
**BRIEF OF ILLINOIS PRISON PROJECT
AS *AMICUS CURIAE* IN SUPPORT OF 43
PETITIONERS FOR EXECUTIVE CLEMENCY**

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INTEREST OF *AMICUS CURIAE* AND EXECUTIVE SUMMARY

The Illinois Prison Project (IPP) is a non-profit entity that works on behalf of incarcerated people through advocacy, public education, and direct representation. IPP advocates for a saner and more humane prison system in Illinois in two ways: first by identifying injustices within our prison system that have harmed countless people and cost taxpayers millions of dollars, and then by representing every person suffering from that harm at once. In helping individuals, these campaigns are also designed to illustrate the inequities across the criminal justice system, to appeal to people across the political spectrum, and to advance the work of others fighting for systemic reform.

IPP submits this *amicus* briefing in support of 43 Petitioners for executive clemency. All seek relief from criminal sentences imposed when they were charged and convicted for acting out in prison because of mental health problems exacerbated or caused by the State's practice of punishing inmates with serious mental illness with placement in solitary confinement.¹

The backgrounds of the 43 Petitioners are similar. Placed in solitary confinement for months or years on end, kept in tiny, windowless cells, Petitioners' mental health deteriorated. As it did, Petitioners acted out in violation of prison rules. Some "assaulted" staff with

¹ Kimball R. Anderson and Adam J. Smith submit this brief as counsel for *amicus curiae* IPP. They do not represent the individual Petitioners. The views expressed in this brief are solely those of IPP.

urine and feces; others merely threw water or words. Not one caused a correctional staff member harm.

Rather than treat their underlying mental health conditions, however, the State charged them with aggravated battery or assault. In effect, the State caused them to manifest symptoms of mental illness—and then criminally punished them for it. The convictions that resulted from these prosecutions dramatically extended the sentences of some of the state's most vulnerable and profoundly ill prisoners. These extensions were imposed without reason, without constraint, and without moral justification. And they demand the Governor's reprieve.

As this briefing argues, the Illinois Department of Corrections (IDOC) has relied on prolonged solitary confinement—for years or even decades at a time—to manage seriously mentally ill people in its custody. Prolonged solitary confinement is torture. The damaging psychological effects of prolonged isolation are even worse for people with underlying mental health conditions. And when seriously mentally ill people are subjected to isolation and deprived of treatment, the consequences can be devastating.

Each of the 43 Petitioners here is or was incarcerated at the maximum-security Pontiac Correctional Center (Pontiac). Each suffers from a serious mental illness. And each was convicted of aggravated battery for throwing fluids or spitting while held in solitary confinement. Nearly every one of these incidents did not (and could not) injure correctional officers or staff. In fact, it was far more likely that they came with other clear signs of psychological distress—like suicide attempts and episodes of paranoia or psychosis. Yet the predictable

results of prolonged isolation were treated not as symptoms requiring treatment but as conduct requiring discipline and criminal prosecution.

It was Pontiac's practice to discipline seriously mentally ill residents by committing them to solitary confinement. When they decompensated, as they routinely did, they faced internal disciplinary charges or felony prosecution. And when they invariably were found legally responsible, either by the prison's internal adjustment committee or by a court, they saw their sentences extended for conduct that harmed no one. These proceedings—for non-injurious conduct borne of gross maltreatment—added years, if not decades, to Petitioners' underlying sentences.

Pontiac's practices were antithetical to common decency. But neither federal court mandates nor IDOC rule changes have undone the harm wrought by Pontiac's use of solitary confinement to manage serious mental illness. Nor did they dissuade Pontiac from treating mental illness as a problem best solved by prosecution. And despite the questionable constitutionality of punishing someone for symptoms of their mental illness, the convictions at issue have been affirmed by the appellate courts.

The Governor, however, need not stand idly by. Indeed, he enjoys an unfettered right to commute or pardon *any* criminal sentence, for *any* reason. And these convictions—racially disparate (if not intentionally discriminatory), penologically unsound, and morally reprehensible—provide him ample grounds for exercising that power. By commuting these convictions to time served or to terms of one day, Governor Pritzker would be undoing some of the worst harms wrought by the criminalization of mental

illness, the mass incarceration of Black and brown Illinoisans, and decades of state-sanctioned torture.

After all, the unjust incarceration of these petitioners does not injure them alone. It leaves an indelible stain on our collective conscience.

ARGUMENT

I. Solitary Confinement Is Torture.

Solitary confinement is the practice of isolating a prisoner in a cell for 22–24 hours per day from social and environmental stimulation, for weeks, months, or even years at a time.² Overwhelming scientific evidence proves that the prolonged isolation of people in conditions of solitary confinement can cause significant psychological and physical harms.³ It imposes an even greater risk of serious harm on those

² See *Solitary Confinement in the United States*, SOLITARY WATCH 1 (2018), available at <https://solitarywatch.org/wp-content/uploads/2019/05/Solitary-Confinement-FAQ-2018-final.pdf>.

³ See, e.g., Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 AM. J. PSYCHIATRY 1450 (1983); Craig Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, 49 CRIME & DELINQUENCY 124 (2003); Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 CRIME & JUSTICE 441 (2006); Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J. L. & POL’Y 325 (2006); David H. Cloud, et al., *Public Health and Solitary Confinement in the United States*, 105 AM. J. PUB. HEALTH 18 (2015).

with pre-existing mental illness.⁴ And it can lead those most vulnerable to its psychic toll to lash out

Indeed, people subjected to the harsh conditions of solitary confinement often respond with a range of noncompliant behavior. That is especially true of those with serious mental illness, whose behavior in solitary confinement stems both from their underlying disorders and from a separate biological imperative—the universal need for human contact. Their conduct frequently includes both serious incidents of self-harm and less-serious acts directed towards others. And it often includes the conduct for which Petitioners were prosecuted and convicted: spitting and throwing bodily fluids or water.

A. Solitary confinement inflicts grave and irreparable psychological harm.

Prisoners placed in solitary confinement—i.e., in “disciplinary segregation,” “administrative detention,” or “extreme isolation”—ordinarily spend their sleeping and waking hours in the same cells in which they eat, read, and pray. Most of these cells are windowless; many are sealed not with bars but with solid steel.⁵ Their beds may be within inches of their toilets.

For people held in solitary, what little access they have to the outside world or to other people is highly constrained. They receive their meals from staff

⁴ Craig Haney, *Restricting the Use of Solitary Confinement*, 1 ANN. REV. CRIMINOLOGY 285, 286 (2018); HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 151 (2003).

⁵ HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 146 (2003).

through a slot in their cell doors. Perhaps once a week, for an hour or so at a time, they are shackled and walked to the shower or solitary yard. And if they are allowed to exercise, they may likely do so in what amounts to a dog kennel.

