IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
NORTHERN DIVISION

JERMAINE DOCKERY, et al.	:	
Plaintiffs,	:	Civil Action No. 3:13cv326-TSL-JCG
v.	:	**ORAL ARGUMENT REQUESTED**
CHRISTOPHER EPPS, et al.	:	
Defendants.	:	

MEMORANDUM OF LAW IN SUPPORT OF PLAINTIFFS' MOTION FOR CLASS CERTIFICATION

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

TABLE OF CONTENTS

TABLE OF CONTENTS

Statutes

Rules

Other Authorities

TABLE OF CONTENTS

Plaintiffs are prisoners confined at the East Mississippi Correctional Facility ("EMCF"). Defendants – the Commissioner, Deputy Commissioner, and Medical Director of the Mississippi Department of Corrections – have violated and continue to violate Plaintiffs' rights under the Eighth Amendment through policies and practices that subject them, and all other prisoners confined at EMCF, to conditions so harsh and inhumane as to deprive them of basic human needs: reasonable protection from violence, access to care for serious medical and mental health needs, sanitation, and adequate nutrition. Defendants' actual knowledge of the substantial risk of serious harm to Plaintiffs and failure to act reasonably to address that risk violates the Eighth Amendment. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

Plaintiffs seek to represent a class of all prisoners who are now or will in the future be confined at EMCF and three subclasses: all prisoners at EMCF subject to Defendants' mental health care policies and practices at EMCF (hereinafter, "the Mental Health Subclass"); all prisoners at EMCF housed in Units 5 and 6 at EMCF ("the Units 5 and 6 subclass"); and all prisoners at EMCF subjected to Defendants' policies and practices of confining prisoners in conditions amounting to solitary confinement at EMCF ("the Isolation Subclass"). Plaintiffs seek no individual relief for themselves or any other prisoners: they request only injunctive relief to abate systemic deficiencies in Defendants' policies and practices that subject all members of the class and subclasses they seek to represent to unreasonable risks of serious harm.

Federal Rule of Civil Procedure 23 sets forth the prerequisites for maintaining a class action and defines the types of actions that may be maintained by a class. Pursuant to Rule 23(a), one or more members of a class may sue as representative parties on behalf of all members if (1) the class is so numerous that joinder of all members is impractical; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are

typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class. Plaintiffs have met each of these requirements. As for Rule 23(b), Plaintiffs have shown that "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declarative relief is appropriate respecting the class as a whole," thus satisfying Rule 23(b)(2).

Plaintiffs' claims fall squarely within the long line of institutional reform cases which the federal courts have found amenable to class treatment. Accordingly the Court should grant Plaintiffs' Motion for Class Certification and certify the requested class and subclasses.

STATEMENT OF FACTS

Approximately twelve hundred prisoners are confined at EMCF,[1] all of whom are in the custody of Mississippi Department of Corrections ("MDOC"). MDOC treats EMCF as its "special needs" facility, and the vast majority of the prisoners at EMCF – at least 844 of the 1200 – suffer from serious mental illness.[2]

The prison consists primarily of six housing units, each divided into four zones, also known as pods. On most units there are approximately 60 single-man cells in each zone. Units 1 through 4 house general population inmates, with Unit 2A housing a "therapeutic community" and Unit 3 designated a Mental Health Unit.[3] Unit 5 houses inmates in long-term segregation. Unit 6D houses inmates in short-term segregation. Inmates in these units are confined in

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[1] Ex. 1, Mississippi Department of Corrections, Daily Inmate Population, http://www.mdoc.state.ms.us/Research%20and%20Statistics/DailyInmatePopn/2014DIP/2014-09%20Daily%20Inmate%20Population.pdf (last accessed Sept. 12, 2014).

[2] Ex. 2, Patients on Psych Meds. Because it is possible that not all Mental Health Subclass members are prescribed psychotropic medication, the actual size of the subclass may be larger than 844. Ex. 4, Expert Report of Dr. Terry Kupers, MD, MS ("Kupers Rep.") at 31.

[3] Ex. 3, Excerpts from Defendants' Expert Report of Kenneth McGinnis and Tom Roth ("McGinnis/Roth Rep.") at 7.

isolation almost round the clock. Units 6A, B, and C are purportedly for housing of general population inmates, but in fact these pods function very much like segregation.[4]

Since July 2012, MDOC has contracted with Management and Training Corporation ("MTC"), a private, for-profit vendor, to act as its agent at EMCF and manage all institutional operations there.[5] MDOC has a separate contract with another private vendor, Health Assurance, LLC ("HALLC"), to provide health care to prisoners at EMCF.[6] Prisoners are in the custody of the state of Mississippi, however, and MDOC is at all times responsible for ensuring that its agents MTC and HALLC provides the prisoners with constitutionally-mandated treatment and care. *See West v. Atkins,* 487 U.S. 42, 56 (1988); *Ancata v. Prison Health Servs., Inc*., 769 F.2d 700, 704-05 (11th Cir. 1985) (explaining that "there can be no serious dispute" that if the actions of a private contractor hired by the state to provide health services in the jail resulted in the deprivation of the detainee's constitutional rights, the state would be liable).

I. SYSTEMIC DEFICIENCIES IN DEFENDANTS' SECURITY POLICIES AND PRACTICES SUBJECT ALL EMCF PRISONERS TO UNREASONABLE RISKS OF SERIOUS HARM FROM INMATE-ON-INMATE VIOLENCE AND EXCESSIVE FORCE.

EMCF is an extraordinarily dangerous prison. Ex. 6, Expert Report of Eldon Vail ("Vail Report") at 6.[7] It is awash in contraband and weapons. *Id.* at 7; Ex. 7, Excerpts from the

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4 Ex. 6, Expert Report of Eldon Vail at 7-8.

5 Ex. 3, McGinnis/Roth Rep. at 5. Prior to July 19, 2012, MDOC contracted with another private prison operator, The GEO Group ("GEO"), to provide all services at EMCF. *Id.*

6 Ex. 5, Expert Report of Dr. Marc Stern, MD, MPH at 5.

7 Eldon Vail has nearly thirty-five years' experience as a corrections administrator. He served as the Deputy Secretary and then as Secretary of the Washington State Department of Corrections ("WSDC"). Earlier he held various line and supervisory level positions at a number of WSDC prisons including the position of Superintendent. Ex. 6, Vail Rep. at 1. His experience as a prisons and corrections administrator included responsibility for the mentally ill population and their custody, housing and treatment. *Id.* He has served as an expert witness and correctional consultant for cases and issues in ten different states. *Id.* at 4.

Deposition of Matthew Naidow ("Naidow Dep.") at 104.[8] Inmate-on-inmate violence is commonplace and the level of violence is extreme, including stabbings, beatings, and sexual assaults. Ex. 7, Naidow Dep. at 160, 169. The security staff is fearful of working at the prison, particularly in the high security units, due to the dangerous conditions in those units. *Id.* at 27, 28. The entire inmate population at EMCF – as well as the staff who work there – are constantly at significant risk of serious harm due to multiple gross defects in basic security measures, both in the physical facility and in the training and supervision of security staff. Ex. 6, Vail Rep. at 7.

These extreme risks are long-standing and well known to prison administrators who have failed to take reasonable measures to address them. For example, the September 23, 2013 minutes of an EMCF staff meeting regarding conditions on Housing Unit 2, which includes what is characterized as the "therapeutic community" at EMCF,[9] contain the following notes:

> 3. The Unit is NOT secure.
>
> . . . .
>
> 5. C/Os [Custody Officers] are bringing in cell phones and drugs (2nd shift).
>
> . . . .
>
> 7. Inmates are being beaten, extorted, and are being forced to pay for security.
>
> . . . .
>
> 10. They [inmates] also claim the UM [Unit Manager] talks to more "affiliated" IMs [inmates] than any others . . . .
>
> 11. **All** Hall and POD workers for HU [Housing Unit] 2 are Gangsters with the exception of IM [inmate] Gates who is a Vice Lord.
>
> 12. Wardens and Investigators are NOT making rounds on Unit 2; are not communicating with staff.

