossly unnecessary suffering.”⁵⁵

These cases included a man who was allowed to go untreated for an extended period without diagnosis or treatment for a kidney stone that was rendering his kidney non-functional. Another man with textbook signs of an impending heart attack was improperly scheduled to be seen in thirty days rather than immediately. By the time he was seen, he was lucky to survive his emergency bypass surgery. Another patient with known symptoms of bowel cancer had his diagnosis delayed for over a year. He proved to have an abnormal, potentially pre-cancerous lesion.⁵⁶ Perhaps equally striking, after the diagnosis, the patient was not scheduled for follow-up until his case was discovered in the random case review.⁵⁷

The last patient whose file was randomly chosen for review had complained that a mole on his back was increasing in size. He kited (prison jargon for sending a written request for assistance to staff) repeatedly and was diagnosed with a “melanocystic skin mole” that

53 *Staphylococcus aureus* is a common skin infection that can become life-threatening under certain conditions. Drug-resistant forms of *Staphylococcus aureus* (methicillin-resistant *Staphylococcus aureus*, or MRSA, and vancomycin-resistant *Staphylococcus aureus*, or VRSA) have recently and notoriously become common in prisons and jails, as well as in hospitals and other institutional settings. Ctrs. for Disease Control & Prevention, *Staphylococcus Aureus Resistant to Vancomycin—United States, 2002*, MORBIDITY & MORTALITY WKLY., July 5, 2002, available at <http://www.cdc.gov/MMWR/preview/mmwrhtml/mm5126a1.htm>; National Institute of Corrections, *Methicillin-Resistant Staphylococcus Aureus (MRSA)*, available at <http://www.nicic.org/MRSA> (last visited Nov. 5, 2008).

54 *Hadix III*, 465 F. Supp. 2d at 780–81.

55 *Id.* at 786.

56 *Id.* at 786–87.

57 Hearing, *supra* note 7, at 593.

needed to be “watched closely.”⁵⁸ Nonetheless, a subsequent medical order to remove the mole in two weeks resulted in no treatment; a nurse told him to apply a hot compress to the mole. More than six months after he began kiting, in January 2006, he saw medical staff again, by which time the mole had grown into a black-red mass with irregular margins and bleeding. About two weeks later, a pathology report indicated malignant melanoma. He did not receive the next necessary step in the diagnostic process, a sentinel node biopsy to determine whether he had metastatic cancer, until April 2006. That biopsy showed that the cancer had spread while he was not receiving treatment.⁵⁹

Unfortunately, the mistreatment of this patient did not end despite the *Hadix* court’s December 2006 opinion noting the previous delays in diagnosing his cancer. The medical monitor subsequently discovered that the patient’s chemotherapy had been significantly interrupted when staff did not order his cancer treatment drugs in a timely manner. When the drugs were ordered, staff specified an insufficient quantity for the chemotherapy.⁶⁰

These delays in care took place in the context of a system that allowed 30% to 40% of the cancer patients at any given time to fail to receive treatment within the time frames set by their physicians. This occurred, even though, as the *Hadix* court found, those physicians often set dates for patients to be seen that were too far in the future and often failed to take appropriate initial steps for timely diagnosis of cancer.⁶¹ For example, another patient waited nine months for a biopsy of his suspected cancer. He finally received a biopsy diagnosing prostate cancer on March 19, 2007. As of early July 2007, the patient had developed bloody urine and was still not yet scheduled for surgery.⁶²

The medication distribution system is also broken. A randomized study of medication prescription and renewal by the medical monitor’s office concluded that each month, hundreds of prisoners kited within the *Hadix* facilities because their medications had been inter-

58 *Hadix III*, 465 F. Supp. 2d at 787.

59 *Id.*

60 *Hadix v. Caruso*, No. 4:92-CV-110, slip op. at 2–3 (W.D. Mich. May 4, 2007).

61 *Hadix III*, 465 F. Supp. 2d at 791.