Within IDOC, prisoners in solitary have enjoyed only limited, discretionary access to phone calls, visitation, recreation, and educational opportunities.⁶ They might leave their five-by-ten cell to shower as rarely as once per week.⁷ In Illinois, there is no statutory limit to how long a prisoner may spend in solitary.⁸ Even the mere suspicion of a disciplinary infraction can land an incarcerated person in solitary for weeks, if not months. Indeed, as IDOC has admitted, some incarcerated people have been isolated—without proof of any wrongdoing—in so-called administrative detention for decades.

Solitary confinement, in other words, is torture—a series of intentional and prolonged deprivations imposed to induce or punish. And like any form of torture, solitary confinement takes a traumatic psychic toll on those subjected to it.

That much is borne out by decades of social-scientific and psychological research. Studies of people subjected to solitary confinement document a wide range of adverse psychological reactions to solitary confinement. Among other things, solitary confinement engenders anxiety, depression, insomnia,

⁶ Plaintiff's Motion for Class Certification at 13, *Davis v. Jeffreys*, 3:16-cv-00600-MAB (filed Dec. 14, 2020) (S.D. Ill.).

⁷ *Id.*

⁸ *Id.* at 14.

panic, paranoia, hypersensitivity, cognitive dysfunction, hallucinations, hopelessness, self-mutilation, and suicidal ideation and behavior.⁹ Together, these symptoms combine to form a “specific psychiatric syndrome associated with solitary confinement” that “has the characteristics of an acute organic brain syndrome.”¹⁰

These symptoms, moreover, all too often prove life-threatening. Studies reveal that suicide rates are disproportionately high among prisoners in solitary confinement.¹¹ Indeed, most state prison systems report their highest rates of self-injury in their segregation or “lockdown” units.¹² And those in solitary often engage in forms of self-mutilation, like amputation and cutting, that (if not fatal) can be

⁹ Craig Haney, *Mental Health Issues in Long-Term Solitary and “Supermax” Confinement*, 49 CRIME & DELINQUENCY 124, 130–131 (2003) (collecting studies).

¹⁰ Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 WASH. U. J. L. & POL’Y 325, 333, 337 (2006).

¹¹ Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics* 316, in HEALTH AND HUMAN RIGHTS IN A CHANGING WORLD (eds. Michael Grodin et al. 2013).

¹² Appelbaum et al., *A National Survey of Self Injurious Behavior in American Prisons*, 62 PSYCHIATRY SERVICES 285, 287; see also Fatos Kaba et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, 104 AM. J. PUBLIC HEALTH 442 (2014) (finding that although only 7.3% of detainees in New York City jails were in solitary confinement, 53.3% of acts of self-harm occurred among those in solitary confinement).

permanently disfiguring.¹³ Others may endanger their lives merely for a moment's reprieve. In a seminal 1973 account of solitary confinement in California, one researcher recalled seeing prisoners "become so desperate for relief that they would set their mattresses afire so as to force the staff to open the door and remove them from the torture chamber."¹⁴

And there is vanishingly little to suggest that solitary confinement serves any valid penological goal. "Supermax" prisons, for instance, were designed to be the most restrictive and most isolating of carceral facilities, imposing solitary-like conditions on a general population. Yet they have never been found to reduce prison violence or contribute to rehabilitation.¹⁵ To the contrary, "[t]he extant empirical research on supermax facilities suggests that these institutions have the potential to damage inmates' mental health while failing to meet their purported goals (e.g., deterring inmates in the general

¹³ See, e.g., HUMAN RIGHTS WATCH, ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS 174–178 (describing incidents of self-mutilation of prisoners in Illinois and throughout the country).

¹⁴ Frank Rundle, *The Roots of Violence at Soledad*, in *THE POLITICS OF PUNISHMENT: A CRITICAL ANALYSIS OF PRISONS IN AMERICA* 163 (Erik Olin Wright, ed., 1973).

¹⁵ Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 *CRIME & JUSTICE* 441 (2006).

prison population from committing criminal acts inside prison).”¹⁶

B. Solitary confinement is especially harmful to those with serious mental illness.

For the mentally fit, solitary confinement almost invariably proves debilitating. But for prisoners with pre-existing mental illnesses—who make up a disproportionate number of those subject to isolation¹⁷—solitary confinement can lead to severe

¹⁶ Jesenia Pizarro & Vanja Stenius, *Supermax Prisons: Their Rise, Current Practices, and Effect on Inmates*, 84 *Prison Journal* 248 (2004). For similar reasons, correctional staff are significantly more likely to be assaulted by prisoners in solitary confinement than by those in the general population. David H. Cloud et al., *Public Health and Solitary Confinement in the United States*, 105 *AM. J. PUB. HEALTH* 18 (2015). States that have reduced their use of solitary confinement, by contrast, have seen steep drops in violence against other incarcerated people and staff. *See, e.g.*, Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences: Hearing Before the Subcomm. on Constitution, Civil Rights, and Human Rights of the Committee on the Judiciary, United States Senate, S. Hrg. 112-879 (2012) (Statement of Michael Jacobson, Vera Institute of Justice) (“Mississippi went from 1,000 to 150 prisoners in segregation; Ohio went from 800 to 90 prisoners. Mississippi not only reduced the number of people held in segregation but also saw an almost 70 percent decrease in prisoner-on-prisoner and prisoner-on-staff violence; and use of force by officers in the unit plummeted.”); Terry Kupers, et al., *Beyond Supermax Administrative Segregation: Mississippi’s Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, 36 *CRIM. JUSTICE & BEHAVIOR* 1037 (2009).

¹⁷ HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 147 (2003).

psychiatric decompensation and even greater risk of self-injury.¹⁸ Studies have also shown that solitary confinement can trigger in mentally ill people symptoms of anger, aggression, and loss of impulse control.

Yet the practice persists, endangering its victims and perpetrators alike. Far from fostering constructive changes in the behavior of those with serious mental illness, harsh administrative punishments like solitary confinement tend to lead to mental decompensation.¹⁹ This decompensation can lead to both self-injury and violence toward staff, like the throwing of waste.²⁰ And because opportunities for human contact for prisoners in solitary are so limited, scholars have observed that prisoners' efforts to elicit human connection often manifest as antisocial conduct.

These behaviors can range from spitting, to severe self-mutilation, to throwing urine, feces, or other

¹⁸ Jeffrey L. Metzner & Jamie Fellner, *Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics* 316, in *HEALTH AND HUMAN RIGHTS IN A CHANGING WORLD* (eds. Michael Grodin et al. 2013); David H. Cloud et al. *Public Health and Solitary Confinement in the United States*, 105 *AM. J. PUB. HEALTH* (2015).

¹⁹ Terry Allen Kupers, *SOLITARY: THE INSIDE STORY OF SUPERMAX ISOLATION AND HOW WE CAN ABOLISH IT* 53 (2017).