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[8] Captain Matthew Naidow is a captain of security at EMCF. He has been employed at EMCF, first by GEO and then by MTC, since November 2011. Ex. 7, Naidow Dep. at 7-9.

[9] See Ex. 4, Kupers Rep. at 35.

Ex. 8, Administrative Meeting Minutes of EMCF Staff, September 23, 2013 (emphasis in original).

A. Systemic Staff Shortages and Failure to Hire and Train Qualified Security Staff Increases the Risk of Violence.

The dangerous conditions and pervasive violence at EMCF are due in significant part to Defendants' systemic failure to hire qualified security staff and to adequately train them. According to a senior correctional officer – an MTC employee and captain of security at EMCF, with years of correctional experience in another state – security officers at EMCF are poorly paid, poorly qualified, and poorly trained. They are not properly trained to deal with inmate-on-inmate violence. Ex. 7, Naidow Dep. at 29-32, 181-184. Even more notable in a prison that houses over 1,000 seriously mentally ill prisoners,[10] security staff are not properly trained to deal with inmates suffering from mental illness. *See id.* at 67; Ex. 6, Vail Rep. at 33-37 (recounting uses of force against mentally ill prisoners).

This is not the first time staff have expressed such concerns about the competence of other staff. In fact, in an email from September 2012, a former correctional officer wrote the following to EMCF administrators: "Staff is grossly undertrained and not capable of doing a sufficient job . . . . [The facility's segregation units] are ridiculously out of control [and] in dire need of well-trained assistance" . . ." Ex. 9, AG_014101, Email from Tony Compton to Emmitt Sparkman, Sept. 13, 2012. *See also* Ex. 10, AG_013620, Email from Emmitt Sparkman to Michael White and Tony Compton, Jan. 24, 2013 (detailing various problems among the author's fellow correctional officers including widespread staff intercourse with staff and other inmates, details about a "buddy" system in which officers cover the beatings of inmates by other officers, the corruption of investigators, and the rehiring of former employees fired for excessive

[10] *See infra* Section III.

use of force). Defendants' systemic failure to properly train and supervise security staff at EMCF results in a profound level of incompetence and ongoing risk of serious harm to prisoners. Ex. 6, Vail Rep. at 47, 51.

The poor quality of the security staff at EMCF is attributable in part to difficulty in recruiting due to very low wages and the practice of rehiring staff who were previously fired. Ex. 7, Naidow Dep. at 185-188. A previous firing for wrongful use of force is not treated as disqualifying an individual to be re-hired at EMCF. *Id.* at 189; *see also* Ex. 10, AG_013620, Email from Emmitt Sparkman to Michael White and Tony Compton, Jan. 24, 2013.

Staffing shortages also contribute to the violence at EMCF. Absenteeism is a problem, requiring staff to work double shifts which negatively affects their performance on the job. Ex. 7, Naidow Dep. at 119-122. Security posts are frequently not covered. Ex. 11, MTC_ESI_0000173, Email from Christopher Epps to Odie Washington, RS Marquardt, and Harold Pizzetta, June 16, 2014 (email from Defendant Epps to MTC asking if they agreed with facility staff's findings that "cell inspections are not being completed" and asking when MTC would "comply with MDOC policy and procedures"); Ex. 12, MTC_ESI_000014, Email from Archie Longley to Jerry Buscher, Apr. 17, 2014 (email noting that on April 16, 2014, a prisoner was found to have accessed the ceiling area of his pod, to which one of the facility's administrators responded: "I find it hard to believe that no staff saw anything. The Control Pod Officer should have seen or heard something as well as the officers making counts."). In some instances, facility administrators are unaware of basic staffing requirements. Ex. 13, AG_008977, Email from Tyeasa Evans to Tony Compton, Aug. 1, 2012 (stating that she "saw no staff was present on 6D and informed [the Warden] that staff must man that post at all times. [The Warden] stated he was not aware of that and asked was it in the policy."); Ex. 14,

AG_010058, Email from Tyeasa Evans to Federico Ovalle, Aug. 16, 2012 ("I asked Sgt. Minchew who was assigned to 6D and he stated no one. I informed him and other staff that 6D is supposed to be a post occupied at all times. Staff then began to say they were not working 6D."). Staff have been absent during facility emergencies, including instances in which prisoners have escaped from their cells or had medical emergencies. Ex. 7, Naidow Dep. at 87-89, 110-113.

B. Widespread Security Staff Corruption at EMCF Contributes to Systemic Violence.

Staff corruption is widespread at EMCF. Staff are involved with gangs, extortion, and dealing in contraband. Ex. 7, Naidow Dep. at 37, 39. Staff frequently smuggle in drugs and weapons in return for payment from prisoners. Ex. 15, AG_013525, Email from Federico Ovalle to Tyeasa Evans and Jerry Buscher, Sept. 3, 2013 (email explaining that officers and inmates are often familiar with each other from having grown up in the area and officers "bring their [former] classmates everything from tobacco to crystal meth"); Ex. 16, MTC_ESI_0000255, Memorandum from Mike Rice to Jerry Buscher, Aug. 20, 2013 ("Officer Smith had been receiving $200 for each package that he brings inside the facility however he was to receive $500 for this particular package. He was receiving money from the unknown inmate[.]"); Ex. 17, AG_013795, Email from Archie Longley to Tony Compton, July 31, 2013 (stating that the facility had been contacted by a Mississippi Drug Task Force Agent regarding an EMCF officer who had in his possession approximately ten ounces of marijuana, 12 hack saw blades, and one iPhone 3 charger).

Security staff sometimes facilitate assaults by helping inmates to open their own cell doors and other prisoners' cell doors and by allowing inmates into other units to extort or injure other inmates. Ex. 7, Naidow Dep. at 92-93, 100-101. Security officers have stood by passively,

allowing inmate-on-inmate beatings, and have purposefully escorted handcuffed inmates to unsecure areas of the facility so that members of rival gangs may attack the handcuffed inmates. *Id.* at 173-175, 177; Ex. 18, MTC_ESI_0000268, Email from Tyeasa Evans to Jerry Buscher, June 12, 2014 ("Offender Powe #135675 stated that offenders tried to get him while he was being escorted to the case managers office. He and staff stated the wrong door was called and offenders came out at him."). For example, staff collusion and extortion were involved in the savage gang attack on Plaintiff Philip Fredenburg. On September 5, 2012, staff escorted Mr. Fredenburg from the showers and locked him in his cell. Shortly thereafter, the officers escorted into his cell another prisoner who disabled the locking mechanism in Mr. Fredenburg's cell. Six other prisoners on the zone also disabled their locks. The officers exited the zone for the day, leaving it unattended. The prisoner whom staff escorted into Mr. Fredenburg's cell took Mr. Fredenburg to another cell where four prisoners viciously beat him and stomped on his face. An officer remained in the control tower throughout the assault, with full access to the security cameras monitoring the zone and an electronic system that indicates when cell doors are open. Security camera footage documented much of the incident. Ex. 7, Naidow Dep. at 220-232.

Staff corruption also contributes to EMCF's serious problem with weapons. Ex. 6, Vail Rep. at 22. Staff reports over two months document the extent of the problem. In July 2013, 17 weapons were found in the prison, 9 of them in Units 5 and 6, and five more in areas in close proximity. Ex. 6, Vail Rep. at 22. According to the contraband report from August 2013, "62 weapons were found in the prison, 20 of them in Units 5 and 6." *Id*. In a standard prison, however, "it is very rare for a blade to make it into a segregation unit, and *never* the numbers and types of blades . . . observed in the records of EMCF[.]" *Id*. (emphasis added).

C. Structural Defects in Cell-Door Locking Mechanism throughout EMCF and Systemic Failure to Conduct Basic Security Measures Contribute to the Risk of Serious Harm from Inmate-on-Inmate Violence.