62 Plaintiffs’ Ex. 8 Hearing on Motion for Temporary Restraining Order, *Hadix v. Caruso*, No. 4:92-CV-110 (W.D. Mich. July 18, 2007); Declaration of Robert Camaj, *Hadix v. Caruso*, No. 4:92-CV-110 (W.D. Mich. July 18, 2007).

rupted.⁶³ There is no functioning system to assure renewals of medications even when staff know of the need for renewals. As a result, even HIV medications go unrenewed. Although the problem is widely known among health care staff, nothing is done to address the problem.⁶⁴ In fact, a physician in the *Hadix* facilities refused to renew medications in a timely fashion. The medical monitor documented that records containing medication renewal requests, abnormal laboratory test results, and specialty consultation reports piled up unread in physicians' offices. The monitor also documented waits of three to four weeks to see a physician, with physicians canceling scheduled patient appointments without cause.⁶⁵

As of the last date for which I have data, half of the registered nurse positions were not filled by permanent staff.⁶⁶ Of those filled by temporary contract staff, 60% of the positions were filled by licensed practical nurses rather than registered nurses.⁶⁷ As a result, licensed practical nurses take actions that they are not qualified to perform.⁶⁸ The nursing shortages also result in medical kites from prisoners going unanswered for days at a time.⁶⁹

Medical treatment is equally bad at the dialysis unit, where a number of the prisoners with the most complex medical problems are housed. An outside nephrologist review reported that the medical director "appeared disengaged"⁷⁰ and that there were serious deficiencies in water testing and documentation, management of vascular access complications, blood pressure management, specialty care referrals and testing, medication continuity, and emergency care.⁷¹ Registered nurses assigned to the dialysis unit have been administering medications in a variety of unapproved ways, including re-labeling medications dispensed by the pharmacist for prisoners who have left the facility in order to administer them to other prisoners, failing to check medication orders correctly before administering them to prisoners, and relying on an outmoded system to check that the cor-

63 First Report of the Office of Independent Medical Monitor 21–23, 31–33, *Hadix v. Caruso*, No. 4:92-CV-110 (W.D. Mich. July 18, 2007).

64 Memorandum from Robert Cohen, M.D., to Barbara Hladki 1 (Feb. 12, 2007) (on file with author).

65 *Id.* at 2.

66 *Hadix III*, 465 F. Supp. 2d at 793.

67 *Id.*

68 *Id.*

69 *Id.*

70 Eric M. Gibney, Report to the Office of the Independent Medical Monitor 1 (Jan. 11, 2008) [hereinafter Gibney Report] (on file with the author).

71 *Id.*

rect medications are administered.⁷² Further, in part because medications are not being consistently ordered electronically, the medication regimens for the dialysis patients are frequently interrupted. According to a review by the medical monitor, 61% of the dialysis prisoners experienced delays or interruptions of their prescribed medications.⁷³ Although dialysis puts patients at risk for sepsis, most of the intravenous medications on hand to treat septic patients following hospital discharge are months or years past their expiration date, even though there can be a three-day delay in the dialysis unit's ability to obtain new supplies of such medications.⁷⁴

Dialysis patients needing specialty care (other than urgent surgery when vascular access for dialysis fails) frequently do not receive that care or receive it only after significant delays. As of December 2007, a dialysis patient with a cerebral aneurysm had been waiting since June 2007 for surgery. Another patient was receiving dialysis through a perma-catheter in his chest wall, which is a dangerous method for dialysis access because of the heightened risk of infection it poses. The patient was delayed between September and December 2007 in obtaining surgery to create a standard arteriovenous shunt for dialysis. Shortly after the surgery, he was found to have a blood infection and was started on intravenous antibiotics.⁷⁵

A nephrologist consultant for the monitor's office reviewed the deaths of a number of dialysis patients. One of those deaths involved a patient whose cardiac symptoms were ignored over a long period, except for one physician's attempt to obtain a stress test for him. The prison contract medical provider, Correctional Medical Services, Inc. ("CMS"), denied the request. Subsequently, the patient died of cardiac arrest after his dialysis was delayed despite a life-threatening elevation in his potassium level.⁷⁶ Another dialysis patient died of a brain hemorrhage after his blood pressure problems were "ignored and mistreated" by medical staff for a year.⁷⁷ He was treated with a single medication that cannot safely be used as the sole medication for severe hypertension, and his death "was directly related to his se-

72 Draft, Office of the Independent Medical Monitor Dialysis Patient Medication Report 10-12 (undated) (on file with the author).