²⁰ Stuart Grassian, *Psychopathological Effects of Solitary Confinement*, 140 *AM. J. PSYCHIATRY* 1450, 1453 (1983); Terry Kupers, *PRISON MADNESS: THE MENTAL HEALTH CRISIS BEHIND BARS AND WHAT WE MUST DO ABOUT IT* 58 (1999).

liquids.²¹ Research on U.S. supermax units and prisons has found that bodily-fluid throwing and feces-smearing are among the most common forms of “acting out” among prisoners incarcerated in highly restrictive settings.²² And these patterns are predictable—so predictable, in fact, that supermax units and prisons routinely make use of plastic cell shields or “special cells” with slippery walls to counter anticipated bodily fluid throwing and smearing.²³

For these reasons, medical professionals, prisoners’ rights advocates, and supranational NGOs alike have acknowledged the grave psychological effects produced by solitary confinement on the most vulnerable of prisoners. The American Psychiatric Association, the National Commission on Correctional Health Care, and the National Alliance on Mental Illness all have opposed the use of solitary for individuals with serious mental illness.²⁴ In 2011, the U.N. Special Rapporteur

²¹ Terry Allen Kupers, *SOLITARY: THE INSIDE STORY OF SUPERMAX ISOLATION AND HOW WE CAN ABOLISH IT* 55 (2017); Lorna A. Rhodes, *TOTAL CONFINEMENT: MADNESS AND REASON IN THE MAXIMUM-SECURITY PRISON* 23, 35, 41–43 (2004); Sharon Shalev, *SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT* 164 (2013).

²² Lorna A. Rhodes, *TOTAL CONFINEMENT: MADNESS AND REASON IN THE MAXIMUM-SECURITY PRISON* 43–44 (2004); Sharon Shalev, *SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT* 165 (2013).

²³ Terry Allen Kupers, *SOLITARY: THE INSIDE STORY OF SUPERMAX ISOLATION AND HOW WE CAN ABOLISH IT* 55–56 (2017).

²⁴ American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness* (last updated

on torture declared prolonged solitary confinement a form of torture.²⁵ And in 2015, the U.N. General Assembly passed rules prohibiting indefinite solitary confinement, solitary confinement in excess of 15 days, and the imposition of solitary confinement of any length on women, children, and persons with mental or physical disabilities.²⁶

Despite a scientific consensus as to its harmfulness, Illinois long relied on solitary confinement as a primary treatment method for serious mental illness within its incarcerated population. The consequences for Petitioners and countless others have been nothing short of calamitous.

Nov. 2012), *available at* <https://www.psychiatry.org/file%20library/about-apa/organization-documents-policies/policies/position-2012-prisoners-segregation.pdf>; National Commission on Correctional Health Care, *Solitary Confinement (Isolation)* (last updated April 10, 2016), *available at* <https://www.ncchc.org/solitary-confinement>; National Alliance on Mental Illness, *Policy Platform: Legal Issues* (last updated 2018), *available at* <https://www.nami.org/About-NAMI/Policy-Platform/9-Legal-Issues>.

²⁵ *Solitary Confinement Should Be Banned in Most Cases, UN expert says*, U.N. News (Oct. 18, 2011), *available at* <https://news.un.org/en/story/2011/10/392012-solitary-confinement-should-be-banned-most-cases-un-expert-says>.

²⁶ [18] United Nations Economic and Social Council, United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules) 16-17 (2016), *available at* <https://undocs.org/A/RES/70/175>.

II. For Decades, IDOC Facilities Treated Mental Illness with Solitary Confinement, Not Care.

For much of the twentieth century, the United States treated severe mental illness in publicly maintained inpatient mental-health facilities.²⁷ Since the deinstitutionalization of psychiatric facilities in the 1960s and 1970s, however, observers have grown increasingly alarmed over the high rate at which people with serious mental illness are incarcerated in America's jails and prisons.²⁸ As carceral populations swelled in the 1980s and 1990s, so too did the share of prisoners with mental illness in the nation's jails and prisons. At the same time, the United States greatly increased its use of long-term solitary confinement and began a "supermax" prison-building boom.²⁹

Conservative estimates suggest that there are now nearly 400,000 individuals with "severe psychiatric disease" in U.S. prisons and jails, or ten times the

²⁷ See, e.g., Patricia Erickson & Steven Erickson, CRIME, PUNISHMENT, AND MENTAL ILLNESS: LAW AND THE BEHAVIORAL SCIENCES IN CONFLICT (2008); Alisa Roth, INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS (2018).

²⁸ See, e.g., Patricia Erickson & Steven Erickson, CRIME, PUNISHMENT, AND MENTAL ILLNESS: LAW AND THE BEHAVIORAL SCIENCES IN CONFLICT (2008); Alisa Roth, INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS (2018).

²⁹ See Sharon Shaley, SUPERMAX: CONTROLLING RISK THROUGH SOLITARY CONFINEMENT 165 (2013); Ryan T. Sakoda and Jessica T. Simes, *Solitary Confinement and the U.S. Prison Boom*, CRIM. JUST. POL. R. (2019).

number remaining in the nations' state hospitals.³⁰ As Cook County Sheriff Tom Dart has observed, "there is a fundamental mismatch between the legions of people with mental illness who inhabit jails and prisons and the services that those jails and prisons are able to provide."³¹

Given the grave consequences of solitary on prisoners with serious mental illness, beginning in the 1990s, several federal courts have either outlawed or significantly curtailed the practice of placing prisoners with mental illness in solitary confinement.³² A growing array of states—including Washington, North Dakota, Colorado, California, and New York—have taken steps in recent years to curtail the use of solitary confinement in their correctional systems.³³

³⁰ Treatment Advocacy Center, *SERIOUS MENTAL ILLNESS (SMI) PREVALENCE IN JAILS AND PRISONS* (September 2016).

³¹ Alisa Roth, *INSANE: AMERICA'S CRIMINAL TREATMENT OF MENTAL ILLNESS* 7 (2018).

³² See, e.g., *Madrid v. Gomez*, 889 F. Supp. 1146 (N.D. Cal. 1995); see also HUMAN RIGHTS WATCH, *ILL-EQUIPPED: U.S. PRISONS AND OFFENDERS WITH MENTAL ILLNESS* 165–167 (2003) (citing *Jones 'El v. Berge*, Judgment in a Civ. Case, Case No. 00-C-0421-C (W.D. Wisconsin, June 24, 2002) (unpublished); *Austin v. Wilkinson*, Case No. 4:01-CV-71 (N.D. Ohio, November 21, 2001), *aff'd in part, rev'd in part*, 372 F.3d 346, 349 (6th Cir. 2004), *aff'd in part, rev'd in part*, 545 U.S. 209 (2005); *Ruiz v. Johnson*, 37 F. Supp. 855 (S.D. Texas, 1999)).