Although "it is a basic and fundamental necessity for prisoners, staff, and the community to know that a prison can actually keep prisoners locked in their cells," this is not the case at EMCF. Ex. 6, Vail Rep. at 17. Individual cell doors in segregation units are not secure and inmates can successfully block the doors' closure. *Id*. at 16. A video from December 2013 illustrates the pervasiveness of this problem:

> [A]n inmate was escorted back to his unit following a trip to medical after a use of force event. The officers placed him in a cell that the inmate tells them has a broken door. The officers place the prisoner, still in restraints, in the cell, and he immediately opens the cell door. They put him in a second cell and its door has the same problem. They attempt to place him in a third cell and the tape ends with the comment that there is a problem with that cell door as well. This sequence would almost be comical were it not for the serious risk of harm unsecure cell doors present[.]

Id. at 18. Prisoners can open their cell doors and extort others at knifepoint, or assault the occupants of cells in other units. Ex. 7, Naidow Dep. at 97, 100-101; Ex. 19, MTC_ESI_0000010, Email from Archie Longley to Tyeasa Evans, Oct. 14, 2013 ("Inmate Darnell Wilson #159643 states that his room door was not locked during lockdown hours and an offender entered his cell and made advances towards him."); *see also* Ex. 20, MTC_ESI_0000353, Email from Tony Compton to Jerry Buscher, May 4, 2014 (questioning "How are these inmates working on units they do not live on" in response to a report that an inmate brought contraband from Unit 5, where he works, to Unit 4A, where he is housed). Staff are not regularly present on the zones, leaving gangs free to attack prisoners. Ex. 6, Vail Rep. at 17.

The risk of harm is compounded by the failure of EMCF staff to adhere to basic principles of prison security. Many of the cells in segregation units have "paper or cloth

covering their windows, making it impossible for staff to see into their cells[.] . . . You cannot check on the welfare of an inmate in a cell if you cannot see into it." Ex. 6, Vail Rep. at 20, 21. Fishing, a practice in which prisoners use strips of sheet as rope to pass contraband from cell to cell, is regularly tolerated. *Id.* at 21. In his inspection of the segregation units at EMCF, Mr. Vail saw "fish lines lay openly on the tiers without any reaction by staff; I even saw fishing occur while we were in the unit." *Id.* Mr. Vail noted that "in every other jurisdiction I have ever been in . . . [the fishing lines] would be confiscated." *Id.* at 22.

Defendants are well aware of these problems. *See* Ex. 21, MTC_ESI_0000656, Email from Warden Frank Shaw to Tyeasa Evans, Apr. 4, 2013 ("Fishing lines were out on B&C pod[.] [S]taff walked by them and left them hanging[.]"); Ex. 22, MTC_ESI_0000397, Email from Warden Frank Shaw to Tony Compton, Oct. 7, 2012 (noting among several issues "Numerous fishing lines in Housing Unit 5"). In an letter from May 2014, one of the facility's administrators recounted a conversation with one of the prison's deputy wardens: "Hogans said that offenders continuously manipulate [their] cells doors on Unit 6 and come out. Hogans stated that he has come to the facility to lock down the offenders and by the time he gets home they are back out." Ex. 23, MTC_ESI_0000076, Memorandum from Tyeasa Evans to Tony Compton, May 2, 2014.

Officers and administrators at the facility informed Mr. Vail that the problem with cell doors at EMCF is "constant" and MDOC has been cited by federal agencies as a result. Ex. 6, Vail Rep. at 17. In June 2012, the Occupational Health and Safety Administration ("OSHA") specifically identified certain systemic, life-threatening security issues at EMCF, including non-locking cell doors and the failure to enforce rules against obstructing the view into cells.[11]

[11] Although the investigation was initiated on behalf of employees at EMCF, the dangers identified in OSHA's report are equally hazardous to the prisoners confined there.

OSHA directed Defendants to "Repair or replace defective cell door lock systems throughout the facility," to "Assure continued maintenance of all door lock systems throughout the facility," and to "Institute a policy prohibiting inmates from placing items on cell doors that obstruct corrections officers' view into cells." Ex. 6, Vail Rep. at 24, citing Ex. 24, U.S. Department of Labor, OSHA, Citation and Notice of Penalty, June 11, 2012. It is a basic and fundamental necessity for a prion to be able to keep its prisoners locked in their cells. Ex. 6, Vail Rep. at 17.

Corrections administrators should treat such problems as life-threatening emergencies, yet, more than two years after OSHA's findings, these problems are still ongoing. Ex. 6, Vail Rep. at 16-18, 24. Recent emails from EMCF's warden confirm the ongoing nature of these problems. *See* Ex. 25, MTC_ESI_000764, Email from Jerry Buscher to Archie Longley, Tyeasa Evans, and Tony Compton, June 17, 2014 (noting that offenders access their doors on Unit 5D by placing bottle caps or objects in the doors and that doors are unsecured in Units 1, 2, and 3); Ex. 26, MTC_ESI_0000762, Email from Jerry Buscher to Tony Compton, June 19, 2014 (recounting the findings of the facility's compliance monitor that doors were seen unsecured on Units 1, 2, and 3 and that offenders have the ability to access their cell doors); Ex. 27, MTC_ESI_0000285, Email from Tyeasa Evans to Norris Hogans, June 23, 2014 (email from facility monitor to facility administrators noting that doors were unsecured in Units 1, 2, 3, 4, 6, and 7).

Another serious security problem is the failure of correctional staff at EMCF to regularly check on inmates in segregation. MDOC policy requires that staff conduct a security inspection of each offender in each segregation cell every 30 minutes and document such inspections in log books. Ex. 28, MDOC 19-01-01, Offender Segregation Policy, at 19. Staff at EMCF do not comply with this policy. Ex. 6, Vail Rep. at 19. Furthermore, security staff sometimes falsely

document that they have made the required rounds in the segregation units without having done so. Ex. 7, Naidow Dep. at 86-87. Sometimes the breakdown in conducting the rounds is due to lack of staff: in a log book from Unit 6, an officer notes "there was no count/security checks on HU6. Due to lack of staff." Ex. 29, MTC_ESI_0055395, MTC Log Book. The failure of staff to conduct the required segregation checks is particular dangerous because of the insecurity of cell doors, which can and does result in inmate escapes and assaults. Ex. 7, Naidow Dep. at 97-104. Compounding the risk of assault even further, many of the emergency call buttons in the cells, which prisoners could use to seek assistance from staff, do not work. Ex. 5, Expert Report of Dr. Marc Stern, MD, MPH ("Stern Report") at 6;[12] Ex. 30, Expert Report of Madeleine LaMarre, MN, FNP-BC ("LaMarre Report") at 9;[13] Ex. 4, Kupers Rep. at 20-21;[14] Ex. 6, Vail Rep. at 20.

[12] Dr. Stern served as the medical director of the Washington Department of Corrections in addition to having held leadership positions in both privatized and state-run prison health care systems. He has served as a consultant to the Department of Homeland Security and the Department of Justice in addition to being appointed as a neutral monitor by federal courts. *See* Ex. 5, Stern Rep. at 93.

[13] Madeleine LaMarre, MN, FNP-BC, is a veteran clinician with 22 years of experience including as an administrator at the Georgia Department of Corrections. She has served as a federal court-appointed monitor in some of the largest correctional actions in United States history. *See* Ex. 30, LaMarre Rep. at 43.

[14] Dr. Terry Kupers is a medical doctor and a Diplomate of the American Board of Psychiatry & Neurology (Psychiatry, 1974, for life). He has testified as an expert in over thirty criminal and civil proceedings regarding jail and prison conditions, and on the quality of mental health services, and the effect of solitary confinement. He has extensive experience monitoring the treatment of mentally ill prisoners in Mississippi. He has published extensively on the subject of mental illness in correctional settings, including, in collaboration with MDOC's Deputy Commissioner, *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, Criminal Justice and Behavior (2009). Ex. 4, Kupers Rep. at 3-8, 56.

