

Article

Lethal Care: The Louisiana State Penitentiary Model of Medical Violence

Ernest K. Chavez 

School of Criminology, Criminal Justice, and Emergency Management, California State University,
Long Beach, CA 90840, USA; ernest.chavez@csulb.edu

Abstract

Under the Eighth Amendment, prisons are legally mandated to provide constitutionally adequate standards of medical care to the incarcerated. But how do we make sense of a carceral structure in which the very delivery of medical care results in preventable death? This article offers a carceral case study of how prison medical care during the era of mass incarceration generates racialized mortality at the Louisiana State Penitentiary, also known as Angola Prison. By analyzing caselaw documents drawn from the docket of *Lewis v. Cain*, an ongoing lawsuit alleging inadequate medical care at Angola, this article seeks to address the limits of pursuing relief from prison conditions through legal interventions and reforms that are always yet to arrive. Rather than examining prison medical care and preventable death as problems to be reformed, this project aims to develop theoretical insight into how Angola Prison enacts “medical violence” against its captive population. This refers to the use of prison healthcare capacities to harm rather than affirm the lives of the incarcerated. As this case study argues, medical violence operates through organized abandonment, disregard, and carceral extraction, which together extend the life of the prison through the deaths of its captive population.

Keywords: Louisiana State Penitentiary; Eighth Amendment litigation; prison mortality; prison medical care; prison hospice; carceral extraction

1. Introduction

In 2004, Shannon Hurd was sentenced to life in prison at the age of 29 and sent to the Louisiana State Penitentiary (LSP), also known as Angola Prison. While incarcerated, he began experiencing extreme bodily pain and made repeated requests for medical attention ([Hamilton and Montagnes 2018](#)). Even though his symptoms worsened between 2010 and 2015 and he lost 100 pounds, Hurd was refused diagnosis.¹ In 2015, he finally received a CT scan, which revealed cancer in his lungs and a tumor in his kidney that had likely been there for several years. Shortly after he was diagnosed with Stage IV terminal cancer, Hurd joined *Lewis v. Cain*, an Eighth Amendment class action lawsuit filed in 2015 alleging inadequate medical care at Angola Prison.² While Hurd’s story is individualized, the Eighth Amendment violations he encountered and the medical treatment he received highlight a core argument of this carceral case study: Angola’s healthcare system operates as an instrument of racialized violence rather than care.

In prison, the denial of medical care is prohibited by the Eighth Amendment as a form of cruel and unusual punishment. In 1976, *Estelle v. Gamble* first established that prisoners have a constitutional right to medical care.³ In 2011, *Brown v. Plata* clarified how overcrowded prison conditions lead to deficient medical and mental healthcare and



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thereby violate Eighth Amendment standards.⁴ While Eighth Amendment jurisprudence obligates prison authorities to protect incarcerated people from harm and to provide basic necessities—including medical care—it does not specify which violations rise to meet the criteria for “inadequate” care in a prison setting ([Armstrong 2022](#)).

Cain catalogues a long list of legal transgressions made by Angola’s medical and administrative staff. The lawsuit was originally filed by 12 named prisoner Plaintiffs—several of whom have died since its filing as a result of the very conditions under litigation. As a class action lawsuit, *Cain*’s list of plaintiffs includes all other “similarly situated” prisoners at Angola.⁵ When the Plaintiffs’ medical experts examined Shannon Hurd’s case, for example, they found 30 separate sick call requests were made in the years leading up to his diagnosis, and yet, the medical staff “routinely failed to conduct meaningful testing or scrutinize his symptoms.”⁶ The Plaintiffs’ experts summarized:

“Mr. Hurd had many of these signs and symptoms for an extended period before he was diagnosed. LSP physicians failed to review abnormal laboratory results, failed to identify longstanding weight loss, and failed to adequately evaluate the patient for years. . . This patient could have had a much earlier diagnosis.”⁷

This pattern, in which a failure to provide basic care contributed to preventable death, appears all throughout *Cain*. When the Plaintiffs’ experts examined a randomized sample of 28 “death summaries” filed by Angola’s medical staff, they reported that 26 involved serious medical errors and/or were preventable. The experts opined, “Given our chart reviews of deaths. . . there are many preventable deaths at LSP that contribute to th[e] extraordinary mortality rate. . . preventable excess deaths are a consequence of systemic inadequacies in the health program. . .”⁸ This case study will later document how Angola’s protocols surrounding “sick-call,” treatment of chronic illness, and hospice each contribute to preventable death.

As *Cain* reveals, numerous patients were denied access to routine appointments and follow-up visits for specialized treatment outside of the prison that could have been life-saving. Najali Niyogi, a New Orleans-based doctor at Tulane Hospital, describes how a majority of patients sent to her from Angola Prison arrive with undiagnosed cancer, heart failure, and lung disease, far past the point of curative treatment. She reports, “By the time that they have lost function of their legs, for instance. . . [and] finally come to the hospital. . . we do an MRI and see that there’s just metastatic disease throughout the spine. . . at that point there is nothing we can do. . .” ([Baird 2021](#)).

In 2017, like many others left at the mercy of Angola’s medical staff, Shannon Hurd died under custody at the age of 42. When in-custody mortality records for Louisiana were obtained through a public records request made by Incarceration Transparency—a Loyola University Law School project led by Andrea Armstrong—Hurd’s cause of death was listed as “medical,” resulting from respiratory failure ([Incarceration Transparency 2021a, 2021b](#)). As if his death was unpreventable, state records made no mention of the extremely late diagnosis he received or alternative outcomes that may have been possible had detection and treatment begun earlier.

Although *Cain* has been litigated since 2015—and an even earlier lawsuit filed against Angola in 1971 documents many of the same medical exigencies—meaningful change in the delivery of healthcare has remained elusive. In 2021, Judge Shelly Dick of the United States District Court for the Middle District of Louisiana ruled in favor of the Plaintiffs, declaring Angola’s medical care system unconstitutional.⁹ In a 2023 opinion that supported the ruling made two years earlier, Judge Dick noted that no significant improvements had occurred at Angola: “The finding is that the ‘care’ is not care at all, but abhorrent cruel and unusual punishment that violates the United States Constitution.”¹⁰

Accordingly, Judge Dick ordered the appointment of three special masters alongside a doctor, nurse, and nurse practitioner, to monitor Angola's compliance with Eighth Amendment standards. When the State of Louisiana appealed the ruling in *Parker v. Hooper* (the caption of the case was temporarily changed from *Lewis v. Cain* to *Parker v. Hooper* in appellate court), the Fifth Circuit rejected the appeal in February 2025, clearing the way for the installation of the special masters and the beginnings of a remedy phase.¹¹ In *Cain's* current remedy phase, the Plaintiffs are pursuing the appointment of an external panel to monitor and enforce compliance. Yet, despite judicial intervention and attempts at meaningful reform, Angola Prison continues to sustain a high mortality rate.

As a carceral case study, this article contributes to the literature that documents the importance of researching incarceration and healthcare at specific sites (Strong 2023; Venters 2019; Fleury-Steiner 2008). While prison mortality and the harms associated with incarceration are not uniform but rather vary by region as well as demographics (i.e., class and gender), this study will primarily focus on *Cain* and the context of Angola to understand how prison mortality and preventable death are both racialized and made routine. More specifically, the overarching goal of this research is to offer theoretical insight into how harm and violence are administered under the guise of medical care at Angola Prison.