³³ See *Solitary Confinement in the United States*, Solitary Watch 1 (2018), available at <https://solitarywatch.org/wp-content/uploads/2019/05/Solitary-Confinement-FAQ-2018-final.pdf>.

Illinois was late to make any changes at all. Before 2010, when it commissioned a study by the Vera Institute of Justice, it had paid the question of solitary confinement only scant attention. And while it has made a modicum of progress over the last several years, those changes came far too late for Petitioners. Instead, as several civil-rights suits made clear, Illinois prisons continued to use solitary confinement to control incarcerated people with serious mental illness. In other words, IDOC has treated illness with torture.

A. IDOC has failed to provide incarcerated people with adequate mental health care.

In *Rasho v. Baldwin*, a class of Illinois prisoners with serious mental illness sued IDOC for its inadequate delivery of mental health services, in violation of the Eighth Amendment, the Americans with Disability Act, and the Rehabilitation Act.³⁴ The putative class alleged that prisoners were “routinely sent to segregation instead of mental health care units.”³⁵ They claimed as well that—like Petitioners— “[y]ears [were] added to their imprisonment for behavior due to their serious mental illness, without any account being taken of their disabilities in the meting-out of that punishment.”³⁶

After five years of litigation (and several failed attempts to dismiss the case), the class reached a

³⁴ Second Amended Class Action Complaint, *Rasho v. Walker*, 1:07-cv-01298-MMM-JAG (N.D. Ill. April 29, 2011).

³⁵ *Id.* at 2.

³⁶ *Id.*

settlement agreement with IDOC in May 2016.³⁷ Its terms were sweeping. The settlement required IDOC to institute mental-health screening at intake, establish inpatient treatment centers throughout its system, improve mental-health staffing levels and training, and overhaul its disciplinary procedures. And it required these changes to be made under the supervision of a court-appointed monitor—the same process by which the Justice Department reforms municipal police departments.

The settlement also touched on IDOC’s frequent placement of prisoners with serious mental illness in solitary confinement. Under Section XV,³⁸ plaintiffs and IDOC agreed that, among other changes, IDOC would conduct a review of all prisoners with serious mental illness then in solitary confinement; eliminate all segregation time accumulated for low-level (“300” and “400”) tickets; and review the mental-health histories and current symptoms of those with pending major disciplinary charges.³⁹ The agreement also mandated substantial out-of-cell time for all prisoners with serious mental illness in segregation.⁴⁰

³⁷ Settlement Agreement, *Rasho v. Baldwin*, 1:07-cv-01298-MMM (C.D. Ill. May 10, 2016).

³⁸ *Id.* at 16–21.

³⁹ *Id.* at 18–19.

⁴⁰ *Id.* at 18. Notably, the settlement did *not* provide for the restoration of good-conduct credit lost by mentally ill people while in solitary confinement. Many were stripped of years—or even decades—of good-conduct credit for behavior they could not control. What’s worse, a substantial number are now

The court designated a monitoring team, led by Dr. Pablo Stewart, to assess the parties' compliance with the settlement agreement. In his first annual monitoring report, filed in June 2017, Dr. Stewart noted significant improvements to the mental health care delivery system at IDOC, including more-timely mental health referrals and significant reductions in the segregation terms of prisoners with serious mental illness.⁴¹ Even so, he found that a paramount challenge for IDOC was its "grossly insufficient and extremely poor quality of psychiatric services."⁴²

But in his second annual monitoring report, submitted in June 2018, Dr. Stewart found IDOC noncompliant with *18 of the 25 terms* of the settlement agreement. First, he found that IDOC was noncompliant in terms of staffing levels. "It has become painfully clear to the monitoring team over the first two years of the Settlement Agreement," Dr. Stewart concluded, "that the staffing levels of the Approved Remedial Plan are totally inadequate to meet the mental health and psychiatric needs of the mentally ill offender population of the Department."⁴³ Inadequate staffing related to failures of IDOC to meet other provisions of the agreement, including timely

serving "dead time," which means they would be released immediately if their good-conduct credit was restored.

⁴¹ First Annual Report of Monitor Pablo Stewart at 9, *Rasho v. Baldwin*, 1:07-cv-01298-MMM-JEH (C.D. Ill. June 5, 2017).

⁴² *Id.* at 10.

⁴³ Second Annual Report of Monitor Pablo Stewart at 10, *Rasho v. Baldwin*, 1:07-cv-01298-MMM-JEH (C.D. Ill. June 8, 2018).

evaluations, medication monitoring, intervention on crisis watch, maintenance of medical records, and treatment of mentally ill prisoners in segregation.

In June 2018, two years after the settlement agreement was entered and a few days before Dr. Stewart submitted his second monitoring report, the *Rasho* class moved for a permanent injunction, alleging that IDOC violated both the Settlement Agreement and the Eighth Amendment of the U.S. Constitution for continuing to provide constitutionally inadequate mental health care to prisoners with mental illness.

On December 20, 2018, Judge Mihm entered an order of specific permanent injunctive relief, finding that IDOC had been “deliberately indifferent to the mental health needs of inmates” in its custody. The court issued an order of immediate payment of attorneys’ fees to plaintiff’s counsel and ordered IDOC to institute changes to staffing requirements, crisis watch, treatment in segregation, medication monitoring, and treatment plans. Rather than comply, however, IDOC appealed the order to the U.S. Court of Appeals for the Seventh Circuit. That appeal remains pending.

Because IDOC failed to comply with Judge Mihm’s order, the plaintiffs moved to hold the defendants in contempt in November 2019.⁴⁴ The trial court refused to hear the motion, but IDOC’s provision of mental health care remains under its jurisdiction to this day.

⁴⁴ Plaintiffs’ Motion for Contempt for Failure to Comply with the Court’s December 20, 2018, Injunction as Reissued and Modified on April 23, 2019, *Rasho v. Jeffreys*, No. 1:07-cv-01298-MMM (C.D. Ill. Nov. 15, 2019).

B. Instead, IDOC has treated mental illness with punishment and solitary confinement.

The *Rasho* class sought in part to reduce IDOC's dependence on solitary confinement as an ill-fitted substitute for mental health care, especially for those with particularly debilitating mental illness. But that dependence was deep seated. Indeed, IDOC has long relied on solitary confinement and other forms of "extreme isolation" to manage those within its care.

In June 2016, a putative class of IDOC residents filed a class action suit seeking to enjoin IDOC's further use of "extreme isolation."⁴⁵ The class comprised anyone then in or previously subjected to extreme isolation, including disciplinary and administrative segregation.⁴⁶ The plaintiffs claimed, as did those in *Rasho*, that IDOC "arbitrarily, capriciously, and routinely uses extreme isolation as means of punishing even the most minor prison infractions."⁴⁷ They argued that the "cumulative effects of extreme isolation, without meaningful access to human contact and physical activity," deprived them of the human dignity and basic needs guaranteed by the Eighth and Fourteenth Amendments.⁴⁸

⁴⁵ Complaint ¶1, *Davis v. Baldwin*, No. 3:16-cv-600 (S.D. Ill. June 2, 2016).