73 *Id.* at 4.

74 *Id.* at 12.

75 Memorandum from Robert Cohen, M.D., to Peter Govorchin, et. al. 4-5 (Jan. 3, 2007) (on file with author).

76 Gibney Report, *supra* note 70, at 7-10.

77 *Id.* at 11.

vere, uncontrolled, and inappropriately managed blood pressure and failure to ensure accurate medication administration.”⁷⁸

Another dialysis death occurred after staff failed to note increasing evidence of unstable cardiac disease. Although one of the patient’s physicians did note that he needed an echocardiogram, the test was not performed. A nurse who thereafter saw the patient at a time when he was experiencing classic symptoms of unstable angina did not refer the patient to a physician. A month later, the physician again remarked that he needed an echocardiogram, but the test was not ordered. The following month, the patient was finally sent to a hospital where he was diagnosed with a heart attack and died of cardiac arrest following a bypass surgery.⁷⁹ Another patient died after a delay in summoning an ambulance after the patient experienced a heart attack. The autopsy indicated that he had a structurally normal heart, so prompt treatment of the heart attack might have saved his life.⁸⁰

After years of reviewing the failures of medical and mental health care, it is perhaps not surprising that the federal judge assigned to *Hadix* wrote that: “[T]here are a large number of complicated cases with interdisciplinary problems that unfortunately are being regularly mistreated and/or ignored by staff. The phenomenon is now a regular feature of the system.”⁸¹

Understanding how such a prison staff culture could become embedded requires a consideration of the larger policies that have shaped the Michigan criminal justice system.

III. MONEY FOR NOTHING

As of the last available statistics, Michigan had per-prisoner medical costs that were about 108% of the national average.⁸² I consider the more significant statistic that Michigan spent \$2,841 per prisoner on medical care in 2001, at a time that national spending on medical care was \$4,370 per person per year.⁸³ Of at least equal significance,

78 *Id.* On several occasions, the patient was not given his prescribed medication, clonidine. Clonidine is particularly dangerous if the patient misses doses because the patient may experience life-threatening levels of “rebound” high blood pressure. *See id.* at 10–11.

79 *Id.* at 12–13.

80 *Id.* at 14–15.

81 *Hadix II*, 461 F. Supp. 2d 574, 577, 598 (W.D. Mich. 2006).

82 JAMES J. STEPHAN, BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, SPECIAL REPORT: STATE PRISON EXPENDITURES, 2001, at 6 (2004), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/spe01.pdf>.

83 *Id.*

Michigan has been receiving limited value for the money that it does spend on prison health care. According to a report by the National Commission on Correctional Health Care (“NCCHC”), commissioned by the Michigan Department of Corrections (“MDOC”), Michigan is getting poor value for the \$300 million per year that it currently spends on medical care.⁸⁴ Part of the problem, according to the report, was that Michigan contracts out physician services (other than psychiatrists) to CMS.⁸⁵

An NCCHC reviewer became concerned about the level of cognitive functioning of one of the CMS physicians. The physician’s medical records had so many errors of spelling and language use that parts of them were incomprehensible. When the reviewer asked supervisors about this physician, the supervisors were familiar with the problem but none believed he or she had the power to take action.⁸⁶

In addition, under its contract with the state, CMS pays for off-site specialty care and it decides whether a physician will be allowed to refer a prisoner for such care. As the NCCHC report suggests, the fact that the physicians work for CMS may explain why they rarely challenge the decision of CMS reviewers to deny their requests for specialty referrals.⁸⁷ Similarly, this fact may explain why 30% to 40% of cancer patients, as noted earlier, experienced disruptions in their chemotherapy under this system.⁸⁸

A subsidiary of CMS, PharmaCorr, provides pharmacy services for the prison system. PharmaCorr is not required to provide a consulting pharmacist under the contract.⁸⁹ Staff reported to the NCCHC that they experienced delays in receiving medications for “same day” delivery under the contract,⁹⁰ which is not surprising because PharmaCorr ships all its medications to Michigan from its warehouse in Oklahoma.⁹¹ The report also found that the formulary (a list of medications that a physician can prescribe without any additional authorization from a reviewer) lacked classes of medications that are commonly included in the formularies of large health care organiza-

84 2007 Mich. Pub. Acts No. 124 §§ 107, 208 (appropriating about \$300 million to prison health care services in 2007).