To better understand the persistence of mortality, this project is guided by the following set of questions: First, what administrative mechanisms enable Angola Prison to manage and sustain mortality? Second, what can we learn from decades of court monitorship and medical reforms that have attempted to prevent unnecessary death at Angola? And, third, in pursuing a theory of Angola's structure of violence, how might we make sense of the deep entanglement between medical care, mortality, and racialized incarceration? In pursuit of these questions, I first offer a brief review of state and institution-level population trends that document a pattern of racialized mass imprisonment, life sentencing, and mortality.

2. Situating Mortality and Race in “The Prison Capital”

Between 1998 and 2020, Louisiana took on the title “the prison capital of the world” because it incarcerated more of its residents per capita than any state or country for all but one year (Pelot-Hobbs 2023; NPR Staff 2012). Like the rest of the nation, mass incarceration in Louisiana has largely concentrated around black populations. Louisiana's prisoner population is nearly 70% black, even though its general population is 33% black (Louisiana Department of Corrections 2025b).

Mortality across the state's prison system has been steadily increasing for two decades, although the true in-custody death count is likely higher than what official counts report (Armstrong 2023; Carson 2021; Louisiana Department of Corrections 2025a). According to Incarceration Transparency, Louisiana's correctional system saw a 50% spike in deaths between 2019 and 2022 (Armstrong 2023; Wolfe 2024). During that time, at least 1168 incarcerated people died under correctional custody; inadequate medical care was listed as the leading cause of death in more than 80% of the cases (Armstrong 2023). Black prisoners constituted more than 57% of these mortalities (Armstrong 2023). Roughly 18% of medical deaths in 2020–2021 were COVID-19 related, but Louisiana's in-custody mortality rate was already one of the highest in the country since 2001 (Armstrong 2023; Carson 2021).

While several conditions may contribute to Angola's unusually high death rate, including the overall increase in elderly prisoners and “accelerated aging” behind bars (Aday and Maschi 2019), one important driver of mortality to consider here is Louisiana's excessive reliance on life sentencing. According to Seeds (2022), life sentencing—and life without the possibility of parole (LWOP) in particular—routinizes both prison death and its deeply racialized distribution (Seeds 2022). Currently, the United States incarcerates roughly

55,000 people under an LWOP sentence, roughly 55% of whom are black (Nellis 2021). In Louisiana, the disparity is notably more severe. Of its roughly 4000 people sentenced to LWOP, an astounding 73% are black (Louisiana Department of Corrections 2025b).

Louisiana also continues to establish new statutes supporting extreme sentencing practices. In August 2024, the state passed HB10, a “truth-in-sentencing” style law that extends prison terms, removes parole opportunities, and mandates that 85% of a sentence be served before a prisoner becomes parole eligible. As a result, the state’s total incarcerated population is projected to nearly double by 2030 from roughly 28,000 to 55,800 people; the law also allocates an additional \$600 million to the state’s correctional budget (Sanders 2024; Webster 2024; Crime and Justice Institute 2024). And yet, previous research has demonstrated how the historical introduction of “truth-in-sentencing” laws on a national scale played a significant role in crafting LWOP and routinizing death by prison (Seeds 2022). In early 2024, Louisiana also became the first state to implement a parole process in which determinations for release are made solely on the basis of a risk-assessment algorithm (Webster 2025; Louisiana State University 2021). However, longstanding critiques have demonstrated how such actuarial methods reduce parole chances and reproduce racial bias (Harcourt 2006). Ultimately, these punitive practices normalize long-term incarceration, resulting in prison death while simultaneously obscuring their deeply racialized distribution.

Angola Prison, in particular, is infamous for both its severe racial disparities and gratuitous utilization of life sentencing, which leads to prison death. Known as the largest maximum-security prison in both the United States and in Louisiana, Angola confines roughly 4240 people—about 72% of whom are black and life-sentenced (Louisiana Department of Corrections 2025b). It also contains by far the largest share of prisoner mortalities of any Louisiana correctional institution. From 2019 to 2024, Angola reported 345 deaths, more than 60% of which were of black inmates (Louisiana Department of Corrections 2025a).

While these statistical indicators and patterns of racialized prison death provide a much-needed backdrop to this study, they alone do not sufficiently explain the role of medical care within Angola’s structure of violence. Afterall, incarceration and punishment are only the most recent expressions of Angola’s regime of violence. In the following theoretical framework, I outline an enduring structure of anti-black violence that is foundational to understanding how harm unfolds through medical care.

3. Theoretical Framework: Structuring Violence

Angola Prison contains an enduring history of violence. The 18,000-acre penitentiary originated in the early 19th century as a cluster of antebellum slave plantations and received its name, “Angola,” from one of Louisiana’s most ruthless slave-traders, Isaac Franklin (Childs 2015; Rothman 2021). While the practice of convict leasing ran concurrent with plantation slavery at Angola, the formal abolition of slavery in 1865 led to a restructuring of the plantations into a convict labor camp, which was consolidated under the private ownership of a former Confederate Major named Samuel James (Carleton 1984). Under this system, inmates were treated as commodities who could be contracted out, traded, and replaced if they died while performing brutal forms of labor. It was not until 1901 that the labor camp was bought out by the state and formally designated as the Louisiana State Penitentiary (Carleton 1984). All throughout the 20th century and into the present, the prison has been characterized as a deeply racialized regime of labor exploitation, torture, and violence (Hosbey 2025; Woodfox 2019; Rideau and Wikberg 1992).

As a former slave plantation turned convict labor camp and eventually state penitentiary, Angola Prison can be understood as a site for racial terror, captivity, and confinement; it contains the traces of what scholars in the field of Black Studies theorize as “slavery’s afterlife” (Hartman 2007; Wilderson 2010; Han 2015; Sexton 2011). As Hartman (2007, p. 6) writes:

If slavery persists as an issue in the political life of black America, it is...because black lives are still imperiled and devalued by a racial calculus and a political arithmetic that were entrenched centuries ago. This is the afterlife of slavery—skewed life chances, limited access to health and education, premature death, incarceration, and impoverishment.

Traces of this afterlife take many forms. In *Slaves of the State*, Childs (2015) argues that the sequestering, segregating, and controlling of black bodies inside Angola's prison cells echo the accumulation and mass commodification of "living death" aboard slave ships that stretched across the antebellum Black Atlantic. For Woodfox (2019), who survived more than 43 years under Angola's bloody regime, the vestiges of slavery's past could always be recognized in the prison's sovereign power over the life and death of its captives. And elaborating upon Hartman's notion that slavery's past continues to unfold in the present, Han (2015) conceptualizes how the permanence of this afterlife is made possible by law's capacity to repeat and reinforce racial injury. Building on these insights, I argue that one permutation of slavery's afterlife can be recognized in Angola Prison's medical practices and the legally protected channels through which it inflicts suffering and premature death against predominantly black populations. In other words, Angola is no longer an antebellum plantation, but its current-day medical and carceral practices continue to exploit life for racial, economic, and social control, thereby containing crucial linkages to slavery's past.