⁴⁶ *Id.* ¶1–2.

⁴⁷ *Id.* ¶4.

⁴⁸ *Id.* ¶213; see also *Farmer v. Brennan*, 511 U.S. 825, 832–33 (1994) (holding that the Eighth Amendment requires humane conditions of confinement).

After surviving IDOC's motions to dismiss, the class plaintiffs sought certification of their constitutional challenge.⁴⁹ In support of their motion for class certification, the *Davis* class retained two of the nation's leading experts on solitary confinement and prison management: Dr. Craig Haney, a professor of social psychology at the University of California San Diego who began his career by assisting in the groundbreaking 1971 Stanford prison experiment⁵⁰; and Eldon Vail, a former secretary and deputy superintendent of the Washington State Department of Corrections.⁵¹

Haney and Vail's work was astonishingly thorough. They reviewed decades' worth of internal memoranda and data, institutional records, and prior litigation materials, including Dr. Stewart's reporting in *Rasho*.⁵² They "toured and inspected all areas of a number of IDOC facilities where prisoners are subjected to conditions of restrictive housing."⁵³ And they interviewed and evaluated dozens of IDOC

⁴⁹ Memorandum in Support of Plaintiffs' Motion for Class Certification, *Davis v. Baldwin*, No. 3:16-cv-600 (S.D. Ill. Dec. 14, 2020), ECF No. 222-1 [hereinafter Class Cert. Memo].

⁵⁰ Report of Dr. Craig Haney ¶¶1–8, *Davis v. Baldwin*, No. 3:16-cv-600 (S.D. Ill. Dec. 14, 2020), ECF No. 222-3 [hereinafter Haney Report].

⁵¹ Report of Eldon Vail ¶¶1–13, *Davis v. Baldwin*, No. 3:16-cv-600 (S.D. Ill. Dec. 14, 2020), ECF No. 222-4 [hereinafter Vail Report].

⁵² Haney Report ¶14.

⁵³ *Id.* ¶15.

prisoners “housed in disciplinary segregation, administrative detention, and investigative status.”⁵⁴

The sum of all this evidence, they concluded, suggested that IDOC’s isolation practices were “an outlier even among the most egregious state prison systems in the nation.”⁵⁵ Vail opined that “the conditions of IDOC’s restrictive housing units are stark and horrific and far below the standards of other state prison systems.”⁵⁶ And Haney found that IDOC “subject[s] prisoners to conditions and forms of treatment that go beyond being painful, unpleasant, and potentially harmful to being outright dangerous to prisoners’ mental health and well-being.”⁵⁷

But their sharpest critiques were reserved for IDOC’s treatment of prisoners with serious mental illness. As Haney’s research revealed, “very seriously mentally ill prisoners are not only housed throughout the IDOC but they are also retained for long periods of time in draconian restrictive housing units.”⁵⁸ In fact, a majority of the prisoners with whom Haney spoke told him that “they were on the prison’s mental health caseload, [and] were taking psychotropic medications (typically as treatment for very serious forms of

⁵⁴ *Id.* ¶¶14, 17.

⁵⁵ Class Cert. Memo at 2.

⁵⁶ Vail Report ¶20.

⁵⁷ Haney Report ¶24.

⁵⁸ Haney Report ¶218.

mental illness, including schizophrenia, psychosis, bipolar disorder, major depression, and PTSD).⁵⁹

Many reported instances of self-harm or attempts to die by suicide while held in isolation.⁶⁰ In one unnerving example, a pregnant woman incarcerated at Logan told Haney that even after several suicide attempts, and even after telling her mental health counsel that she would rather kill herself than “live in seg,” she was retained in restrictive housing.⁶¹

Yet rather than receive “meaningful treatment under conditions where their mental health is likely to improve,” these incarcerated people were “cycled back and forth from crisis watch cells to segregation.”⁶² An adverse response to their conditions of confinement, in other words, only left them more severely punished.

For instance, one prisoner at Menard with schizoaffective disorder received six months of segregation for “covering his window and not responding, which he explained that he did because he wanted to talk to a crisis team.”⁶³ Another man at Menard—suffering from schizoaffective, bipolar, and post-traumatic stress disorders—received two months of segregation for disobeying a direct order while in segregation, “*even though the adjustment report stated*

⁵⁹ *Id.* ¶103.

⁶⁰ *Id.* ¶206.

⁶¹ *Id.* ¶207.

⁶² *Id.* ¶218.

⁶³ *Id.* ¶216.

*that he was unable to participate in the hearing due to his mental health status.*⁶⁴

Indeed, Haney found decompensation to be the rule among IDOC's seriously mentally ill population, not the exception. One woman's experience at Logan was particularly illustrative: She was "given numerous very serious mental health diagnoses by the IDOC, and was prescribed numerous psychotropic medications."⁶⁵ Despite her "repeated suicide attempts" and pleas for transfer to a psychiatric unit, her "acting out behavior simply resulted in her receiving more punishment—*punishment in the form of extending her stay in the very restrictive housing unit she told IDOC staff was tormenting her.*"⁶⁶ Yet IDOC's mental health staff was unmoved. Instead, they continued to accede to her continued isolation, finding time and again that there was "[n]o indication that patient's mental illness affected patient's behavior related to charges."⁶⁷

In all, Haney found, IDOC's use of solitary confinement and isolation to restrict the seriously mentally ill was "contrary to sound correctional and clinical practice, the weight of psychological and psychiatric opinion, and a violation of international human rights standards."⁶⁸ And it left the "mental

⁶⁴ *Id.* ¶210 (emphasis added).

⁶⁵ *Id.* ¶208.

⁶⁶ *Id.* (emphasis added).

⁶⁷ *Id.*

⁶⁸ *Id.* ¶237.

health and well-being” of IDOC’s seriously mentally ill residents “at grave risk of even further harm.”⁶⁹

In June 2021, over IDOC’s objections, a federal magistrate judge certified the class.⁷⁰ That alone was a monumental achievement for incarcerated people in Illinois. Indeed, it may well have opened the door to halting permanently the state’s use of segregation and isolation. But even a lasting end to solitary confinement cannot remedy its past harms. That is especially true for those who, like Petitioners, must endure the lasting consequences of those harms from behind bars.

III. Pontiac Correctional Center Punished Serious Mental Illness with Prolonged Solitary Confinement.

The facility known today as Pontiac Correctional Center, a collection of imposing masonry structures running along Route 66, dates to the end of Reconstruction. In 1871, “prompted by the idea that juvenile offenders should not be placed in penal institutions with older offenders, the state of Illinois opened up the Illinois Boys Reformatory School in the

⁶⁹ *Id.* ¶218.