85 NAT’L COMM’N ON CORR. HEALTH CARE, A COMPREHENSIVE ASSESSMENT OF THE MICHIGAN DEPARTMENT OF CORRECTIONS HEALTH CARE SYSTEM 24 (2008), *available at* http://www.michigan.gov/documents/corrections/Final_MDOC_HCS_Report_222383_7.pdf.

86 *Id.* at 6.

87 *Id.* at 9.

88 *See supra* note 61 and accompanying text.

89 NAT’L COMM’N ON CORR. HEALTH CARE, *supra* note 85, at 11.

90 *Id.*

91 First Report of the Office of Independent Medical Monitor, *supra* note 63, at 25.

tions, and the procedures for ordering non-formulary medications could pose serious safety concerns, aside from the paperwork burden the inadequacies of the formulary posed.⁹²

The process for dispensing medication is unnecessarily time-consuming and wasteful.⁹³ The medical records, which are partly electronic and partly paper, pose a barrier to patient care and decrease the productivity of staff, in significant part because of problems with the electronic medical records system that Michigan uses.⁹⁴ In fact, Serapis, the electronic medical records system, is so flawed that the NCCHC recommended that if Michigan intends to continue using it for any purpose, it should at least stop using it to record certain medical functions and instead revert to paper records.⁹⁵

The report also commented that the MDOC was “one of the most bureaucratic systems we have ever encountered,” and the report questioned whether the proliferation of bureaucratic procedures of dubious value undermined the system’s ability to complete necessary procedures.⁹⁶ The proliferation of paperwork is “even worse” in health care, with the fifty-one Michigan prisons generating hundreds of reports each month that the NCCHC doubted would be read by anyone.⁹⁷

At the same time, the productivity of CMS medical staff was strikingly low. While the reviewers expected physicians to see an average of twenty patients per day, most CMS providers averaged eight to twelve per day, and one provider averaged five per day. The NCCHC identified three factors contributing to the low productivity: Serapis, the poorly functioning electronic medical record system; certain custody rules; and the fact that the providers are not employees of the MDOC.⁹⁸

The third point is the heart of the matter:

The providers have no incentive other than their own professionalism to see more patients. All MDOC facilities have been completing [provider] Productivity Reports for several years. The [MDOC Bureau of Health Care] administration says they cannot do anything about the situation, because they do not supervise the [providers]. They send the information on to the CMS administration, but nothing ever changes. We were told by several MDOC staff that CMS administrators say they cannot

92 NAT’L COMM’N ON CORR. HEALTH CARE, *supra* note 85, at 13–14.

93 *Id.* at 16.

94 *Id.* at 16–20.

95 *Id.* at 20.

96 *Id.* at 22.

97 *Id.* at 22–23.

98 *Id.* at 23.

tell the [providers] what to do, because they are independent contractors and not employees. Whatever the truth is, this situation must change.

....

The MDOC should seriously reconsider the advantages and disadvantages of continuing to contract out provider services.⁹⁹

Not surprisingly, the report also found that the system lacked an effective quality improvement program or a functioning peer review system to assure health care quality. Instead, the system's ostensible quality improvement system amounted to mere "paper pushing."¹⁰⁰

Many if not all of the problems the report identified stemmed from Michigan's failure to write a proper contract with CMS and other contractors, including the company that provided the Serapis program. The NCCHC reviewers were told that CMS often unilaterally reduced its staff coverage for a particular position from five days a week to two days a week, and the contract did not provide any disincentive for CMS to do so. In fact, the contract allows the prison system to require CMS to fill these hours, but the system has not insisted on full staffing.¹⁰¹ Perhaps most damning, over the ten years of the contract, the NCCHC monitors were not provided with a single monitoring report, although the state was supposed to perform regular audits and CMS was supposed to be assessed liquidated damages at any facility that failed to achieve a designated level of compliance. Notwithstanding this provision, not a single claim for liquidated damages was ever made by the state:¹⁰²

Many staff verbalized that they have "heard from Lansing" [where the headquarters of the MDOC is located] that the MDOC simply needs to make the relationship with CMS "work." Whether or not anyone in the [MDOC] central office actually said this, this is what staff perceives. The most glaring example of this is practitioner staffing shortages. . . . Staff speculates that if the MDOC and CMS were operating in a truly arm's length relationship, there should be an immediate response from the MDOC followed by rapid resolution of the problem, legal action, and/or termination of the contract.¹⁰³

Although the causes differ in part, the mental health program is also strikingly inefficient. The program is divided between the Michigan Department of Community Health, which provides the psychiatrists and certain other staff, and the MDOC, which provides most of the psychologists. Certain prisoners are placed on the outpatient

99 *Id.* at 24.