D. Systemic Failures in Policy and Practice Regarding Basic Security Measures Facilitate a Culture of Excessive Force by Security Staff and Create Risk of Serious Harm to All Prisoners.

Defendants' defective policies and procedures subject all prisoners at EMCF not only to excessive risk of harm inmate-on-inmate violence, but also to substantial risk of serious harm – including death – from the unnecessary, dangerous and excessive use of force by security officers. Ex. 6, Vail Rep. at 41, 51.

1. Staff Engages in Abusive Use of Pepper Spray.

There is widespread abuse of pepper spray by security staff. Ex. 6, Vail Rep. at 41-43. Pepper spray is dangerous and painful: it burns the skin, can cause temporary blindness, and restricts the airways and makes it difficult to breathe. For this reason, it is critical to decontaminate a prisoner who has been pepper sprayed, as well as his cell and the surrounding area, as quickly as possible once staff gains control of a situation and the inmate is in restraints. *Id.* at 42. The inmate must have prompt access to a shower with cool water and his cell must be decontaminated before he is returned to it. Failure to do so inflicts unnecessary and gratuitous pain. *Id.*

At EMCF, decontamination after use of pepper spray is permitted, if at all, only after a lengthy wait, causing inmates to suffer unnecessary pain and injury. Ex. 6, Vail Rep. at 45. EMCF training materials provide that once a prisoner is exposed to chemical agents, staff should flush his face with cool water, and thoroughly wash down the area with soapy water. Ex. 31, DEF-00111, Chemical Agents and Decontamination PowerPoint Slides at DEF-00112 – DEF-00113. Staff seldom adhere to these requirements, however; inmates are almost always simply placed back into their contaminated cells to suffer the effects of the spray. Ex. 6, Vail Rep. at 45.

In a use of force that was captured on video, an inmate who is said to have asthma, was sprayed with chemicals and then left in his contaminated cell with the tray-slot closed for a

minimum of fifteen minutes, and possibly much longer, with the dangerous effects obvious from the blood he coughs up and his extreme distress:

> You can see inmate two through cell window coughing and leaning against the cell wall. Restraints are applied and the cell door is opened. Inside, you can see blood on the wall of his cell. The inmate is visibly gasping for air. He walks across the pod under escort, and then collapses on the day room floor. He is wheezing uncontrollably. His white t-shirt is stained with multiple blood splatters and he coughs up a large amount of blood on the floor. The officers pick him up and get him through the door to the exercise area, and he collapses again. The tape then abruptly ends.

Ex. 6, Vail Rep. at 50.

A video from March 2014 shows a prisoner left in his cell for over twelve minutes after he was sprayed with pepper spray. Ex. 6, Vail Rep. at 37. "The force used by letting the inmate sit with the pepper spray was not only unnecessary, but also was excessive, if not abusive." *Id.* In some cases, staff actively try to increase prisoner suffering. A video from November 2013 shows a recently sprayed prisoner begging for a shower, while screaming that he cannot breathe. A woman from medical responds that she "doesn't think he deserves it right now." *Id*. at 45.[15]

2. The Policies, Practice, Training and Supervision on Use of Force Are Defective.

Security staff are not properly trained to respond to inmates who resist staff direction. Ex. 6, Vail Rep. at 45-47. Frequently, as a result, staff at EMCF immediately and unnecessarily respond to these behaviors with force that results in unnecessary harm. *Id*. Staff members' abusive and unnecessary uses of force are the result not only of improper training and supervision, but also of the inadequacy of MDOC's Use of Force Policy, which does not include

[15] The failure of staff to respond appropriately to a prisoner against whom force has been used is not limited to merely prisoners sprayed with chemicals, but includes other uses of force as well. Ex. 32, AG_013645, Email from Tyeasa Evans to Frank Shaw and Federico Ovalle, Sept. 20, 2012 (stating that the facility's contract monitor observed an inmate in medical "with numerous wounds to the body, boot prints on his back, and old wounds from a weapon" who "allege[d] that force has been used on him for 3 days but this was his first trip to medical").

any clear instruction on how a planned use of force should proceed. *Id.* at 32; Ex. 33, DEF-00010, MDOC 16-13-01, Use of Force Policy ("MDOC Use of Force Policy"), at DEF00015. Nor do MDOC policies contain sufficient guidance on what circumstances justify spontaneous uses of force. Ex. 6, Vail Rep. at 35; *see generally* Ex. 33, MDOC Use of Force Policy. There is a dangerous practice of using spontaneous force simply because an inmate has refused an order, and not because the inmate's behavior presents any imminent threat of harm. This practice stems in part from the inadequate policy, which fails to specify that the level of threat presented must justify the immediate use of force, essentially leaving it to the discretion of officers to use force whenever an inmate refuses or fails to follow any order, no matter how trivial. Ex. 6, Vail Rep. at 35; Ex. 7, Naidow Dep. at 154.

Many of the prisoners against whom force is employed suffer from mental illness; often they cannot understand or immediately conform their conduct in response to an officer's order. As a result, security officers who are assigned to work with the mentally ill need intensive and specialized training. Ex. 6, Vail Rep. at 54. Security staff at EMCF, however, are not adequately trained to manage prisoners with mental illness. Ex. 7, Naidow Dep. at 67.

MDOC policy provides that "mental health staff and security staff shall be utilized to employ verbal intervention strategies to gain voluntary compliance from the disruptive offender." Ex. 33, MDOC Use of Force Policy at DEF-00015. Requiring efforts to secure prisoners' voluntary compliance by engaging with them and attempting to understand their concerns serves the important purpose of avoiding unnecessary force, particularly with prisoners who suffer from mental illness. Ex. 6, Vail Rep. at 33-34; Ex. 7, Naidow Dep. at 81. EMCF staff demonstrate a lack of awareness of the purpose of these interventions. Security staff do not allow enough time for a meaningful conversation to occur between the prisoner and mental

health staff before administering chemical agents. The "interventions" staff employ are empty formalities; in many cases, prisoners are subjected to pepper spray or other use of force within five or ten seconds of mental health staff addressing a prisoner, or are sprayed while actively engaged in discussions with mental health staff. Ex. 6, Vail Rep. at 35-37. Security videotapes prove that these dangerous and abusive practices are commonplace at EMCF, yet facility administration hardly acknowledges them in their written reports on use of force events. *Id.* at 41.

Making matters worse is that prisoners have no legitimate means to seek redress for such abuses. Critical to the operation of any prison is an internal grievance system. If prisoners do not believe the grievance system is effective, they will find other ways to express their frustration, often by acting out. Ex. 6, Vail Rep. at 26. But prisoners at EMCF cannot rely on the grievance system to obtain assistance: staff responses at EMCF to prisoners' non-frivolous grievances range from incoherent to openly hostile. *Id.* at 25-26. For example, one prisoner complained in January 2013 that he was not receiving recreation five days a week as MDOC policy requires. *Id*. at 27. He received the following response: "Although you may not receive recreation yard daily due to limited rec space available, you are afforded to shower . . . at least three (3) time per week. Therefore . . . your request is granted." Ex. 34, MTC_ESI_0004222, Inmate Receipt, MDOC Administrative Remedy Program, Apr. 11, 2013. The response is nonsensical: the inmate was not granted relief; he was told that staff was not going to follow MDOC policy. Ex. 6, Vail Rep. at 27. Another prisoner, requesting a copy of the minutes from his treatment team meeting held in February 2014, was told: "You will not be provided a copy of anything. We are following policies and procedures. If you weren't so scary, we would release you to another unit." *Id*. at 25-26.