⁷⁰ Memorandum and Order Granting Plaintiffs’ Motion for Class Certification, *Davis v. Baldwin*, No. 3:16-cv-600 (S.D. Ill. June 14, 2021), ECF No. 230. It is worth mentioning the seeming willingness of IDOC to concede the truth of the class’s allegations: “Notably, [IDOC] does not have any rebuttal experts, and Dr. Haney and Mr. Vail’s reports are uncontested at this time.” *Id.* at 7.

town of Pontiac.”⁷¹ By the early 1930s, it had been renamed the Illinois State Penitentiary and converted into an all-ages facility.⁷² It would not adopt its current guise or its maximum-security status until the 1970s; a few years later, in 1978, it would host the deadliest prison riot in Illinois history.⁷³

Besides its name and its residents’ demographics, little else about Pontiac seems to have changed since 1871. Not the buildings themselves. Not its ever-fraught racial dynamic,⁷⁴ with a mostly Black population guarded by a nearly all-white cadre of correctional officers.⁷⁵ Not those guards’ predilection

⁷¹ Sarah Millender, *History Of Pontiac Correctional Center: A Bibliography Of Sources Available At The Pontiac Public Library*, PRISON PUBLIC MEMORY PROJECT (July 2017), available at https://static1.squarespace.com/static/53ee7a8ce4b077338ed01813/t/5a8d9658ec212d3f4724c294/1519228506510/PPMP_Illinois_2017_Bibliography1.pdf.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Cf.* Ryan Lugalía-Hollon & Daniel Cooper, THE WAR ON NEIGHBORHOODS: POLICING, PRISON, AND PUNISHMENT IN A DIVIDED CITY 132 (2019) (“Why would a Pontiac resident want to see increased investment in human and community development in black communities like Austin [on Chicago’s West Side], and fewer prison sentences? Likewise, why would Austin residents want to see Pontiac Correctional Center employees maintain their jobs housing inmates?”).

⁷⁵ March 2021 Prison Stock Population Spreadsheet.

for violence, particularly against Black inmates⁷⁶ and those with mental illness. And certainly not the quality of its facilities or its provision of care—especially for the seriously mentally ill.

Indeed, Pontiac took the failings laid bare by *Rasho* and *Davis* even further. Infamously one of the State’s most dangerous and derelict carceral facilities, Pontiac regularly subjected its mentally ill residents to a torturous cycle: first starving them of human contact, basic necessities, and adequate care; then punishing their adverse responses with prolonged isolation; and then repeating those steps ad infinitum. It was a process best summed up by the testimony of one prisoner held in Pontiac’s West House: “I bug up [in solitary confinement and] when I do, then they beat on me and write me up, which keeps me here . . . I’m SMI [seriously mentally ill] and they don’t care.”⁷⁷

⁷⁶ See, e.g., *Ellis v. Pfister*, No. 16 C 9449, 2017 WL 1436967, at *3 (N.D. Ill. Apr. 24, 2017) (alleging that inmate with contraband tissue in pocket was killed after Pontiac guards “slammed [him] against the floor, restrained him with handcuffs and leg irons, led him into a room out of the view of the other prisoners, and then beat [him] about the face, head, neck, back, wrists, ankles, and knee,” and then “proceeded to shove a piece of paper down [his] throat and smothered him with their weight” until he died).

⁷⁷ Haney Report ¶121.

First, as the monitor’s reporting in *Rasho* makes clear, Pontiac used solitary confinement as a wholesale substitute for mental-health treatment. In his initial visit as *Rasho*’s court-appointed monitor, Dr. Stewart found the “crisis cells” in the prison’s notorious North House to be “the most chaotic and anti-therapeutic prison unit” he had ever toured in 30 years as a prison psychiatric expert.⁷⁸ Later, in his first monitoring report, he reported to his dismay that the situation at North House was “unchanged” from his first visit.⁷⁹

In his third annual monitoring report, filed three years after the *Rasho* settlement was first reached, Dr. Stewart found that Pontiac—designated as one of only three IDOC facilities allowed to house the seriously mentally ill—had still failed to create a Residential Treatment Unit for prisoners with serious mental illness, as required by the consent decree. He found as well that Pontiac continued to have significant treatment backlogs, kept mental health staff positions vacant, and held patients on “crisis watch” in cages in a hallway.⁸⁰

More disturbing still, Dr. Stewart also found evidence of a “culture of abuse” toward mentally ill prisoners in both the mental health units and segregated housing units at Pontiac.⁸¹ That included

⁷⁸ First Annual Report of Monitor Pablo Stewart at 42, *Rasho v. Baldwin*, 1:07-cv-01298-MMM-JEH (C.D. Ill. June 5, 2017).

⁷⁹ *Id.* at 42.

⁸⁰ *Id.*

⁸¹ *Id.* at 107.

a disturbing and “elaborate system of retaliation perpetrated by the custody staff against the mentally ill offenders at Pontiac.”⁸² As Dr. Stewart wrote, the scheme involved

. . . withholding food, visits, phone calls; restricting them from participating in required activities; setting up inmates for assault by labeling them ‘snitches’; providing them the means (staples, paper clips, other sharp objects) to perform self-injurious behaviors; [and] placing incriminating evidence in their cells, including weapons or other forms of contraband.⁸³

Second, as the reports of plaintiffs’ expert witnesses in *Davis* reveal, Pontiac supplemented its lack of adequate treatment with conditions of confinement that plainly shock the conscience. This was most apparent in North House, the dilapidated brick structure that held Pontiac’s mentally ill residents during their stints in solitary confinement, and where Dr. Craig Haney and Eldon Vail began their tour of Pontiac.⁸⁴

⁸² Midyear Report of Monitor Pablo Stewart at 93, *Rasho v. Baldwin*, 1:07-cv-01298-MMM (C.D. Ill. Dec. 3, 2018).

⁸³ *Id.* (emphasis added).

⁸⁴ See Haney Report ¶122.

By Haney’s account, as he entered North House for the first time, he found “a prisoner in a restraint cage and clothed in a suicide smock.”⁸⁵ The prisoner was “nearly incoherent.”⁸⁶ Though he could “confirm for [Haney] that he was on suicide watch,” he could not say “how long he had been there or when he . . . had been last checked on by mental health staff.”⁸⁷



“TREATMENT CAGE,” NORTH HOUSE⁸⁸

⁸⁵ Haney Report ¶123.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ Haney Report at 216.