This persistent violence has been further shaped by a political economy that compels organized abandonment and premature death (Strong 2023; Gilmore 2022; De Giorgi 2018). Organized abandonment refers to late-20th-century political-economic restructuring in the United States, characterized in large part by a retraction of the welfare state and public services and coupled with an expansion of the carceral state and punitive capacities. According to Ruth Wilson Gilmore, as this state of abandonment accelerates, public agencies increasingly take on punitive operations, and punitive institutions take on the state's social responsibilities, including the provision of a bare minimum level of constitutionally adequate healthcare: "[M]any public agencies—education, healthcare, and so forth—have absorbed policing functions...at the same time...agencies of organized violence, such as jails and prisons and police, are absorbing social work functions, mental health care functions, things that they actually can't do" (Chenjerai 2020). Put simply, institutions designed for the purpose of confinement are now being charged with the unwanted and perhaps impossible task of providing healthcare in a meaningful way. Under these conditions, premature death results from the failure to provide basic healthcare. However, death also serves a purpose for prison institutions (Strong 2023; Gilmore 2007, 2022). The vitality of Angola's regime of mass imprisonment relies upon the accumulation and extraction of incarcerated life. As I will exposit in greater detail in the analysis of this article, carceral extraction and death are essentially what enable the prison to maintain and expand its capacities.

Abandonment's political-economic structure is accompanied by a symbolic economy in which an association between racial and criminal stigma sustains extreme forms of punishment such as LWOP, while normalizing a disregard for how incarcerated life and death is treated (Seeds 2022; Sexton 2017; Wacquant 2002a). As Sexton (2017, p. 92) argues, the economic structure of mass imprisonment may shift, adapt, or otherwise renew over time, but no matter the form it takes, the reproduction of racial stigma, which is to say "the derivation of symbolic value from the condemnation of black social status" or a "symbolic economy of antiblackness" remains in force. At Angola Prison, premature and preventable death is always already racialized and made possible by deadly carceral practices, including life and LWOP sentences. According to Seeds (2022), the American public and policymakers alike fail to fully comprehend LWOP as "...fundamentally a

process of neglect, symptomatic of a willingness if not eagerness to forget what happens after sentence. . .to forget the responsibility of imprisonment and the people who are the prisoners” (Seeds 2022, p. 182). This disregard for what happens to human life once it is held in prison is intensified by the fact that a vast majority of Angola’s life-sentenced prisoners are positioned at the intersection of racial and criminal stigma.

From this theoretical context, we can begin to understand Sufrin’s (2017, p. 8) insight that “the health status of incarcerated persons is a case study in structural violence.” At Angola, this structure is inextricable from the past regimes of racial violence that have always made human life disposable. Administering medical care against this backdrop of racialized confinement, abandonment, stigma, and disregard has given way to a structure that conceals harm as care. Alongside Shannon Hurd, the medical failures, constitutional violations, and preventable deaths experienced by *Cain’s* Plaintiffs begin to reveal the contours of a violence made legally permissible as it is delivered under the guise of medical care. I will ultimately argue that, through a “strategy of inclusion” (Stanley 2021), Angola positions its prisoners as recipients of care—but a form of “care” which is itself lethal and administered as medical violence.

4. Method: A Case Study of Angola Prison and *Lewis v. Cain*

In the past, qualitative prison research relied heavily on ethnographies made possible by institutional access (i.e., Sykes 1958; Goffman 1961). However, increasingly restrictive and narrowed accessibility during an era of massive carceral expansion has prompted qualitative prison researchers to turn to different modes of study and methodological experimentation (Lynch 2017; Simon 2000). As Wacquant (2002b, p. 387) observed just after the turn of the century, “. . .penitentiaries have turned into opaque organizations that can be difficult and sometimes nearly impossible to penetrate. . .But this opacity is highly variable and it can be circumvented or overcome. . .” One strategy for overcoming this opacity is to engage caselaw documents and news media accounts that enable the reader to “see” the inner-workings of the institution. This project builds on emergent methods in qualitative prison research that do not require accessibility but instead focus on various forms of archival knowledge (see Seeds 2022; Strong 2023; Cate 2022; Benson 2019; Lynch 2009; Perkinson 2010; Gilmore 2007). Specifically, I combine a carceral case study approach alongside an analysis of various court and institutionally generated documents that form an archive of Angola’s medical care practices.

A carceral case study often examines geographically and historically specific developments in penal practices, court interventions, and reforms. By focusing on a distinct locale—whether that be an institution, region, or state—a case study is well-suited to “illuminate general knowledge and understanding of penal phenomena, draw attention to the contingencies and diverse conditions that produce variance across jurisdictions, and encourage thinking about penal change with greater complexity” (Seeds 2022, p. 13). The strength of a case study lies in the ability to examine particularities, providing key insight and nuance that may otherwise be overlooked in macro-level work (Seeds 2022). To this end, Angola Prison presents a unique case for generating theoretical insight into how race, long-term sentencing, and poor medical care coalesce to naturalize a lethal form of punishment.

To examine these conditions, I rely mainly on court documents from *Cain’s* docket. Court documents offer a valuable data source for generating empirical and theoretical knowledge as they can help trace the impact of legal actions on shaping policies, standards, beliefs, and even paradigms about punishment (Degenshein and Leslie 2025; Strong 2023; Seeds 2022; Lynch 2017). While *Cain’s* docket is extensive, I focused my analysis on discovery documents, judicial orders, expert evaluations, as well as depositions and testimonies offered

by incarcerated patients, incarcerated orderlies, Angola's medical staff, and prison healthcare experts. Documents were excluded if they were not relevant to the study's aims or contained no new relevant information. However, it is important to note the limitations that come with court documents. Procedurally, these documents only include evidence deemed admissible during a specific discovery period, and they must adhere to arguments that can be made within a legal context. Furthermore, they are limited in their scope and do not include *all* relevant violations that have occurred at Angola but rather only those in which a prisoner willingly agrees to come forward as a formal plaintiff (an action that can potentially put them in danger within a prison setting). And finally, the presentation of these violations may be limited to what the plaintiffs' attorneys perceive as the most relevant details to winning a case, potentially leaving other points out of frame (Degenshein and Leslie 2025).

Together, these materials form an archive of penal artifacts, or a paper trail left by the carceral state, for analyzing Angola Prison's claim that it provides constitutionally adequate medical care to its prisoners (Skarpelis 2020; Benson 2019; Lynch 2017). Still, Skarpelis (2020) warns that archives may serve multiple purposes. They are not simply a repository of information but can be mobilized as a means to stabilize and expand governmental power by manufacturing narratives and controlling the contents of public knowledge. Any archival analysis that deals with prison institutions then comes with the risk of obscuring rather than revealing penal phenomena, especially where its contents present a threat to institutional legitimacy. In this sense, it is crucial to read an archive for its silences, omissions, assumptions, and careful maneuverings. Building on these methodological insights, the aim of this article is to assess *Cain's* docket as an archive of penal artifacts through which the prison's dead make their metaphorical return (Skarpelis 2020) by exposing a form of medical "care" so brutal and deadly that it amounts to systematic violence.