100 *Id.* at 25.

101 *Id.* at 32.

102 *Id.* at 33.

103 *Id.*

mental health team case load, and these prisoners have their mental health care provided by the Department of Community Health. All of the other prisoners supposedly have their health care provided by the MDOC, including identification and initial treatment of patients experiencing a mental health crisis.¹⁰⁴ This organizational structure is cumbersome and wastes resources. It also creates problems because of disagreements between the two entities as to whether a prisoner needs treatment, and allows staff to disclaim responsibility for services that they consider not within their duties.

IV. TROUBLE AHEAD, TROUBLE BEHIND

Michigan citizens are justly proud that their state supports one of the nation's finest public universities, including a leading medical school. In my view, they should also be proud that the state lacks a judicially-imposed death penalty. Unfortunately, as the death of Mr. Souders and many others illustrate, Michigan has a randomly-imposed death penalty for too many of its prisoners who have the misfortune to suffer from serious medical needs, and this accidental death penalty stems directly from public policy choices that have resulted in an underfunded prison system confining prisoners for whom it is unable to provide minimally adequate medical care.

Michigan has the sixth-largest prison population among the states,¹⁰⁵ although it ranks eighth in total population.¹⁰⁶ Three states with larger total populations—Ohio, Illinois, and Pennsylvania—have smaller prison populations.¹⁰⁷ Michigan's comparatively high rank in prison size¹⁰⁸ reflects its comparatively high incarceration rate.¹⁰⁹ This

¹⁰⁴ *Id.* at 33–34.

¹⁰⁵ See PUB. SAFETY PERFORMANCE PROJECT, PEW CHARITABLE TRUSTS, PUBLIC SAFETY, PUBLIC SPENDING: FORECASTING AMERICA'S PRISON POPULATION 2007-2011, at 27 (rev. 2007), <http://www.pewcenteronthestates.org/uploadedFiles/Public%20Safety%20Public%20Spending.pdf>.

¹⁰⁶ See U.S. Census Bureau, Resident Population of the 50 States, the District of Columbia, and Puerto Rico: Census 2000, <http://www.census.gov/population/www/cen2000/maps/files/tab02.pdf> (last visited Nov. 5, 2008).

¹⁰⁷ Compare *id.*, with PUB. SAFETY PERFORMANCE PROJECT, *supra* note 105, at 27.

¹⁰⁸ Of course, the reality is that all fifty states have extremely draconian sentencing policies when compared to world norms. The United States now has the highest incarceration rate in the world, and almost one-quarter of the world's prisoners. See CHRISTOPHER HARTNEY, NAT'L COUNCIL ON CRIME AND DELINQUENCY, FACT SHEET: U.S. RATES OF INCARCERATION: A GLOBAL PERSPECTIVE 1–2 (2006), available at http://www.nccd-crc.org/nccd/pubs/2006nov_factsheet_incarceration.pdf. If all the men, women, and children confined in our nation's prisons and jail were gathered in one city, it would be the fourth largest city in the country. Compare WILLIAM J. SABOL ET AL., BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PRISON AND JAIL INMATES AT MIDYEAR 2006

rate is an outlier in the Midwest region, and ten of the eleven other states in the region have rates lower than Michigan's.¹¹⁰

Nor can Michigan's high incarceration rate be explained simply by its crime rate. As shown in the table below, Michigan has the eleventh highest incarceration rate in the country, although it ranks seventeenth in crime rates:¹¹¹

	Incarceration Rate Rank	Crime Rate Rank
Louisiana	1	6
Texas	2	12
Mississippi	3	32
Oklahoma	4	14
Alabama	5	22
Georgia	6	39
Missouri	7	16
South Carolina	8	1
Arizona	9	13
Florida	10	2
Michigan	11	17

(2007), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim06.pdf>, with Press Release, U.S. Census Bureau, Census Bureau Announces Most Populous Cities (June 28, 2007), available at <http://www.census.gov/Press-Release/www/2007/cb07-91table1.pdf>.