As a result, prisoners in the segregation units conclude that they have no meaningful avenue to seek urgent medical care or attention to other basic human needs other than to act out by setting fires, flooding their cells, cutting themselves, or refusing to remove their arms from the food slots in their cells doors. Ex. 6, Vail Rep. at 6. The result is an overwhelming number of unnecessary and dangerous uses of force and abusive practices, putting prisoners at significant risk of harm. *Id*. In almost every case, no matter how trivial the rule violation, prisoners are subjected to pepper spray, in most cases unnecessarily. *See id*. at 30, 33-35. Mr. Vail recounts an incident from January 2013 which was captured on video:

> The prisoner is refusing to allow the tray slot on his cell door to be closed. . . . You can . . . see the scorched cell doors from previous fires in the unit . . . . As the officers get close to the cell door[,] you can clearly hear the inmate say he is not going to allow the tray slot to be closed until he gets access to sick call and the medications that he needs. His request is refused . . . [T]he inmate explains that he also needs a haircut and would like to take a shower. In the middle of the dialogue, the officer surprises the inmate and sprays him directly in the face . . . . [I]t was not made clear to him that the conversation was over and the use of force would immediately proceed. . . He appeared to be in great distress and kneeled on the ground, spitting from the impacts of the spray. As he regained his composure, he asked to be taken to the medical. The nurse present denied his request.

Id. at 30-31. Some prisoners are subjected to ever more severe forms of force:

> In a use of force video from January 2014, the prisoner is sprayed through his tray slot with no warning. Officers then attempt to force the tray slot closed while the inmate's fingers are in the hinge area between the tray and the cell door. As they do so, the inmate screams in pain. They do it a second time and the inmate screams in pain again; staff spray him again. *It is hard to see this event as anything other than physical torture.*

Id. at 38 (emphasis added). Again, the failure to respond appropriately is not simply the result of a staff member's poor choice, whether due to poor training or otherwise; rather, it is a product of

the failure of MDOC's Use of Force Policy to clearly explain how staff should conduct a planned use of force. *Id*. at 32.

The risk of prisoner abuse is increased by deficiencies in the policy and practice regarding video recording of planned use of force at EMCF. Ex. 6, Vail Rep. at 49. To provide protection to inmates as well as staff, a video record of a planned uses of force must capture the entire incident, from the beginning, when the team identifies itself to the inmate, to the final return of the inmate to his cell. *Id.* at 36, 49. At EMCF, however, it is common, as in the example provided above, for staff not to record the beginning or end of an incident of planned use of force, thus thwarting effective review of such events and opening the door to repeated unnecessary and inappropriate uses of force. *Id.* at 36, 47-51.

The risk of abusive and excessive force is also increased by systemic deficiencies in the supervision and monitoring of security staff. There is essentially no effective internal monitoring of correctional staff at EMCF in the performance of their duties, and no effective external monitoring by MDOC. Ex. 6, Vail Rep. at 51-52. For example, in a video from January 2013, staff laugh as an apparently mentally ill inmate quivers uncontrollably after being given a medical shot and screams as the nurse administers medication a second time. *Id*. at 52-53. The staff's conduct should have been the subject of serious investigation and analysis by MDOC, as it was captured on video, yet there is no written record documenting any concern by MDOC administration about the behavior of staff. *Id.* at 52-53. The misconduct and profound incompetence of the custody staff at EMCF and the lack of sufficient supervisory review place the inmates as well as staff at risk of serious and significant injury. *Id.* at 51.

II. THE DYSFUNCTIONAL MEDICAL CARE SYSTEM AT EMCF ENDANGERS THE ENTIRE CLASS.

MDOC fails to provide for the medical needs of the prisoners housed at EMCF. "The system of delivering medical care at EMCF is broken, and at every level staff are unable or unwilling to fix it." Ex. 5, Stern Rep. at 3. The deficiencies in health-care delivery at EMCF "are systemic; they permeate the health care operation" and create "equal opportunity dangers" that "can affect any inmate at any time without regard to age, race, crime, housing unit, or medical condition." *Id.* at 89.

Risks are pervasive, and so is harm. Examples include:

- A 25-year-old patient with metastatic testicular cancer who did not have timely access to a urologist following an abnormal ultrasound that show testicular mass.
- A 31-year-old patient with a brain tumor who has not received timely CT scan and referral to a neurosurgeon.
- A 64-year-old patient with undiagnosed and untreated diabetes who reports losing his vision and has not received an ophthalmological evaluation and referral to a retinal specialist.
- A 28-year-old patient with bilateral glaucoma who was blind in his left eye, and lost vision in his right eye because he did not receive his glaucoma medications.
- A 40-year-old asthma patient sent to the emergency room and/or hospitalized seven times in three months partly due to not receiving his medication.
- A 33-year-old asthma patient hospitalized three times from January to June 2013. The patient also has left eye blindness and blurriness and pain in his right eye and has not received an ophthalmological evaluation.
- A 36-year-old patient diagnosed with early glaucoma in May 2012 who had not received glaucoma medications and as of April 2014 has had no further follow-up.
- A 53-year-old poorly-controlled diabetic with diabetic retinopathy and glaucoma who has not received ophthalmological follow-up or glaucoma medications.
- A 55-year-old patient with a subdural hematoma following correctional officer use of force who did not received a recommended MRI and neurology follow-up.

- A 70 year-old patient with prostate cancer who did not receive urology follow-up and for whom EMCF providers are unaware of August 2013 bone scan and oncology radiation recommendations.

Ex. 30, LaMarre Rep. at 6.[16]

A constitutionally adequate health care system must integrate multiple critical, interdependent elements. B. Jaye Anno, *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System* 149 (2001). These elements, which must work together, *see* Ex. 30, LaMarre Rep. at 6, include access to care, sound clinical judgment by appropriately credentialed staff, functional medication and pharmacy programs, meaningful medical records, care that is timely and properly delivered as ordered, competent dental and optical care, care for chronic conditions, quality improvement programs, sufficient medical equipment, proper infirmary care, and access to offsite services when indicated. *Id.* at 6, 14, 23, 38-39; Ex. 5, Stern Rep at 1, 17-18. At EMCF, each of these critical components is either lacking or deficient. As a result, MDOC cannot and does not meet the health needs of EMCF prisoners, thereby placing each and every one at constant and substantial risk of harm. Ex. 5, Stern Rep. at 1.

A. The Deficiencies in the Health Care System at EMCF Are Systemic, Pervasive, and Subject the Entire Class to Risk of Serious Injury.

The deep-seated deficiencies in the medical system at EMCF create substantial risks of serious harm to the class. These deficiencies are neither isolated nor transient; they are endemic to the system. *See* Ex. 5, Stern Rep. at 4. Failures are evident across all clinical disciplines, including physicians, nurse practitioners, nurses, and dentists. *Id*. at 10. Regardless of how Plaintiffs' medical expert, Dr. Marc Stern, selected a particular patient record to review, nearly

[16] The care reviews by Dr. Stern and Ms. LaMarre are based on the charts as they existed during their April 2014 visits to EMCF, or as of the date that they were printed for production in hard copy by Defendants.

every record contained multiple examples of dangerous and even life-threatening failings. Dr. Stern concluded with a high degree of certainty, based on his experience operating, auditing, and investigating correctional health care operations, that the problems he identified at EMCF are systemic. *Id*. at 4. Plaintiffs' nursing expert, nurse practitioner Madeleine LaMarre, similarly concluded that all patients at EMCF, "regardless of their diagnosis, acuity, or health status," are at risk due to "the deficiencies in the health care system at EMCF." Ex. 30, LaMarre Rep. at 8.

B. Defendants Deny the EMCF Class Timely Access to Medical Care.

"Access to care" means that patients can request and receive the care they need in a timely manner and is the foundation of any functioning health care system. Ex. 5, Stern Rep. at 5. EMCF's medical care system is riddled with structural impediments that delay – and often deny – necessary care, including dental care. *Id*. at 5-8, 35; Ex. 30, LaMarre Rep. at 9-13.

1. Prisoners at EMCF Are Placed in Danger by Inadequate Access to Urgent Care.

Prisoners at EMCF lack adequate access to urgent care for medical emergencies. Ex. 5, Stern Rep. at 5; *see also* Ex. 6, Vail Rep. at 20. Prisoners with urgent health needs cannot express those needs; even patients who are able to attract staff attention do not receive timely care, to the extent they receive any care at all. Ex. 5, Stern Rep. at 7. Lack of access to urgent care is especially egregious in Units 5 and 6, the segregation units, where the level of neglect is "incredible, abhorrent, and far beneath all standards of correctional care and decency." Ex. 4, Kupers Rep. at 20.