5. Litigating Medical Care at Angola: From the Hayes-Williams Lawsuit to *Lewis v. Cain*

"In our collective experience of over 60 years in correctional medicine, the Louisiana State Penitentiary's delivery of medical care is one of the worst we have ever reviewed."—Dr. Michael Pisis, Madeleine LaMarre, and Dr. Susi Vasallo¹²

Lewis v. Cain establishes a pattern in which Angola's prisoners are routinely denied access to constitutionally adequate medical care, resulting in preventable death and unnecessary suffering. *Cain* emerged between two crucial 21st-century events, which brought unprecedented scrutiny to prison healthcare. First, the 2011 U.S. Supreme Court ruling in *Brown v. Plata* declared prison overcrowding in California to be a violation of the Eighth Amendment. The court's argument largely focused on how overcrowding generated deficient healthcare capacities behind bars, leading to preventable in-custody death. And second, the 2020 outbreak of COVID-19 inside American prisons and jails magnified the issue of carceral medical care, in-custody death, and administrative accountability. The pandemic underscored the fact that captive populations are trapped, unable to fend for themselves, and that prisoners experience heightened exposure to infection, morbidity, and mortality, with little to no access to meaningful medical care.

Cain's most significant ruling to date occurred on the heels of these two events. In 2021, Judge Dick ruled that Angola was in violation of the Eighth Amendment and reasoned that prison administrators had been well aware of its failing healthcare system for some time but refused any meaningful attempt to make improvements or address underlying prison conditions. Ultimately, Judge Dick stated that refusing to make changes even in the face of ongoing litigation and consistently high rates of in-custody death was indicative of both deliberate indifference and wanton disregard.¹³ While the suit emerged from another set of appeals in *Parker v Hooper* in favor of the Plaintiffs and is currently moving toward

monitorship under a panel of special masters and medical professionals, a longer history of litigation at Angola helps to make sense of its enduring refusal to change.

Concerns over the quality of healthcare at Angola began in 1971 with the filing of *Williams v. McKeithen*, otherwise known as the “Hayes–Williams” lawsuit.¹⁴ This suit identified a litany of constitutional and civil rights violations inside Angola, including the use of racial segregation, solitary confinement, and a trusty system that encouraged violence amongst prisoners. Allegations also included the denial of adequate medical care, a lack of trained medical professionals and basic equipment, and an institutional culture that fostered repression and retaliation against prisoners for requesting medical care (Pelot-Hobbs 2018). Attempts to correct such violations spanned for decades, beginning with the appointment of a special master in 1973 who was charged with monitoring the prison. The Special Master, U.S. Magistrate Frank Polozola, published a rigorous criticism of Angola’s internal operations in 1975.¹⁵ That same year, Polozola’s review was adopted by a U.S. District Judge, Elmer West, charged with overseeing the case. West declared Angola Prison to be an “extreme public emergency” requiring court intervention, in part, to address its system of medical care.¹⁶

By 1981, Polozola had become the presiding judge over the Hayes–Williams case and placed the state’s entire adult penal system under judicial monitoring before implementing sweeping injunctions and court-mandated reforms, which lasted until 1998 (Pelot-Hobbs 2018). At the time, however, Polozola failed to diagnose constitutional violations as part of Angola’s brutal prison conditions. Instead, he framed “prisoner-on-prisoner” violence caused by overcrowding as the source of Angola’s dire situation. To alleviate these concerns, Polozola pursued reforms aimed at expanding the prison, creating more bed space, hiring hundreds of new correctional officers, and modestly increasing the prison’s medical staff (Pelot-Hobbs 2018). Thus, while these reforms altered Angola Prison, they ultimately failed to resolve the essential conditions articulated by the Hayes–Williams litigants as the source of cruel and unusual punishment. This failure enabled many of the issues to persist, including harm caused by ineffective medical care.

In 1992, when prisoner–plaintiffs filed *Lynn v. Williams* in connection with the original Hayes–Williams lawsuit, the U.S. Department of Justice (DOJ) had already concluded an investigation of Angola’s distressing institutional practices. The findings were published in a 1991 letter penned by then-Assistant Attorney General John R. Dunne, who flagged two important issues concerning the prison’s medical system.¹⁷ These issues—“sick call” guidelines and chronic disease management—closely echo violations that still persist at the core of *Cain*. A brief comparison between the DOJ’s 1991 investigation findings and *Cain*’s 2016 healthcare evaluation demonstrates this point.

Stated briefly, “sick call” establishes the initial steps required of a prisoner seeking to meet with a medical professional to have their symptoms examined. Dunne’s 1991 letter identified severe problems with its implementation. Medical evaluations usually took place in the middle of the night, between the hours of midnight and 3 a.m. These examinations were administered by “untrained, uncertified nurse assistants who spend less than a minute with each inmate. . .” and who “. . .are simply not qualified to conduct sick call and assess which inmates should be seen by a physician.”¹⁸ “Sick call” procedures are significant because they serve as the entry point for a prisoner to be seen by a healthcare professional. Without access to timely and accurate diagnoses, even a treatable medical condition can quickly intensify.

In 2016, a panel of correctional healthcare experts working with *Cain*’s Plaintiffs conducted an independent evaluation of Angola’s medical facilities, policies, and practices.¹⁹ The team of experts reviewed a long list of documents, training procedures, patient records, and reports, while also touring the prison’s medical units and observing “sick call” along-

side medication administration and emergency response. While they found that “sick call” was no longer conducted in the middle of the night, similar problems were evident. “Sick call” continues to be conducted by unsupervised medical personnel, namely emergency medical technicians (EMTs) who are not licensed or trained to make independent health assessments. Against protocol, Angola’s EMTs often failed to consult with a supervising physician about the assessments they made and were also managing patients suffering from acute and life-threatening conditions, who should have been seen by a physician instead.²⁰

Furthermore, the Plaintiffs’ medical experts remarked that EMTs conducted “sick call” without first checking a patient’s medical records—either because they did not have access to them or because they did not bother to access them. As a result, they often overlooked past diagnoses and treatments and unknowingly prescribed a medical regimen that either previously failed or negatively interacted with current medication. And after reviewing several patient records, their evaluation also concluded that between serious clinical errors, incorrect diagnoses, and a lack of oversight by Angola’s physicians during the early stages of medical care, patients were often untreated or treated with great delay, which ultimately resulted in several preventable deaths.

Apart from sick calls, Angola also continues to subject its prisoners who suffer from chronic diseases to inadequate treatment. Dunne’s 1991 investigation report concluded that medical provisions for prisoners struggling with chronic illness were grossly inadequate.²¹ For example, while Angola provided 60 chronic care beds at the time, the ward was severely understaffed, and the prison’s healthcare protocols lacked any real strategy for managing long-term illnesses. Patients suffering from chronic disease were regularly denied basic care such as monitoring for high blood pressure, running blood tests, and making follow-up visits or calls with a physician or specialist.

In *Cain*, the Plaintiffs’ experts not only found similar violations in the management of chronic disease, but their chart reviews revealed how mismanagement of patients ultimately led to several preventable deaths. For example, “Patient #3” had been diagnosed with five co-occurring chronic conditions, including uncontrolled diabetes for two years.²² During the two-year period, the patient only received two blood tests when he should have been tested every 3 months. He also showed 23 separate readings of abnormally high blood pressure but only received medication for 6 of the intervals. The patient was denied a timely hospital visit even as he developed extremely high blood pressure and symptoms of a leg infection. The experts concluded that although the patient’s condition was likely treatable, a lack of timely medical attention led to his preventable death.