¹⁰⁹ Notwithstanding Michigan's eleventh-place ranking among the states in incarceration rates, its incarceration rate of 489 prisoners per 100,000 total population is below the national average of 500 per 100,000. Only nine states have above-average incarceration rates. The nine states with incarceration rates higher than the national average are, in order, Louisiana, Texas, Mississippi, Oklahoma, Alabama, Georgia, Missouri, South Carolina, and Arizona. SABOL ET AL., *supra* note 108, at 13.

¹¹⁰ Missouri is the exception with the seventh highest incarceration rate in the nation. *Id.*

¹¹¹ U.S. Census Bureau, Statistical Abstract of the United States: Violent Crime Per 100,000 Population—2004, <http://www.census.gov/statab/ranks/rank21.html> (last visited Nov. 5, 2008).

The chart demonstrates that incarceration rates are as much influenced by criminal justice sentencing policies as by crime rates. Only three of the eleven states with the highest incarceration rates have crime rates that also rank in the top eleven among the states. While crime rates matter in determining incarceration rates, criminal justice policies related to prosecution, sentencing, and parole matter at least as much.

Michigan has adopted a relatively punitive set of criminal justice policies, in significant part related to its history of extraordinarily tough punishment for drug offenders. In 1978, the state legislature imposed a mandatory punishment of life imprisonment without parole for persons convicted of possession of 650 grams of cocaine or heroin.¹¹² Not even convictions for rape or mayhem were punished as harshly as persons punished under this drug possession statute; the only other crime that Michigan punished equally harshly was first degree murder.¹¹³ No other jurisdiction imposed a mandatory sentence of life imprisonment without parole for first-time possession of illegal drugs in comparable quantities.¹¹⁴ Although the statute requiring a mandatory life sentence for drug possession was repealed in 1998, and prisoners convicted under the law subsequently received parole eligibility,¹¹⁵ in the last five years, the Parole Board has granted parole to eligible lifers at the rate of 0.2% per year.¹¹⁶ In 2002 to 2003, more than 9% of the Michigan prison population was serving a life sentence, amounting to almost 4,600 prisoners. As of 2002 to 2003, Michigan had the fourth-largest number of lifers of any prison system in the nation.¹¹⁷ More than half of those prisoners were serving life

112 Families Against Mandatory Minimums, Background on Michigan Mandatory Minimum Drug Law Reforms, <http://www.famm.org/ExploreSentencing/StateSentencing/MichiganFAMMCampaign.aspx> (last visited Nov. 5, 2008).

113 Harmelin v. Michigan, 501 U.S. 957, 1025–26 (1991) (White, J., dissenting).

114 *Id.* at 1026.

115 For a background on Michigan reforms, see *supra* note 112. See also BETHANY WICKSALL, MICH. STATE SENATE FISCAL AGENCY, STATE NOTES: THE MICHIGAN PRISON POPULATION: MEN'S DECLINING BUT WOMEN'S STILL RISING (2003), available at <http://www.senate.michigan.gov/sfa/Publications/Notes/2003Notes/NotesJulAug03bw.pdf>.

116 Foster-Bey v. Rubitschun, No. 05-71318, slip. op. at 42 (E.D. Mich. Oct. 23, 2007) (finding that changes in parole policy have resulted in decreased eligibility for paroles of non-mandatory life sentences; in the last five years the Parole Board has granted such paroles at the rate of 0.2% of eligible prisoners). The state legislative research bureau noted that as many as 700 persons serving a lifetime sentence for drug possession with no other convictions were eligible to be paroled. WICKSALL, *supra* note 115.