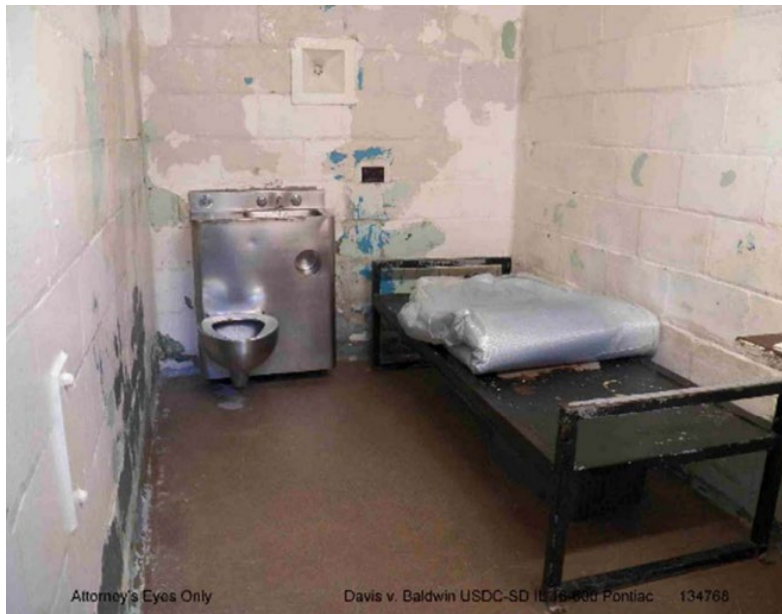
As the tour progressed, so too did North House's horrors. Vail saw "cells where the legs of the bunk beds were rusted. In one cell a prisoner showed me a hole in the wall that he said was used by rats. Multiple prisoners complained about rodent and insect infestation."⁸⁹



SEG. HOUSING CELL, PONTIAC CORR. CTR.⁹⁰

⁸⁹ Vail Report ¶24.

⁹⁰ *Id.*



SEG. HOUSING CELL, PONTIAC CORR. CTR.⁹¹

⁹¹ *Id.*

Prisoners also called out to Haney and Vail to show them “the water that came out of the sinks in their cells . . . There were small black specs [sic] in the water. [They] had great concern that the water was contaminated in some way.”⁹²

As for the shower stalls (to which isolated prisoners perhaps had weekly access, if that), Haney found them “in terrible condition”: rusted, caked in excrement at worst and in mildew at best.⁹³



SHOWER, NORTH HOUSE⁹⁴

⁹² *Id.*

⁹³ Haney Report ¶125.

⁹⁴ *Id.* at 216.

There was scant respite to be found outside, either. Those allowed out of doors (a revocable privilege limited to a few hours per week) generally took in their allotted fresh air from a glorified dog kennel.



“RECREATION CAGE,” NORTH HOUSE⁹⁵

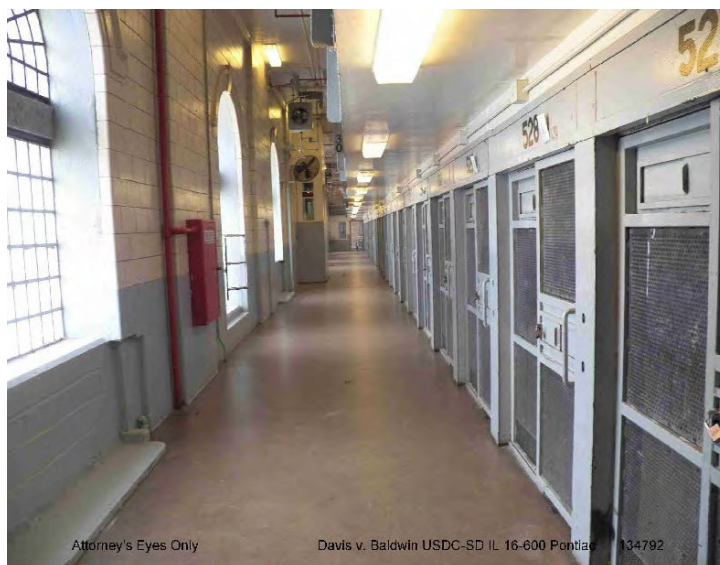
Indeed, Haney and Vail found in Pontiac’s segregated housing facilities little more than profound human suffering. Some came at the hands of the prison’s own staff. Seventy-seven percent of the prisoners Mr. Vail interviewed at Pontiac reported—without prompting—being “physically abused or witnessing beatings of other prisoners” while in segregation.⁹⁶ But the lion’s share came simply from deprivation and neglect. And far too much of it was shouldered by those least able to endure it.

⁹⁵ Haney Report ¶216.

⁹⁶ Class Cert. Memo at 34 (citing Vail Report ¶¶152–157).

Haney and Vail's tour of North House ended on the unit's ground floor. It contained 12 "crisis cells," which housed segregated prisoners being monitored for suicide or self-harm. One man, Haney recalled,

. . . appeared to be very psychologically disturbed. He showed me cuts on his arms from self-mutilation. He told me that he had come from West House and was not supposed to be in segregation. He complained about what he described as a total lack of programming: "I'm not getting any counseling, no yard, no soap, no toothpaste, no group." As he put it, "I am just back here, deteriorating."⁹⁷



HALLWAY, NORTH HOUSE, PONTIAC CORR. CTR.⁹⁸

⁹⁷ Haney Report ¶126.

⁹⁸ *Id.* at 213.

Third, when seriously mentally ill prisoners decompensated in solitary confinement, Pontiac had them brought up on disciplinary charges—if not felony indictments. For conduct as innocuous as throwing liquids or spitting at a passing guard, untold numbers of seriously mentally ill people lost years of good-time sentencing credits. Others, like Petitioners, were charged with and convicted of felony aggravated battery. And many were subjected to these measures repeatedly. These practices worked no deterrent or rehabilitative effect. To the contrary, they targeted those least able to control their behavior in the face of prolonged torture or under threat of sanction.

Tony was one such inmate.⁹⁹ He was born to drug-addicted parents and raised in Chicago's notorious Robert Taylor Homes. He stole to feed himself from a young age. His father beat him and his siblings with regularity, as did his mother, who seemed to relish locking Tony in a dark closet for hours at a time. By 14, Tony was in the custody of the Department of Child and Family Services, shuffled from juvenile detention facility to foster home to group home and back again. At 18, he was convicted of armed robbery and sentenced to ten years' incarceration.

Tony was placed in solitary shortly after entering Pontiac in 1994. He would break up the endless days of deafening noise, oppressive silence, and psychological trauma by cutting his arms with a staple or nail. His arms are covered in scars from self-harm.

⁹⁹ "Tony" is a pseudonym. To maintain his confidentiality as a mentally ill victim of state-sanctioned torture, his real name will not be disclosed in this brief.

Twice, in failed suicide attempts, Tony cut his arteries so deeply that he required emergency hospital care.

Correctional officers at Pontiac went out of their way to demean him, delighting in small acts that destabilized his fragile psychology and left him paranoid and fearful. They would contaminate his food; sometimes, they took it away entirely. They would call him a “bitch.” They told him that no one cared about him, and that he would die in prison.