When Angola’s own medical team examined the circumstances of Patient #3’s mortality as part of their required Death Summary, they reported finding no issues with the treatment he received. However, upon reviewing his chart, the Plaintiffs’ experts countered, “The death was preventable but the Death Summary failed to identify any problems with care.”²³ In fact, almost every chart review of chronic disease patients they conducted showed that ill-defined protocols and guidelines resulted in shoddy diagnosis, monitoring, and treatment. Many of these patients eventually perished under preventable circumstances, and yet the Death Summaries produced by Angola’s medical team failed to identify any potential treatment issues. The Plaintiffs’ experts concluded, “Although we observed major deviations from standards of care in nearly every case, no Death Summaries acknowledged any problems with care.”²⁴

These longstanding and recurring patterns between the Hayes–Williams and *Cain* lawsuits have not been lost on Judge Shelley Dick. In a 2021 ruling, the judge reflected on how, despite decades of attempted reform, many of the same violations remain in place:

In 1998, a settlement was reached. . . Given the fact that many of the complaints in [*Cain*]. . . —the deficiencies proven at trial—are the same as those ‘settled’ in

1998, the Court finds that Defendants have been aware of these deficiencies in the delivery of medical care at LSP for decades.²⁵

After the 2021 ruling, Judge Dick waited another two years to see if the prison would improve its healthcare system before ordering a panel of special masters to oversee remedial plans for eliminating these deficiencies.

This brief recounting of the Hayes–Williams suit and its overlap with *Cain* begins to illustrate how the organized abandonment and disregard of Angola’s most vulnerable prisoners continues despite ongoing attempts for reform. Under organized abandonment, these prisoner–patients are exposed to medical practices designed to neither treat nor cure but instead to propel them toward illness, vulnerability, and death. The failure to establish a sufficient “sick call” procedure as an entry point for seeking medical attention and the refusal to conduct meaningful post-mortem reviews to evaluate the course of treatment demonstrate a blatant disregard for preventable death. Examining this history of litigation at Angola allows us to recognize that if court interventions are incapable of implementing a base standard of medical care, perhaps it is because the institution is, above all else, designed for confinement even at the expense of unnecessary loss of life.

6. Hospice at Angola

While *Cain* is replete with instances of indifference toward unnecessary suffering and preventable death, a closer look at Angola Prison’s hospice ward begins to clarify how even the act of palliative caregiving is entangled with violence. Angola’s hospice ward has been a focal point of litigation under *Cain*.²⁶ The ward is located within the prison’s R.E. Barrow Treatment Center, which is composed of two infirmaries, also called Nursing Unit 1 and Unit 2. Nursing Unit 2 contains the hospice ward, made up of 24 dormitory-style beds and 10 locked rooms, where care is provided to Angola’s most vulnerable patients, including those suffering from severe disabilities or approaching the end of life. The sheer size of this hospice is rather significant, considering that most prisons do not even have one. And yet, it also indicates the normalization and high prevalence of mortality at this institution.

In 2000, The American Hospital Association awarded Angola’s hospice with the “Circle of Life Award,” stating the following:

The maximum security prison in Angola, Louisiana, is known as ‘the graveyard’—few of its inmates are ever expected to leave. . . But a glimmer of humanity is now shining into the grim interiors of Louisiana State Penitentiary, thanks to Warden Burl Cain. . . After a year of efforts to cobble together an end-of-life program at the prison while spending no extra money, Louisiana State Penitentiary now boasts an innovative hospice program that’s become a model for other prisons in Louisiana and across the nation. Inmates dying in the prison hospital can now spend more time with their families, be comforted by specially trained fellow inmate volunteers, and have more focused pain management in a setting that is especially wary of the use of drugs. (Campbell and Davidson 2000, p. 9)

Angola’s hospice ward and treatment of dying prisoners have also been the subject of several documentary films, including *Serving Life* (Cohen 2011), *The Farm: Angola, USA* (Garbus et al. 1998), and *Angola Prison Hospice: Opening the Door* (Barens 2011), as well as the photo-documentary *Grace Before Dying* (Waselchuk and Powell 2011). Academic articles have also catalogued and explored Angola’s hospice (i.e., Harbin 2015; Cloyes et al. 2014; Supiano et al. 2014). These various media largely engender humanizing narratives by focusing on sensational aspects and rehabilitative ideals found in Angola’s hospice, such as the social bonds that form between inmate orderlies and patients, the basic needs met through palliative care, the visitations from family members, the participation in ornate

funeral rituals, and the recognition that life behind bars is both valuable and grievable. In other words, Angola's end-of-life care practices are operationalized as providing humane care to the dying and rehabilitation to inmate orderlies. However, evidence from *Cain* reveals a different reality.

According to testimonies and depositions offered by Angola's hospice patients as well as the Plaintiffs' healthcare evaluation, hospice introduces its own set of routinized misery and harm. Angola's medical staff often exposes hospice patients to harmful conditions by forcing them to rely on overworked inmate orderlies as caretakers because the ward is severely understaffed.²⁷ Approximately two orderlies tend to more than 40 of Angola's most vulnerable patients at a time under the supervision of correctional officers rather than medical personnel.²⁸ The use of inmate orderlies violates the prison's own Health Care Assistants policy, which states, "Inmates are not to be used for performing direct patient care services...except under direct supervision, by specialty training staff, in a vocational training program."²⁹ The orderlies are often overburdened with caregiving responsibilities, including assisting patients with eating and bathing, changing bandages and soiled bedding, and cleaning the facilities.³⁰ Such conditions agitate an already tense and frustrating prison environment, inviting both intentional abuse and unintentional harm of hospice patients.³¹ The point here is not to detract from the significance of the physical and emotional labor provided by incarcerated people who volunteer as hospice orderlies and caregivers (i.e., Cloyes et al. 2014; Supiano et al. 2014; Waselchuk and Powell 2011), but rather, to highlight how incarcerated caregivers are also exploited for the management of prison mortality.

However, perhaps the most heinous scandal to emerge out of Angola's hospice ward is the fact that several patients with non-terminal health conditions were pressured to sign a Do-Not-Resuscitate (DNR) order and unnecessarily admitted into hospice. *Cain's* filings reveal at least four such cases.³² The Plaintiffs' medical expert, Dr. Michael Puisis, clarified that such a practice was medically inappropriate given that a DNR order is usually a last resort for a patient who has little to no chance of recovery from their illness, is approaching the end of life, and chooses hospice to receive palliative treatment.³³ Not only does the firsthand experience of *Cain's* Plaintiff, Farrell Sampier, reveal the hidden cruelties of hospice at Angola, but it is also significant to understanding how violence becomes mystified as medical care.

7. Surviving Hospice: A Profile of Farrell Sampier

On 9 October 2018, Farrell Sampier testified as a named plaintiff to the hospice treatment he received at Angola.³⁴ Roughly six months later, on 25 March 2019, he passed away at age 51 from preventable causes. Sampier was one of several named plaintiffs in *Cain* who have been re-listed as "former plaintiffs," as they continue to die in real time under the very system of medical care facing litigation. His cause of death was officially listed as cardiopulmonary arrest or sudden cardiac arrest resulting from a pre-existing medical condition (*Incarceration Transparency 2021a, 2021b*). However, a fuller picture of Sampier's mortality circumstances reveals a fatal form of medical "care" that led to his otherwise preventable death.