117 MARC MAUER ET AL., THE SENTENCING PROJECT, THE MEANING OF "LIFE": LONG PRISON SENTENCES IN CONTEXT 10 (2004), available at http://www.sentencingproject.org/Admin/Documents/publications/inc_meaningoflife.pdf.

without the possibility of parole.¹¹⁸ For lifers who were eligible for parole, the average sentence length for lifers who did gain release increased to an average of 23.2 years during 2000 to 2004; apparently many of the lifers released in these years were released on medical parole,¹¹⁹ which typically implies that the prisoner has a terminal illness or some other incapacitating medical or mental health condition.¹²⁰ Thus, the combination of a large state population, a relatively high crime rate, and a particularly severe set of sentencing and release policies have resulted in nearly 50,000 prisoners behind bars.

V. AND IT'S A HARD RAIN'S-A-GONNA FALL

As noted above, Michigan's criminal justice system combines a number of elements that fuel a particularly expensive prison system; that is, a state with a large population, a state with a very high incarceration rate and an aging prisoner population reflecting a history of unusually punitive criminal justice policies, and a state that receives poor value for its expenditures on prison health care. In addition, Michigan, unlike the majority of the states with comparatively high incarceration rates, also has comparatively high per prisoner incarceration costs. Locking people in prison is, under any circumstances, an expensive business, and Michigan policy makers appear to have done virtually everything within their power to make it more expensive.

By 2003, the nation spent \$61 billion just on corrections, out of a total spending on the criminal justice system of \$186 billion.¹²¹ The most recent available figures for the cost of incarceration per prisoner average \$22,650.¹²² That average cost, however, is subject to wide variation. If we look again at the eleven states including Michigan with the highest incarceration rates in the country, we find that six of them rank among the ten states with the lowest per prisoner costs.¹²³

118 *Id.*

119 *Foster-Bey*, No. 05-71318, at 25–26, 38, 42.

120 Michigan law provides that the “parole board may grant a medical parole for a prisoner determined to be physically or mentally incapacitated.” MICH. COMP. LAWS § 791.235(10) (2008).

121 PUB. SAFETY PERFORMANCE PROJECT, *supra* note 105, at 2.

122 *Id.* at 18.

123 The data in the Table are derived from *id.* at 27, 33.

	Incarceration Rate Rank	Lowest Per-Prisoner Cost Rank
Louisiana	1	1
Texas	2	7
Mississippi	3	4
Oklahoma	4	10
Alabama	5	2
Georgia	6	11
Missouri	7	6
South Carolina	8	3
Arizona	9	16
Florida	10	22
Michigan	11	36

Michigan is the only state with a high incarceration rate that also ranks above the state median in per-prisoner cost. In fact, Michigan also ranks well above the national average cost of incarceration, and it is the only state on the chart with a per-prisoner cost that exceeds the national average.

The approximately 50,000 Michigan prisoners cost the state an average of \$28,743 per prisoner, in contrast to a federal average per-prisoner cost of \$23,429 and a state average per-prisoner cost of \$23,876.¹²⁴ The Pew Charitable Trust analysis found that the two critical factors in determining comparative per-prisoner incarceration costs among the states are variations in the cost of employee wages and benefits and variations in the prisoner-to-staff ratio.¹²⁵ In a 2002 survey, base pay for correctional officers in Michigan was the sixth

¹²⁴ *Id.* at 33.

¹²⁵ *Id.* at 19.

highest in the country.¹²⁶ Wages and benefits have made up 71% of the total operating costs of the Michigan prison system,¹²⁷ although on average, these expenses in state correctional systems account for about two-thirds of the systems' total operating costs.¹²⁸

Aside from the fact that MDOC wages and benefits account for a somewhat high percentage of operating expenses, there is other evidence that its comparatively high per-prisoner cost does not reflect a high ratio of staff to prisoner. The union that represents correctional officers in Michigan claims that the number of state correctional officers declined from 10,600 to 9,200 between 2000 and 2005, despite an increase of several thousand in the prison population.¹²⁹

Michigan can no longer afford to pursue this discordant cluster of policies. Most states that provide abysmal medical care at least get what they pay for; Michigan cannot even make that statement. Even in the best of times, high incarceration rates combined with high incarceration costs result in difficult financial burdens, as large numbers of states have recognized.¹³⁰ Because of the state's high number of lifers and its long sentences for drug crimes, Michigan's prison population contains many older prisoners who tend to need more expensive medical care. When one adds in the high staff costs and the waste of large amounts of money in the dysfunctional medical care system, the cost of the system would not be sustainable over the long term in relatively good economic times.

