Middle Ground Prison Reform
Protecting and Defining the Rights of the Incarcerated Since 1983
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May 24, 2009

Hon. Jan Brewer
Governor/State of Arizona
Executive Tower
1700 West Washington
Phoenix, Arizona 85007

Dear Governor Brewer:

The purpose of this letter is to request that you intervene at once in the decision made by DOC Director Charles Ryan to conduct a criminal investigation, by his own department employees, of the incident which ended the life of Inmate Marcia Powell, DOC # 109416,[1] in the early morning hours of May 20th.

As I am sure you are aware, Ms. Powell was a known mental health patient. Her weight listed on the DOC website is 124 lbs, but prisoners who knew her advise me that she probably weighed under 100 lbs on the day she was placed in the metal cages (euphemistically referred to by the ADOC as "outdoor enclosures"). It is unknown what, if any medications she was taking or provided. The Department has claimed to the media and to others that she was provided a source of water while locked inside the cage, but that information has been disputed by some inmates who have contacted me since Ms. Powell's death. In fact, the television media coverage of the incident included some aerial views by helicopter of the outdoor cages and, if taken on the day of or the day after Ms. Powell's death, they depict a somewhat "staged" view of the cage. The media coverage shows several cages in the middle of a dirt yard, with one cage containing a neatly displayed red/white cooler of the type one would take on a picnic. There appeared to be no chairs or benches; no shade or covering over the top; and - frankly - if the cage with the cooler was the one in which Marcia Powell was detained until her collapse and death - one would have expected to see the detritus from paramedics who would have treated her at the scene before taking her to a hospital to be pronounced dead.

The above two points alone are sufficient justification for my argument that the ADOC should not be conducting its own investigation into this possibly criminal matter. Why? Because the implications of the possible truth about both issues (not providing water as claimed; staging a crime scene for the media) above are ugly, insulting, and make the Department of Corrections criminally liable without question. But they are uncomfortable questions; questions that the Department will not ask of itself. Instead, they will focus on the people who were supposed to be monitoring her; on the people who gave approval for her to be placed in the cage in the summer heat to begin with.

Many additional questions need to be answered as a result of a professional, unbiased and thorough

[1] Since she died on May 20th, Ms. Powell's DOC Internet records have been altered by someone at the DOC. On May 20, 2009, I downloaded her records from the DOC website, and noted a photo ("mug shot") of her in the record. Soon thereafter, the entire record disappeared from the DOC website for a few days. On May 25, I searched for her record on the same website, and found that the record reappeared, but that her photo had been changed to one that portrayed a much less alarming countenance, and a smile. Why would the DOC alter the "mug shot" of a prisoner who had already died?

investigation of this incident. We do not believe that the Department will address these issues at all.

They include, but are not limited to:

1. What policies or procedures exist within the ADOC for "punishment" of mentally ill inmates?
2. If unmedicated or not under any type of treatment program, how are inmates who are mentally ill treated when they do not follow rules; act out, or engage in many of the behaviors that an untreated, unmedicated mentally ill person would be expected to engage in?
3. If Ms. Powell was taking any type of medication on May 19, 2009, including any type of mental health medication, was it a medication that would make her especially sensitive to the sun? Did anyone check?
4. Why was there a violation of Director's Order #231, in effect since August 19, 2005, entitled, "Use of Holding Enclosures," which limits their use beyond a two-hour time frame? What procedures were in place to monitor the total time that the inmate was in the enclosure? What procedures were in place to periodically check on her welfare? Produce the logs. Produce the records.
5. At any time during the approximately four (4) hours that the DOC claims Ms. Powell was in the enclosure, did she request to use the bathroom, and was permission granted as per D.O. #231? If no request was made, was that because no one was paying any attention to her or monitoring her? If she was yelling or otherwise indicating her needs, including distress from the heat, was anyone around to hear her?
6. If she did use the bathroom, produce the logs or paperwork showing who escorted her; what observations where made about her condition, and what time the bathroom break occurred.
7. As per D.O. # 231, for confinement in the hold enclosure beyond two hours, a Deputy Warden must approve. Did this occur? Which Deputy Warden signed off on the extension beyond two hours? Was Ms. Powell's condition checked before an extension was granted? If no extension was granted, why was policy violated? Why was she held beyond two-hours without authorization?
8. Ms. Powell had a list of disciplinary write-ups, but most appeared to be the type that one would expect of a mentally ill person (especially one who might not be receiving appropriate care and/or medication). It seems that with her known mental health problems, she would represent a heightened risk requiring extra attention. The current photo of Ms. Powell on the DOC website has been altered since Ms. Powell's death. I suspect that she appeared more like the photo that originally was posted. If so, she appeared fragile, underweight, stunned. What type of decision-making is involved in placing someone such as Ms. Powell is such a vulnerable location?
9. Throughout the entire Department of Corrections, including private prisons contracted with the ADOC, what incidents have occurred over the past five (5) years which have resulted in policy violations regarding the use of the cages? (See attached letter of December 31, 2007, written to then-director Dora Schriro).
10. What type of comprehensive investigation was conducted on Ms. Powell's background or known family history before removing her from life support? Did someone investigate whether she wrote to or received mail from anyone? Produce the report (Incident Report or other documents) which documents this. Did someone check to see if she received any visitors at any time? Produce the report. Was there any discussion or influence of economics of keeping her on life-support for a few additional days, just to see if a family member could be located, before the decision to terminate her life-support was made?
11. Was there any videotape made of Ms. Powell's placement in the enclosure? Any cameras or videotape of her actions while in the enclosure, including display of signs of distress/alarm?
12. Produce the logs, post orders, and any and all records made on May 19, 2009 or in effect on the same date, which have anything whatsoever with Marcia Powell or her DOC # 109416.
13. What is the DOC justification for altering Ms. Powell's photo on its DOC website? The photo was changed sometime between May 20 and May 24, and the new photo is what can only be described as a "happy face" when compared with the disturbing image that was published on the Internet on May 19th.
14. Did Ms. Powell make or display any signs of distress while in the enclosure? Were they ignored because no one was monitoring her or paying attention? Worse, were they deliberately ignored because of indifference to inmates who are stereotyped as "whiners?"