7.1. Deferred Care

Sampier was sentenced to 20 years in prison in 2012 (Lartey 2021). While in custody at Orleans Parish Prison (the New Orleans jail) and awaiting transfer to Angola, he began to experience numbness and stinging sensations in his foot. He testified that the pain "felt like I was walking on broken glass, and it started moving its way up..."³⁵ While Sampier complained about the pain, staff ignored his concerns, and he began to suffer from

partial paralysis before losing the ability to walk two days prior to his transfer to Angola. He was briefly transported to a medical facility at Louisiana State University, where a doctor diagnosed him with transverse myelitis. The doctor explained that while transverse myelitis is a non-fatal and treatable neurological condition that involves inflammation of the spine, it can cause permanent paralysis if left untreated.³⁶ While it is unclear exactly how Sampier contracted transverse myelitis—in part because he was initially denied medical diagnoses—he later recounted to his mother that the New Orleans jail had flooded during Hurricane Isaac when he was held there, leaving many jail inmates standing in ankle-deep sewage water and potentially exposing them to infectious pathogens (Lartey 2021). Whatever the precise cause, by the time Sampier was moved to Angola Prison, he was already paralyzed from the waist down and bound to a wheelchair.

Upon his arrival at Angola in May 2013, Sampier was placed in the prison infirmary that contains the most vulnerable and terminally ill prisoners, where he remained until late 2016. While testifying in 2018, Sampier recalled that when he was moved to Angola, he received little explanation about his medical condition or why he was housed in the infirmary. When asked by his attorneys to describe the infirmary, he stated:

It was dark. . . It was sad. It was just a lot of death. You got a lot of guys that's hungry, that. . . don't have no support, no family. . . no money. . . It was a real sad situation. . . You know, these guys 20, 30 years into their sentence, they know it's the end. . . You hear moaning, you hear guys crying out. . . it's just sad.³⁷

Sampier also explained that the ward was unsanitary and under-staffed, with patients often left to sit in their own feces and urine while incarcerated orderlies were overwhelmed with caretaking responsibilities. But when attorneys made known visits to the infirmary, Angola's administrators instructed the inmate orderlies to conceal the deplorable conditions, to clean and mop the floors, and to use air fresheners to hide odors.

7.2. *Abandoned to Hospice: "Made DNR"*

Sampier's health quickly worsened after admission. Even though transverse myelitis is non-fatal, Angola's physician, Dr. Toce, convinced him to sign a DNR order and begin hospice care under the pretense that resuscitation would involve an extremely painful and traumatic procedure. Sampier testified:

At that time, Dr. Toce explained to me in pretty much graphic detail how I would have to have some ribs cracked and lungs punctured, and he was like, are you sure that's what you want to do? . . . It was just a lot of confusion when he mentioned that to me. . . I was like, well I'm not going to have them resuscitate me. . . I just didn't know what was going on at the time I agreed to get in hospice. . . I wasn't exactly sure what I had. I didn't know why I couldn't walk or I couldn't urinate [sic] or had problems holding my bowels. And. . . just the way [they were] saying it, like, you know, hospice would be best for you, I just went on and. . . got in the hospice program.³⁸

However, the Plaintiffs' medical expert, Dr. Puisis, later testified that a DNR order should be strictly reserved for patients in the terminal stages of life who are willfully choosing to reject life-saving intervention and that it is completely inappropriate for a medical professional to even discuss a DNR order with a non-terminal patient in the first place.³⁹ Dr. Puisis also clarified that resuscitation does not typically result in broken ribs and that Dr. Toce was describing the worst-case scenario of resuscitation, likely in order to intimidate Sampier into signing the DNR order. In this way, like other Plaintiffs who were diagnosed with acute but non-fatal conditions and inappropriately assigned to hospice, Sampier was denied curative treatment and "made DNR."⁴⁰

7.3. Basic Care Denied

But even after Sampier was admitted into hospice, the degrading medical practices continued, and he struggled to receive basic care and medical supplies. He suffered from painful bedsores and requested a bedside trapeze bar so that he could pull himself up and rotate his body in bed. He was initially denied the basic equipment and resorted to tying a bedsheet to the bottom of the bunkbed above him as a makeshift trapeze bar. After several weeks of seeing this, Angola's medical staff ordered the trapeze bar, but Sampier continued to be denied other basic equipment. He requested gloves to protect his hands from blisters while using his wheelchair but received none. When his mother sent him gloves designed for use with a wheelchair, they were rejected by the prison staff. Instead of proper gloves, Sampier eventually received a pair of fieldwork gloves from another prisoner with no help from the medical staff. Sampier also requested a wheelchair designed for use by a paraplegic patient but was again denied. He only obtained the appropriate wheelchair after another paraplegic prisoner was paroled and left it to him.

During his time in hospice, Sampier's mother, Lois Ratcliff, a certified nursing assistant with 40 years of experience in the healthcare field providing care to elderly and infirm patients visited him often but was shocked at the sight of Angola's hospice ward (Lartey 2021). She observed that basic sanitary and medical precautions were nonexistent. Specifically, she recalls nurses distributing medication without gloves or masks to patients with open wounds, old and unsanitized blankets being cut and used as patient washrags, tabletops and surfaces that seemed to never be cleaned, and a nauseating smell of feces that filled the space and made it impossible to share a simple meal together. She stated that Sampier would sometimes call her at night in tears because the staff failed to provide his pain management medication.

In a rather visceral example emerging from Sampier's own testimony, he described an infection resulting from a Foley catheter, which he relied on to urinate. Because the catheter was only changed once every month, he developed a severe flesh tear at the insertion point.⁴¹ Even though he was in pain and repeatedly requested treatment, Angola's medical staff refused to repair the damaged skin, ultimately resulting in an infection.⁴² After a year passed, Sampier only received treatment once he agreed to join *Cain* as a plaintiff.

Even though Angola's medical staff wanted Sampier to remain in hospice, he was resolute on getting out. He began teaching himself about transverse myelitis and worked to become independent enough to leave the hospice ward. He focused on physical therapy movements he learned from another prisoner and made dietary changes, which were only possible by using money provided by his family to purchase food from the commissary. Although Sampier initially survived a hospice program meant to kill him, his overall health continued to decline. Even after his death in early 2019, Angola's medical staff defended his treatment as constitutionally adequate, claiming that he received hospice care, a trapeze bar, gloves, wheelchair, dietary changes, and surgery—much of which he was made to obtain on his own.

While Sampier's story is tragic, it is not exceptional. The care he received is consistent with a pattern of fatal medical practices identified by *Cain's* Plaintiffs as the source of preventable death at Angola. He displayed symptoms of a serious medical condition early into his incarceration but was deferred care and denied access to specialists. Although he was held in the medical ward, he was rarely evaluated by a qualified physician. He was abandoned to the ward alongside other vulnerable people, who were left to languish in misery while awaiting a certain death. His condition continued to be mismanaged even as he developed clear "red flag" warnings before his death. As was the case with Shannon Hurd, attributing Farrell Sampier's death to a preexisting health condition individualizes

and decontextualizes a set of institutionalized medical practices that directly contributed to his fatality.