Of course, these are not good economic times, particularly in Michigan. For over a year, the state has been caught up in a "one-state recession," with the highest unemployment rate in the nation.¹³¹ As the economic downturn has worsened, the state has experienced a major state budget crisis.¹³² Part of the MDOC's response to the reduction in its share of the state budget was to close the Southern

126 Posting of Tom Walsh, Michigan's Budget Crisis Means We Have to Live Like We're No. 25, to WZZM13.com, http://wzzm13.com/news/news_article.aspx?storyid=70480 (Feb. 12, 2007, 08:55:24 EST).

127 STEPHAN, *supra* note 82, at 4.

128 *Id.*

129 Press Release, Mich. Corr. Org., Michigan Corrections Officer Union to Hold Statewide Pickets to Protest Dangerous Staffing and Safety Levels in State Prisons (May 24, 2005), available at <http://seiu526m.localsonline.org/ourlocal/press.cfm?pressReleaseID=1612&bSuppressLayout=1>.

130 MAUER ET AL., *supra* note 117, at 25–26.

131 CNNMoney.com, Unemployment State by State, http://money.cnn.com/pf/features/lists/state_unemployment/ (last visited Nov. 5, 2008).

132 Michigan Department of Treasury, Budget Crisis Grows Deeper, http://www.michigan.gov/treasury/0,1607,7-121-1755_1963-168824-,00.html (last visited Nov. 5, 2008).

Michigan Correctional Facility, the prison where Mr. Souders and many others died.¹³³ I have no doubt that the major motivating factor for the closure was the desire to save money by moving the concentrated population of sick prisoners to prisons not subject to the *Hadix* orders. Now that these high-risk prisoners have been dispersed throughout the system, it is highly likely that their medical care will deteriorate further.

Aside from the moral responsibility that Michigan politicians and the MDOC bear for Mr. Souders's death and their refusal to prevent future deaths, the current cluster of policies and practices are on a collision course with reality. Michigan taxpayers are likely to find the state paying large jury damages awards related to some of these deaths.¹³⁴ The MDOC also risks new class actions seeking injunctive relief at the facilities to which large numbers of the chronically ill prisoners were transferred.¹³⁵

More importantly, until Michigan fundamentally reforms its sentencing and parole policies, as well as its system for delivering health care, prisoners like Timothy Souders will continue to suffer a death sentence for the crime of mental or physical illness. Until fundamental change occurs, I can only echo the words of Richard A. Enslin, the *Hadix* federal judge who brought to public attention the failures in the Michigan system: "Say a prayer for T.S. and the others who have passed. Any earthly help comes far too late for them."¹³⁶

133 Michigan Department of Corrections, Southern Michigan Correctional Facility (JMF) Closed November 17, 2007, http://www.michigan.gov/corrections/0,1607,7-119-1381_1388-5357-,00.html (last visited Nov. 5, 2008).

134 The estate of Jeffrey Clark, a prisoner at the Bellamy Creek Correctional Facility in Michigan, was awarded \$2,750,000 by a federal jury based on his death from dehydration in a hot cell after prison staff turned off the water in his cell and failed to give him water to drink at a time when he suffered from apparent mental illness. *Firm Fights for Justice in Prison Deaths*, THE FIEGER TIMES (Fieger, Fieger, Kenney, Johnson & Giroux P.C., Southfield, Mich.), Winter 2007-2008, at 3, available at <http://www.fiegerlaw.com/pdf/2008-vol17.pdf>. A damages action in federal court on behalf of the estate of Timothy Souders was recently settled by the state for an undisclosed sum. Dennis Pelham, *State Settles Lawsuit Over Adrian Man's Prison Death*, DAILY TELEGRAM (Adrian, Mich.), July 7, 2008, available at <http://www.lenconnect.com/archive/x1346879050/State-settles-lawsuit-over-Adrian-man-s-prison-death>.

135 Most of the chronically ill prisoners were transferred to a handful of prisons. See Cohen Letter, *supra* note 47 (describing and critiquing the state's proposed transfer plan).

136 *Hadix II*, 461 F. Supp. 2d 574, 576 (W.D. Mich. 2006).