Tests of in-cell emergency buttons conducted in multiple housing units revealed several buttons to be inoperable. Ex. 5, Stern Rep. at 6; Ex. 30, LaMarre Rep. at 9; Ex. 4, Kupers Rep. at 20-21. In one case, the button was missing, leaving only a hole in the wall. Ex. 5, Stern Rep. at 6. A senior security officer reported that the emergency buzzer system was very old and

subject to malfunctioning. Ex. 30, LaMarre Rep. at 9. More than half of the call buttons tested by Dr. Kupers in a Unit 5 segregation zone did not register in the security control booth. Ex. 4, Kupers Rep. at 20-21. This failure is particularly dangerous since prisoners in Unit 5 have only minimal access to staff and little opportunity to seek help or assistance of any kind. Ex. 6, Vail Rep. at 19; Ex. 4, Kupers Rep. at 20, 23. For example, a seriously ill cardiac patient in Unit 5 – who had already suffered months of "blatant and callous lack of care" – had to set a fire in his cell in the final two days of his life in an effort to receive necessary medical attention. Ex. 5, Stern Rep. at 2, 31.

EMCF also fails to maintain adequate equipment to respond to medical emergencies. The medical emergency kit does not include oxygen, a bag mask breather, airways, or an oxygen mask; medications such as aspirin and nitroglycerin for treating heart attacks; inhalers for asthma attacks; or glucose or glucagon for low blood sugar. Ex. 5, Stern Rep. at 17-18. In medical emergencies in which seconds count, the basic failure to stock proper equipment places all patients at risk.

2. Access to Non-Emergency Care Is Impeded and Delayed.

Prisoners with non-emergency medical needs submit written requests for care known as "sick call slips." Following a triage of the requests, patients are to be seen and assessed by health care staff at sick call. Timely access to sick call is an essential element of a properly functioning correctional health care system. However, prisoners at EMCF systemically lack such fundamental access. Ex. 5, Stern Rep. at 7; Ex. 30, LaMarre Rep. at Rep. at 7. Delays in receiving necessary medical care abound. *See, e.g.,* Ex. 5, Stern Rep. at 7-8, 34-35, 37, 41, 44, 54, 55, 66, 72, 82, 83; Ex. 30, LaMarre Rep. at 10, 12, 13-14. Indeed, delays are built into the sick call system by design, since a nurse conducts sick call only twice a week in each housing unit, which falls far short of accepted national standards. Ex. 30, LaMarre Rep. at 9.

A particularly insidious form of denied access is "care by correspondence," which occurs when health care staff respond to patient health needs in writing rather than by actually seeing the patient in person and conducting an assessment. Ex. 5, Stern Rep. at 7. For example, on March 30, 2014, a diabetic patient submitted a sick call request complaining of stomach and foot pain. Foot pain is a red-flag symptom for diabetic patients, who are at high risk for foot infections and amputation. Rather than actually assessing the patient, a nurse simply wrote back "Have you hurt your foot? You are on Zantac for your stomach." *Id.* at 60; *see also id.* at 7, 64, 66, 68. This practice is dangerous and unacceptable because it means that no qualified medical provider is actually evaluating the patient's condition and symptoms. *Id.* at 7. Security staff also impose barriers to accessing necessary medical care by denying care for security-related reasons or simply because there is insufficient staff to escort patients to medical appointments. *Id.*; *see also id.* at 19 (medical record documenting "Security failed to bring [patient] to the medical room . . . Stated short on staff. This is an ongoing issue with security."); *id.* at 50-51; Ex. 35, Expert Report of Dr. Bart Abplanalp ("Abplanalp Report") at 25, 37.[17]

Patients lack timely access to urologists, ophthalmologists, and other medical specialists, Ex. 30, LaMarre Rep. at 6, 25-26, and medical staff fail to follow up on care recommendations made by such specialists. Ms. LaMarre found such problems in 11 of the 18 charts she reviewed, including a 31-year-old patient with a brain tumor who had not received timely CT scan and referral to a neurosurgeon, a 70-year-old patient with prostate cancer who did not receive a urology follow-up, and a 25-year-old patient with metastatic testicular cancer who did not have

[17] Dr. Bart Abplanalp is Chief Psychologist for the Washington State Department of Corrections and has served as Director or Operations for Mental Health at the Washington Corrections' Reception and Diagnostic Center. He has a Ph.D. in clinical psychology. Ex. 35, Abplanalp Rep. at 1-2.

timely access to a urologist following an abnormal ultrasound that showed a testicular mass. *Id.* at 6, 25-26.

3. Access to Infirmary and Observational Care Is Inadequate.

The system for providing EMCF prisoners with infirmary-level care is also broken and places the prison's sickest and most unstable patients at a significant risk of serious harm.[18] Ex. 30, LaMarre Rep. at 6; Ex. 5, Stern Rep. at 13, 14, 89. Patients suffer serious preventable harm due to inadequate policies and procedures, insufficient monitoring, and poor quality treatment by medical staff. Ex. 30, LaMarre Rep. at 33.

The medical unit cells are little more than regular prison cells and lack emergency call buttons. In one cell, the glass in the cell door was so obscured that it was difficult to see the patient inside. Even though the cells contain metal bars from which a patient can hang himself, EMCF staff routinely use the cells to house patients who are suicidal. Ex. 30, LaMarre Rep. at 34; *see also* Ex. 36, MTC_ESI_0000389, Email from Tony Compton to Tyeasa Evans and Chandra Berryman-Willis, June 24, 2014 (a prisoner "was observed while on suicide precaution with material tied around his neck"). For many patients, conditions in the medical/observation units are the functional equivalent of solitary confinement. Ex. 4, Kupers Rep. at 11. Although these cells are intended to house patients in need of more acute levels of care, patients housed in them also suffer from neglect and poor care by medical staff. Some patients worsen or even develop new medical conditions that go undetected. *See e.g.,* Ex. 30, LaMarre Rep. at 36-37; Ex. 5, Stern Rep. at 21-22, 26, 56, 85.

[18] In the prison context, infirmary-level care is generally used for patients who are too sick to live in the general population but who not require hospitalization. Ex. 5, Stern Rep. at 13.

C. The Health Care System at EMCF Fails to Provide the Class with Necessary Medical Care by Qualified Clinicians.

1. Clinicians Perform Duties that Exceed the Scope of Their Professional Licenses, Training, and Knowledge.

An adequate system of prison health care must do more than simply allow patients to see health care staff on a timely basis. The clinician who the patient sees must (1) practice within the scope of his or her professional licensure; and (2) recognize and provide the care clinically indicated. Patients at EMCF suffer because the health care system fails to ensure that clinicians perform these core functions. Ex. 5, Stern Rep. at 8-10; Ex. 30, LaMarre Rep. at 9.

At EMCF, health care staff perform functions that exceed the scope of their training, abilities, and the limits imposed on them by their state-issued professional licenses. *See, e.g.,* Ex. 5, Stern Rep. at 9, 21, 31, 35, 38, 44, 54, 64, 65-66, 69-70; Ex. 30, LaMarre Rep. at 7, 13. Mississippi law prohibits registered nurses ("RNs") from performing functions reserved for doctors, nurse practitioners, and physician assistants, such as independently prescribing medications or ordering x-rays. Ex. 5, Stern Rep. at 9 n.5 (citing Mississippi Nursing Practice Law, Section 73-15-5(2)). However, RNs at EMCF perform these duties, thus denying patients the benefit of a clinical judgment by a person trained and licensed to provide such care. Ex. 5, Stern Rep. at 9. Likewise, due to the limits of their skills, judgment, and knowledge, licensed practical nurses ("LPNs") in Mississippi are limited to collecting data to be used by higher-level clinicians. *See* Miss. Code Ann. § 73-15-5(5). LPNs should not independently assess patients, make clinical decisions, or design plans of care. Ex. 5, Stern Rep. at 9. However, "[t]he culture and practice at EMCF allow LPNs to make decisions well beyond their safe limit." *Id.* at 69.