8. Analysis: Lethal Care and Medical Violence

My argument is not that Sampier or others failed to receive medical care. Rather, every attempt to seek out care culminates in what would more accurately be described as medical violence. This violence is doled out to Angola's prisoners as a form of lethal care made possible by organized abandonment and carceral extraction, disregard, and a performance of inclusion.

8.1. Organized Abandonment and Carceral Extraction

Under abandonment, incarcerated life is treated like an extractable resource that sustains the vitality of the prison. As [Gilmore \(2022\)](#) posits, through an extractive process that is always-already racialized, bodies held in tiny cells are extracted of “the resource of life: time.” Whether through prolonged suffering in hospice or a slow death under LWOP, life itself is first held in suspension and then siphoned off by the state before it is eventually converted into prison employee payrolls, medical vendor billings, or funding meant to expand Angola's medical infrastructure. In other words, this form of penal “care” treats the prisoner's life as a commodity for resource extraction and prison expansion ([Strong 2023](#)) while the life of the institution is extended in exchange for the deaths of those it holds captive ([Friedman 2021](#)).

Building on Gilmore's framework of organized abandonment and carceral extraction, [Strong's \(2023, p. 6\)](#) case study of prison healthcare in the state of Arizona offers insight into how “[b]odies with holes in them—the sick and dying—are the raw material and by-product of the penal state's ceaseless restructuring.” As [Strong \(2023\)](#) demonstrates, in the case of Arizona, endless legal motions, scapegoating private prison healthcare vendors, and reforms that fail to deliver on the promise of institutional improvement culminate in a perpetual denial of care for the incarcerated. *Cain's* docket evinces similar patterns. At Angola Prison, abandonment and extraction take many forms, including perpetually delayed or denied diagnoses, medical “treatment” that propels a patient toward vulnerability and premature death, post-mortem reviews that erase traces of harm inflicted onto patients, and the use of coerced DNR orders—all of which are taken as evidence for the need to reform and expand Angola's medical regime. And herein lies the parasitic function of carceral extraction: life is taken from the incarcerated and converted to capital that maintains and expands the prison. In this sense, prolonged suffering and slow death are mobilized as a means for extending the prison's sovereign power over life and death, clarifying the central role of “care” within a structure of medical violence.

8.2. Disregard

If organized abandonment and carceral extraction begin to delineate a modality of violence that is administered through medical care, then the concept of disregard as offered by [Seeds \(2022\)](#) explains one way in which incarcerated life is rendered disposable and prison mortality normalized. As [Seeds \(2022, p. 23\)](#) discerns, “acceptance, acquiescence, ambivalence, a failure to care, a discarding of responsibility—all sorts of not doing and disposing” at a societal level sustains our current carceral configuration in which life sentencing and mortality have become routine matters. Because U.S. society fails to reflect on *how* punishment is implemented, it is in large part unconcerned with the fact that prisons like Angola are now becoming “old age homes” for warehousing the sick, the aging, and the life-sentenced to death ([Seeds 2022](#)).

Instead of contemplating the capacity for human beings to undergo meaningful personal transformation during a lifetime, the stigma of criminality normalizes a disregard for what happens to human life and death behind bars. Had Sampier's life been regarded with value, he would have received the initial treatment required and may still be alive today. But rather than extending care to Sampier, Angola's medical staff chose to force a DNR order upon him. In this sense, between Louisiana's life-sentencing policies and Angola's medical practices, thousands of aging and life-sentenced people are essentially positioned as terminal subjects in the making.

8.3. *Performing Inclusion*

Finally, this case study offers a reading of how violence can be strategically implemented through what Stanley (2021) identifies as the performative logics of inclusion. Inclusionary violence functions by claiming to act in the best interest of a subject, but in reality, it serves to conceal subjugation and harm. In the context of medical care at Angola, prisoners are formally included as rights-bearing subjects who have access to the Constitution's Eighth Amendment protections. But in practice, inclusion as a subject of prison medical care is precisely what makes the prisoner vulnerable to violence.

Farrell Sampier's treatment exemplifies how medical violence is made possible through performative inclusion. The only way Sampier could receive even the bare minimum level of medical care required that he first enlist himself as a terminal subject by signing an unnecessary DNR order. Here, what might initially appear as a contradiction—the conflation of care with harm—represents the very logic of inclusionary violence (Stanley 2021). Inside Angola's hospice program, inmates are constructed as cooperative agents who consent to end-of-life care. But here, agency is also twisted as part of a strategy for masking violence. As in the case of Sampier, who was coerced into a DNR order, Angola Prison maintains an illusion of agency and consent while its medical staff orchestrate premature death by deferring or denying curative treatment and instead abandoning patients to hospice or slow death. In this sense, while depictions of humanized caregiving within Angola's hospice are important to consider, so is the performative backdrop in which they take place—a lethal environment in which human life is devalued, and individuals are abandoned to suffer, deteriorate, and perish in captivity.

Beyond hospice, the use of inclusive strategies to justify violence appear throughout other aspects of Angola's mortality practices: prisoner orderlies who provide deathcare to dying patients; prisoners who hand-build coffins used in funeral ceremonies for one another; prisoners who choose to be buried within the prison's cemeteries and memorialized by a headstone; and prisoners who receive medical care only to continue a life sentence. Each scene operates under an inclusionary logic that prolongs suffering under the pretense of agency. In other words, notions of agency and consent are distorted as prisoners are made to participate in their own suffering and death.

Moreover, these inclusive gestures operate as a performance of care that conceals a method for disposing of the prisoner's life. As with all extractive industries, there remains a question as to how to dispose of the "waste" or "excess" that is generated during the process of production. While disposal may take many forms, in the case of Angola, it requires the ability to impose death without signifying violence. To this end, Angola's hospice program attempts to humanize lethal punishment or to dispose of death while playing the role of caretaker. Angola Prison proclaims to care while it inflicts harm and mortality through abandonment, disregard, and a violence that is always-already racialized.

Through symbolic performances of care, the prison is better able to expand and grow its capacity for managing mortality while simultaneously refusing life-saving remedies, such as mass decarceration or the abolition of life sentencing. What initially appear as

acts of inclusion, care, or recognition of the prisoner's humanity are, in fact, revealing of a desire to perfect violence behind the veil of care. At their very core, these performances constitute a part of the institution's extractive mechanism by quietly disposing of and disappearing the prison's dead while camouflaging violence as medical care. This is why "care" cannot serve as the antidote: it is precisely the mechanism through which medical violence is administered.

9. Conclusions: The Ruse of Prison Medical Care

Whether as a slave plantation, convict lease prison, or state penitentiary, mortality—and in particular, the death of black captives—has always been a part of Angola's lifeblood. One manifestation of this dynamic is marked by the prison's two formal cemeteries: Point Lookout I and its annex, Point Lookout II (Hinton 2012; Waselchuk and Powell 2011; Bares 2011). The demand for space to bury and disappear the prison's dead is inextricable from Angola's incarceration practices. Under organized abandonment, its prisoners are left to face dire health needs that go unaddressed even following extensive periods of litigation stretching as far back as the Hayes–Williams suit. The only remaining recourse for the prisoner who is made dependent upon the institution is to pursue gradual relief through the law's convoluted and drawn-out procedures. Given that many of the same exigencies remain in place despite decades of legal challenges, and Angola's mortality rate proliferates even as *Cain's* Plaintiffs continue to perish, it appears that such reforms are capable of shifting the protocols surrounding death, but fail to address the prison's underlying need for mortality.