These are the elements of which criminal charges are borne. They are disturbing, probing and extremely uncomfortable questions to ask – especially by a Department that is so interested in avoiding the types of stories that will make "headline" news (in a bad way). Mr. Ryan cannot ask such questions of his own agency without risking impairment of his ability to effectively manage the Department. Such questions, if asked by the Director, could easily cause dissension in the ranks of employees at every level and lead to department employees undermining his authority. An independent, outside investigation – before any cover-ups are made – is required.

An example of how willing some DOC employees are to cover for each other or abdicate responsibility can be seen in the reports (Incident Reports or "IR's") produced in the case of Brian Stallings, whose feet were damaged with 2nd and 3rd degree burns when he was marched across a boiling hot blacktop lot in his bare feet in the late summer several years ago. Two employees escorted him. Their IR's indicated that "he never cried out in pain and we didn't notice that his feet were burning or that he wasn't wearing shoes." At least one other employee, who claimed to be observing the "march," claimed in an written IR that he observed the two escort officers "squirting water on Stalling's feet from a water bottle as he walked." In other words, this would have been an acknowledgment by the escort officers that Stallings' feet were being burned; that they knew he wasn't wearing shoes, but that they were protecting him from burns. Such widely disparate reports of the actual events (in actuality, there were no water bottles or protection from burns at all) indicate that certain employees of the Department are willing to lie to protect themselves and others. No discipline was ever administered to the employee who wrote the false IR.

As previously noted, the actions of the Department's employees which resulted in the death of Marcia Powell are potentially criminally negligent. Pursuant to A.R.S. 13-201, the minimum requirement for criminal liability is the performance by a person of conduct which includes a voluntary act or the omission to perform a duty imposed by law which the person is physically capable of performing. At A.R.S. 13-204, ignorance or a mistaken belief as to a matter of fact does not relieve a person of criminal liability.

Ms. Powell's 8th (Prohibition Against Cruel and Unusual Punishment) and 14th (Due Process) rights appear to have been trounced on by the Arizona Department of Corrections. Further, it is entirely possible that the actions of the Department constitute a violation of 18 U.S.C. 242, Deprivation of Rights Under Color of Law. Her heirs, if any, would also have an action under 42 U.S.C. 1983 Civil Rights Laws.

My letter to then-Director Dora Schriro in December 2007 (also sent to Susan Rogers, General Counsel) demonstrates that this problem is not an isolated one which began on May 19, 2009. The Arizona Department of Corrections has abused outdoor metal cages for punishment, not temporary detainment, of prisoners for several years. It appears to be a pattern and practice. This is unconstitutional at its base; unconscionable in the eyes of a just society of laws.

In almost every forum I attend, whether it be a legislative hearing, a media event, etc, there is always a great deal of back-slapping and congratulatory rhetoric directed toward corrections personnel and among themselves about what a difficult job they have; how well they do it; how dangerous it is for them; and how low their salaries are for the self-sacrifice they endure. Not everyone should be painted with the same brush, but such statements are clearly belied by actual on-the-job conduct (and underlying policies in place prior to the conduct) of the type discussed in this letter and in my attachment.

We urge you to intervene in this matter at once. Do the right thing. Order an independent, professional and unbiased investigation of all matters (direct and ancillary).

Sincerely,

Donna Leone Hamm
Director

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