Particularly egregious is the fact that EMCF employs an optician (a discipline that is not licensed in Mississippi and does not require any medical degree) to perform examinations and makes diagnoses that he is completely unqualified to perform. Ex. 30, LaMarre Rep. at 23; *see*

also Ex. 5, Stern Rep. at 9.[19] In one instance, the "optometry technician" wrote that a patient's eyes were normal when one eye was so clouded by a cataract that the retina could not be visualized. Ex. 30, LaMarre Rep. at 24. Patients with serious eye diseases, including those who are at risk for vision loss, do not have timely access to a medical professional qualified to treat their conditions; some patients have lost their vision. *Id.* at 23.

2. The Medical Care Provided at EMCF Is Grossly Inadequate, Incompetent, and Dangerous.

Even when patients at EMCF overcome the myriad obstacles to seeing a qualified clinician, the care provided is often dangerously substandard. Patient records abound with examples of failure by clinicians, including physicians, nurse practitioners, RNs, LPNs, and dentists, to provide care that is obviously necessary. The system is so broken that, "in some cases professionals provided such a paucity of actual hands-on care, that it was doubtful that these events should be classified as clinical encounters at all; they might more properly be classified as examples of complete lack of access to care."[20] Ex. 5, Stern Rep. at 10.

Physicians, nurse practitioners, and RNs perform evaluations that are "grossly inadequate." Ex. 30, LaMarre Rep. at 6; s*ee also id.* at 9 (assessments by nurses "were almost universally inadequate"). Patients with chronic diseases are placed at significant risk by medical staff who, time and again, fail to provide simple, adequate treatment. *See, e.g., id.* at 7, 14-25. In the case of one patient who ultimately died of his medical condition, Dr. Stern found that

[19] The optician, Titus Snell, is referred to as an "ophthalmology technician" in his contract with HALLC. Ex. 37, Ophthalmology Technician Service Agreement, Sept. 1, 2013. It does not appear that an ophthalmology technician is a certification, specialty, or discipline recognized by any board or licensing entity in Mississippi.

[20] In the case of one patient, for example, "when the patient had markedly to dangerously high blood pressure readings, practitioners did little . . . or nothing." Ex. 5, Stern Rep. at 21.

"[t]here are so many errors in his medical management that it is impossible to accurately capture the magnitude of the problem in a case summary." Ex. 5, Stern Rep. at 21.

Plaintiffs' expert reports describe so many examples of poor quality care that such care must be considered the norm.[21] It is commonplace that medical histories and physical examinations are inadequate or non-existent,[22] nurses fail to refer patients to higher-level providers when indicated,[23] and necessary follow-up does not occur.[24] Even obvious medical emergencies, such as possible intentional overdoses, are treated casually and inadequately. *See* Ex. 5, Stern Rep. at Rep. at 28-29, 37; Ex. 35, Abplanalp Rep. at 13, 45, 100-01. The care provided is not only dangerously inadequate but, at times, "callous," "unconscionable," and "shocking and cruel." Ex. 5, Stern Rep. at 22, 24; Ex. 30, LaMarre Rep. at 6-7,12.

EMCF physicians regularly choose to send unstable, acutely ill patients to the emergency room by passenger van rather than ambulance. The passenger van lacks medical equipment and the patient is not accompanied by medical personnel. There is no stretcher; the patient remains seated upright. In the first 10 months of 2013, EMCF used a passenger van rather than ambulance for 125 of the 168 patient evacuations to the emergency room, in many cases placing the inmates at medical risk. Ex. 5, Stern Rep. at 11.[25]

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[21] *See, e.g.,* Ex. 5, Stern Rep. at 19, 22-23, 24, 25-32, 33, 34, 35, 36, 37-38, 40, 41, 42, 43, 44, 45-46, 47-48, 49, 50-52, 53-54, 55, 56-58, 59-61, 63-64, 65, 66-67, 68, 69, 70, 71, 72, 74, 75-78, 79, 80-81, 82, 83-84, 85-87, 88; Ex. 30, LaMarre Rep. at 6-7, 10-14, 15-27, 29-30, 34-37.

[22] *See, e.g.,* Ex. 5, Stern Rep. at 25, 31, 34, 35, 36, 37-38, 42, 44, 48, 51, 53, 54, 59, 60, 63, 66-67, 72, 80, 83; Ex. 30, LaMarre Rep. at 10-11, 15, 19, 21, 22, 25, 35.

[23] *See, e.g.,* Ex. 5, Stern Rep. at 22, 24, 25, 28, 63, 69, 70, 71, 86; Ex. 30, LaMarre Rep. at 12, 13, 16, 36.

[24] *See, e.g.,* Ex. 5, Stern Rep. at 26, 29, 30, 34, 36-37, 38, 40, 41-42, 43, 45, 47, 48, 50, 51, 57, 65, 66, 74, 76, 78, 79, 85-86; Ex. 30, LaMarre Rep. at 12, 14, 15, 17, 22, 25, 27, 36.

[25] Ambulance trips are billed to the institution; trips in the passenger van, which is owned by EMCF, are not. Ex. 5, Stern Rep. at 9.

D. A Systemic Failure to Carry out Orders for Carry Subjects the Entire Class to Frisk of Serious Injury.

1. Orders for Care Are Delayed or Ignored.

As in the community, clinicians in correctional settings write orders for care. Typical orders include instructions to start, stop or change medications; instructions for follow-up care; specialist visits; x-rays; and instructions to conduct periodic checks of vital signs. Such orders must be carried out within the time frame specified or in an otherwise clinically appropriate time frame. Ex. 5, Stern Rep. at 11. At EMCF, such orders – including orders for critically important care – "are systematically delayed for significant periods, or simply ignored altogether." *Id.*; *see also* Ex. 30, LaMarre Rep. at 10, 16-17, 19, 22, 27, 29-30. Common examples include x-rays never obtained, follow-up appointments not occurring for months or at all, and medications never reaching patients.[26] These failures to follow physician orders are truly systemic and put all patients at ECMF at risk. *See* Ex. 5, Stern Rep. at 13.

Staff at EMCF routinely fail to provide patients with the medications ordered for them. When patients receive doses of nurse-administered medications, nurses must make a notation on the patient's Medication Administration Record ("MAR") to indicate that the patient received and swallowed the medication intended for him. Ex. 5, Stern Rep. at 12; Ex. 30, LaMarre Rep. at 32. It is an axiom of health care documentation that "If it isn't documented in the medical record, it didn't happen." Ex. 5, Stern Rep. at 14. Accordingly, the lack of a nursing notation on a MAR means that the patient never received the particular dose ordered for him. Nearly every MAR reviewed by Dr. Stern demonstrated that patients failed to receive their medications as ordered, placing these patients in potentially grave danger. *Id*. at 12.

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[26] *See e.g.,* Ex. 5, Stern Rep. at 11-13, 23, 33, 36-37, 38-39, 40, 43, 44, 45, 47, 48, 49, 50, 51, 53, 54, 55, 56, 58, 59, 65, 74, 75, 79, 80, 85, 86, 87.

2. Medical Staff Engage in Unsafe Medication Administration Practices.

The ability to safely and accurately administer medications to patients is an essential nursing skill. Nurses must ensure that the correct medication is given to the correct patients at the correct dosage and by the correct means and then complete documentation as discussed above. Ex. 30, LaMarre Rep. at 32. In institutional settings, nurses must follow established procedures for medication administration that include, *inter alia*, checking the identity of the patient, observing the patient swallow the pillow, and performing an oral cavity check to ensure that the patient did, indeed, take the pill. *Id.* at 30-31; *see also* Lorry Schoenly, *Safety for the Nurse and Patient, in* Essentials of Correctional Nursing (Lorry Schoenly & Catherine M. Knox, eds.) 72-77 (2013). Nurses at EMCF fail to adhere to these procedures. Ex. 30, LaMarre Rep. at 30-31; *see also* Ex. 38, MTC_ESI_0000283, Email from Tyeasa Evans to Norris Hogans, June 23, 2014 (reporting that medications were being passed out without prisoners showing identification); Ex. 27, MTC_ESI_0000285, Email from Tyeasa Evans to Norris Hogans, June 23, 2014 (same).