While this case study has focused on *Cain*, Angola Prison, and the State of Louisiana, the lessons derived from it regarding penal change need not be siloed. For example, following the aftermath of the landmark 2011 U.S. Supreme Court Case, *Brown v. Plata*, the state of California embarked on a decades-long federal receivership and prison reform project aimed at medicalizing its entire prison system in the hopes of reducing in-custody mortality. In the aftermath of *Plata*, California expanded its statewide prison medical infrastructure to an unprecedented degree. While this expansion was funded and fueled under the assumption that medicalized prisons would put a stop to unnecessary death, prison mortality in California continued to trend high and even reached a new peak in recent years. Whether in the case of Louisiana or California, even when legal victories create a significant opportunity for reorganizing carceral practices, they continue to be haunted by the all-too-real capacity for violence to find expression through the very channels established by way of reform and restructuring. This point remains crucial as *Cain* moves toward a remedy in the form of court monitorship and the possibility of a federal receivership.

The pursuit of reform at Angola then raises an important question. Stanley (2021, p. 103) asks, "Are the changes we are fighting for now helping to shrink or expand the prison's capacity to kill?" As this analysis of *Cain* shows, Angola's capacity to kill is sustained through legal mandates and loose interpretations of constitutional rights that ultimately serve to restructure the prison environment but in ways that remain loyal to the administrative command to warehouse, extract, and dispose. Rather than looking to legal pathways for relief, then, the very idea that medical violence can be reformed or humanized must be rejected and replaced with the recognition that carceral death is not a sign of failure but rather part of the institution's very design (Friedman 2021).

Abolitionists have long argued that legal remedies that depend on prison administrators to protect incarcerated people are precisely what preserve the state's monopoly on violence by reproducing the very idea that there is no solution beyond a "better" prison (Davis 2003). This is the ruse of "prison medical care" operating vis-à-vis promises of reform and relief that are still deferred and always yet to arrive. The ruse obscures medical

violence and the way in which ostensibly life-affirming and care-affirming practices are in fact essential to sustaining the prison's structural imperatives for extraction, disregard, and disposal. In the afterlife of slavery at Angola, one finds a medical–carceral practice of violence in which imprisoned life—and, in particular, black life—is reconstituted as an extractive object within a process of carceral re-production before it is neutralized, eliminated, and dispensed with. The idea that Angola—a product of centuries of violence—could ever be reformed into providing meaningful care to its captives is a fantasy requiring disavowal of its very compulsion for prisoner death.

The argument here is not to imply that we should surrender our desire for change or to deny that a different model of justice is possible. Afterall, the need for immediate relief for incarcerated people is evident, and the potential pathways for such relief are numerous. Providing timely access to effective medical care, extending provisions for medical parole and compassionate release, increasing the use of off-site medical facilities for treatment, and eliminating the use of LWOP sentencing altogether—each of these actions presents an important opportunity for initiating a significant shift in how incarcerated life is treated. However, the analysis provided in this article takes a further step to suggest that future researchers, advocates, and policymakers ought to contextualize the pursuit for change through an abolitionist ethos that understands the limits of gradual legal change and recognizes Angola Prison first and foremost as an institution designed by and for racial violence, captivity, and death.

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Notes

- ¹ See *Lewis v. Cain*, Second Amended Class Action Complaint, 25 July 2016 and *Lewis v. Cain*, Corrected Proposed Finding of Fact, 17 April 2019.
- ² *Lewis v. Cain*, 3:15-cv-00318, 20 May 2015.
- ³ *Estelle v. Gamble* (1976). 429 U.S. 97.
- ⁴ *Brown v. Plata* (2011). 563 U.S. 493.
- ⁵ See *Lewis v. Cain*, Second Amended Class Action Complaint, 25 July 2016 and *Lewis v. Cain*.
- ⁶ See *Lewis v. Cain*, Judge's Opinion, 31 March 2021, p. 27.
- ⁷ See *Lewis v. Cain*, Corrected Proposed Finding of Fact, 17 April 2019, pp. 70–71.
- ⁸ See *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016, pp. 84–85.
- ⁹ See *Lewis v. Cain*, Judge's Ruling, 8 October 2021.
- ¹⁰ See *Lewis v. Cain*, Judge's Ruling, 6 November 2023, p. 2.
- ¹¹ See *Parker v. Hooper*, 23-30825, 12 February 2025.
- ¹² See *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016, p. 9. The evaluation was authored by Michael Puisis (Doctor of Osteopathic Medicine), Madeleine LaMarre (Master of Nursing, Family Nurser Practitioner—Board Certified), and Susi Vasallo (Doctor of Medicine).
- ¹³ See *Lewis v. Cain*, Judge's Ruling, 31 March 2021, p. 38.
- ¹⁴ See *Williams v. McKeithen*, 3:71-cv-00098, 26 March 1971.
- ¹⁵ See *Williams v. McKeithen*, Special Master's Report, 28 April 1975.
- ¹⁶ See *Williams v. McKeithen*, Judgement and Order, 10 June 1975.
- ¹⁷ See *Williams & U.S. v. Lynn*, Findings Letter re: CRIPA Investigation of Louisiana State Penitentiary at Angola, 13 May 1991.
- ¹⁸ *Ibid*, p. 2.
- ¹⁹ See *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016.

- ²⁰ Ibid, p. 8.
- ²¹ See *Williams & U.S. v. Lynn*, Findings Letter re: CRIPA Investigation of Louisiana State Penitentiary at Angola, 13 May 1991, p. 3.
- ²² See *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016, p. 44.
- ²³ Ibid, p. 44.
- ²⁴ See Note 23.
- ²⁵ See *Lewis v. Cain*, Judge's Opinion, 31 March 2021, pp. 42–43.
- ²⁶ See *Lewis v. Cain*, Corrected Proposed Finding of Fact, 17 April 2019.
- ²⁷ See *Lewis v. Cain*, Corrected Proposed Finding of Fact, 17 April 2019, p. 48.
- ²⁸ See *Lewis v. Cain*, Plaintiffs' Finding of Fact and Conclusion of Law, 17 April 2019, p. 144.
- ²⁹ See *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016, p. 81.
- ³⁰ See Note 26.
- ³¹ Ibid, p. 81.
- ³² See Patients #9, #10, #23, and #32 in *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016.
- ³³ See *Lewis v. Cain*, Transcript of Testimony, filed 18 March 2019, p. 178.
- ³⁴ See *Lewis v. Cain*, Transcript of Testimony, filed 18 March 2019.
- ³⁵ See *Lewis v. Cain*, Transcript of Testimony, filed 18 March 2019, p. 44.
- ³⁶ See *Lewis v. Cain*, Second Amended Class Action Complaint, 25 July 2016, p. 13–14.
- ³⁷ See *Lewis v. Cain*, Transcript of Testimony, filed 18 March 2019, p. 45.
- ³⁸ Ibid, p. 51–56.
- ³⁹ Ibid, p. 179.
- ⁴⁰ See *Lewis v. Cain*, Louisiana State Penitentiary at Angola Health Care Evaluation, 5 October 2016, p. 71.
- ⁴¹ Ibid, p. 57.
- ⁴² See *Lewis v. Cain*, Class Action Complaint, 20 May 2015, p. 8.

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