Tony begged for help. Despite the obvious mental illness he wore on his sleeve, correctional officers would not send him to a psychiatric unit. He was kept on suicide watch for weeks on end. He was confined to a straitjacket. It was only when he threw feces or urine at his steel cell door—in desperate attempts simply to get someone to notice his agony—that Tony was let out of isolation. But if he was not taken to the Livingston County courthouse to be arraigned on felony charges, he would be walked in shackles to face more internal sanctions.

Tony’s experience is heartbreaking. For more than 23 years, most of it at Pontiac, he lived in total isolation. While suffering from a litany of untreated mental illnesses, he was prosecuted nearly *15 times* for conduct stemming from his treatment in solitary confinement. Today, Tony is 61 years old. He has spent no more than two years of his adult life outside an Illinois prison.

Yet Tony was no outlier. The accounts of his fellow petitioners make as much clear. The appellate

reporters, too, teem with indistinguishable cases.¹⁰⁰ The stories they tell are all the same. Time and again, Pontiac failed to treat its seriously mentally ill inmates with anything more than isolation and torture. And time and again, it answered their cries for help with punishment and prosecution.

IV. Governor Pritzker Should Use His Commutation Powers to Remedy the Harms of Solitary Confinement.

Petitioners do not seek reprieve from the convictions underlying their original terms of incarceration. They merely ask that their illnesses be treated with care, not punishment. To that end, they request that Governor Pritzker commute their aggravated battery convictions and restore their underlying terms of incarceration—for crimes they committed at liberty—to their status quo *ante*.

Governor Pritzker, after all, is fully empowered to commute these sentences. The Governor has the constitutional authority to commute any person's sentence, and it is in his sole discretion to do so.

¹⁰⁰ *E.g.*, *People v. Farner*, 2020 IL App (4th) 180796-U (Ill. App. Ct. 2020) (affirming aggravated battery conviction, for throwing “unknown substance,” of Pontiac resident diagnosed with “bipolar disorder, post-traumatic stress disorder, impulse control disorder, antisocial personality disorder, and borderline personality disorders,” and who had “attempted to commit suicide at least twice while in prison and attempted suicide three or four times before he was in prison”); *People v. Ludwick*, 2011 IL App (4th) 100587-U (Ill. App. Ct. 2011) (affirming aggravated battery conviction, for throwing liquid “smell[ing] of urine,” of Pontiac resident with schizoaffective disorder who had suffered “psychiatric problems since the age of four and heard voices since childhood”).

Since the enactment of the 1970 Illinois Constitution, this State's courts have recognized that the Governor has nearly limitless authority to "grant reprieves, commutations and pardons, after convictions, for all offenses on such terms as he thinks proper."¹⁰¹ As the Illinois Supreme Court has declared, the Governor's power to pardon or grant clemency is constrained only by his conscience and his sense of public duty; it cannot be controlled by the courts or legislature.¹⁰²

Upon a defendant's adjudication of guilt, the Governor may grant reprieve in several ways.¹⁰³ One—the manner of relief requested by Petitioners—is commutation.¹⁰⁴ Through a commutation, the Governor may reduce the severity of a judicially imposed sentence, a procedure that often involves the substitution of a lesser term or the complete discharge of the sentence.¹⁰⁵ Moreover, the Governor may grant a commutation with or without conditions attached, or he may only remove some possible consequences for an offense.¹⁰⁶ Governor Ryan did just this in 1999, when

¹⁰¹ Ill. Const. art. V § 12; *People ex rel. Madigan v. Snyder*, 804 N.E.2d 546, 551 (Ill. 2004).

¹⁰² *People ex rel. Madigan*, 804 N.E.2d at 551.

¹⁰³ *Id.* at 558.

¹⁰⁴ *Id.* at 558.

¹⁰⁵ *Id.* at 557; *see also People v. Rissley*, 795 N.E.2d 174, 206 (Ill. 2003).

¹⁰⁶ *People ex rel. Madigan*, 804 N.E.2d at 558.

commuted the sentences of every prisoner held on death row to terms of life incarceration.¹⁰⁷

Thus, it is well within Governor Pritzker's constitutional authority to restore Petitioners to the terms of incarceration they would have served absent their relegation to solitary confinement. The only judicially recognized limitation on a governor's power to grant a commutation is that the governor "may not change [an inmate's] conviction from one crime into a conviction for another"¹⁰⁸—a request not made here.

Most importantly, granting clemency to Petitioners would be in keeping with a widely held understanding of the power's best and highest use. Clemency has long been recognized in Illinois as the proper remedy for miscarriages of justice when "the judicial process has been exhausted."¹⁰⁹ As the Illinois Supreme Court has observed, the drafters of the Illinois Constitution granted the Governor a broad power to grant reprieves with the intent that this power be used to prevent or remedy mass injustices.¹¹⁰

That use has ample precedent. Former Governor Ryan, as noted above, used his constitutional authority to commute the sentences of 167 inmates on

¹⁰⁷ *Id.*

¹⁰⁸ *Id.* at 557 (citing *People ex rel. Fullenwider*, 152 N.E. 549, 550–51 (Ill. 1926)).

¹⁰⁹ *Id.* at 560 (citing *Cherrix v. Braxton*, 131 F. Supp. 2d 756, 768 (E.D. Va. 2001)).

¹¹⁰ *Id.*

death row.¹¹¹ His justification for the action was simple: he viewed the “Illinois death penalty system [as] arbitrary and capricious—and therefore immoral.”¹¹² And Governor Pritzker himself has used the clemency power in such a broad manner. Hours before the possession and sale of cannabis were to become legal in Illinois, the Governor pardoned more than 11,000 people convicted of marijuana offenses.

Petitioners’ cases represent no less of a mass injustice. Placing seriously mentally ill prisoners in solitary confinement is, as one federal court has observed, “the mental equivalent of putting an asthmatic in a place with little air to breathe.”¹¹³ The IDOC turned Petitioners’ asthma attacks into felonies. Whatever prospective changes the State or IDOC might plan to make, they cannot redress the harms done to Petitioners by decades of malfeasance and mismanagement. The only remedy that can even begin such a process is executive clemency.

¹¹¹ Jodi Wilgoren, *Citing Issues of Fairness, Governor Clears Out Death Row in Illinois*, N.Y. TIMES (Jan. 12, 2003), available at <https://www.nytimes.com/2003/01/12/us/citing-issue-of-fairness-governor-clears-out-death-row-in-illinois.html>.

¹¹² *Id.*

¹¹³ *See Madrid v. Gomez*, 889 F. Supp. 1146, 1265 (N.D. Cal. 1995).

CONCLUSION

For these reasons, the Governor should grant
Petitioners' requests for commutation.

Respectfully submitted,

Illinois Prison Project

by 

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