E. The Dysfunctional Structurally Deficient Policies and Procedures and Medical Record System Subject the EMCF Class to Risk of Serious Harm.

1. EMCF lacks adequate policies and procedures to guide its medical care system.

A functioning correctional health care system must have a written set of policies and procedures to provide specific and standardized operational instructions to staff. B. Jaye Anno, *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System* 307 (2001); *see also* Ex. 30, LaMarre Rep. at 6. A facility's policies and procedures govern, on a systemic level, the care provided to all patients. Policies must be site-specific and reviewed at least annually. *See* National Commission on Correctional Health Care, *Standards for Health Services in Prisons* 10 (2014).

MDOC and HALLC's policies and procedures are neither current nor specific to EMCF. Ex. 30, LaMarre Rep. at 8. For example, the policy governing care for patients with chronic diseases (e.g., diabetes, hypertension) is devoid of adequate EMCF-specific guidelines and thus fails to provide sufficient guidance on how to implement the policy. Ex. 30, LaMarre Rep. at 8; Ex. 39, HALLC Chronic Care Policy. Such poor policies add to the "'perfect storm' for dangerous patient care." Ex. 5, Stern Rep. at 70. Given the serious and pervasive failures of the staff to provide timely and obviously necessary health care, the fact that EMCF lacks appropriate guidelines regarding the provision of that care has foreseeably created dangers to prisoners at EMCF.

2. EMCF's Medical Record-Keeping System Is Broken, Dysfunctional, and Endangers All Patients.

There can be no safe patient care without a complete and accurate medical record. Medical records at EMCF, however, are dangerously unreliable and place patients at risk. Ex. 5, Stern Rep. at 17; Ex. 35, Abplanalp Rep. at 21. EMCF medical records are deficient both by design and in the way that staff misuse them. Ex. 5, Stern Rep. at 15. And, because MDOC uses the same medical record system for all patients at EMCF, Ex. 30, LaMarre Rep. at 37, every member of the EMCF class is endangered by these deficiencies.

The medical records at EMCF cannot be relied upon as a true and reliable record of patient care. Ex. 5, Stern Rep. at 17. The records are markedly incomplete, with nearly all records reviewed by Plaintiffs' experts missing nearly six months of MARs that had yet to be scanned into the system as of the time of the experts' visits to the faculty. Such a failure is more than merely a clerical delay; it creates risks of harm to patients. Ex. 30, LaMarre Rep. at 28, 38.

EMCF medical staff cut and paste text into the medical record to such an extent that the record is unreliable. Ex. 5, Stern Rep. at 16; Ex. 35, Abplanalp Rep. at 22. For example, the

following note appeared *verbatim* in a patient's chart on *seven separate occasions over three years*: "Bronchitis, c/o swollen R foot; hemorrhoids, c/o dental problems on bottom L[eft] side; accucheck [blood sugar] 169 @ 3:50pm." Ex. 5, Stern Rep. at 16. If one were to take this patient's chart at face value, this would mean that on seven separate occasions, over three years, the patient complained of precisely the same symptoms and always had a blood sugar measured to be 169mg/uL at 3:50 p.m.

Health care staff record patient assessments that are of dubious accuracy and validity. Ex. 30, LaMarre Rep. at 14 (examinations of patients with chronic diseases are almost always documented as "normal"). Some records are clearly false, either through carelessness or intent. For example, a mental health counselor documented that a patient had no complaints at a time when the patients was offsite at a hospital. *Id.* at 19 n.21; *see also* Ex. 35, Abplanalp Rep. at 20 (noting medical record entries that are "grossly incomplete, unreliable, and in many cases with entries that were apparently fabricated"). In another example, a nurse documented that a patient had normal vital signs and was in no acute distress – ten hours after the patient had died of heart disease. Ex. 5, Stern Rep. at 32.

F. The Lack of Meaningful Oversight of the Medical Delivery System at EMCF Subjects the Class to Risk of Serious Injury.

The risks and deficiencies discussed above demonstrate a "profound lack of oversight and abdication of responsibility" by MDOC leadership. Ex. 5, Stern Rep. at 2-3. MDOC has known since at least 2011 that the health care system at EMCF is dangerously deficient, but has deliberately ignored opportunities to remedy the system. Madeleine LaMarre evaluated the medical care system in 2011 and submitted her findings to MDOC:

> In 2011, I prepared a report on health care at EMCF pursuant to the provisions of the settlement agreement in *Presley v. Epps*, No. 4:05-cv-00148. At that time, I found pervasive deficiencies in health care at EMCF that I would have expected MDOC to address

> the profound problems I found. Apparently the officials of the Mississippi Department of Corrections did not challenge my conclusions about health care at EMCF, as I understand that they cited it in informing the previous contractor that these deficiencies violated their contract to operate the facility.
>
> Unfortunately, as this report makes obvious, my previous review with accompanying recommendations did not lead to reform of the systemic deficiencies in medical care at EMCF.

Ex. 30, LaMarre Rep. at 7. In the years since Ms. LaMarre's 2011 assessment, the system of care has worsened and "the risk of harm to patients has increased." *Id.*

In March 2012, MDOC pointedly ignored damning findings regarding MDOC's medical vendor, HALLC, made by Judge Carlton Reeves in approving a settlement agreement in *DePriest v. Epps*, a class action alleging unconstitutional conditions of confinement at the Walnut Grove Youth Correctional Facility. Judge Reeves found that youth were "denied necessary medical care" and that MDOC was deliberately indifferent to the youth's medical and mental health needs. Ex. 40, Order Approving Settlement, *DePriest v. Epps*, No. 3:10-cv-00663 (S.D. Miss. March 26, 2012) at 3, 6. Judge Reeves specifically identified HALLC as contributing to "a picture of such horror as should be unrealized anywhere in the civilized world." *Id.* at 6. Yet only three months after the court's condemnation, MDOC awarded HALLC the contract to provide medical and mental health care at EMCF. Ex. 41, HALLC_ESI_0000676, Email from Carl Reddix to Stan Flint, June 14, 2012.

MDOC, on a systemic basis, fails to monitor or take steps to abate the myriad risks of harm posed by the medical care system at EMCF. There is "no evidence of MDOC ownership and oversight of health care provided to patients at this facility, as shown by the lack of any meaningful quality improvement or external monitoring program; if there were such oversight, these problems could not exist to this magnitude." Ex. 30, LaMarre Rep. at 7.

Another oversight failure is the quality improvement system at EMCF. Quality improvement is a component of an adequately functioning prison health care system. Ex. 30, LaMarre Rep. at 6. Health care quality improvement activities include programs such as peer review of clinical care, continuous quality improvement ("CQI"),[27] and mortality reviews. Such programs are vital as they identify and facilitate the solution of system-wide problems with care. B. Jaye Anno, *Correctional Health Care: Guidelines for the Management of an Adequate Delivery System* 327-34 (2001); Michael F. Kelley & Lannette Linthicum, *Mortality in Jails and Prisons,* Clinical Practice in Correctional Health Care 413 (1996). In her 2011 assessment of the EMCF health care system, Plaintiffs' expert, Madeleine LaMarre, warned MDOC of the lack of a meaningful quality improvement program at EMCF. Ex. 42, Madeleine LaMarre, MN, FNP-BC, East Mississippi Correctional Facility (EMCF) Report, Feb. 25, 2011, at 16. Three years later, her conclusion is essentially the same: "that for all intents and purposes there is virtually no meaningful quality improvement program at EMCF." Ex. 30, LaMarre Rep. at 38.

By contractual design, MDOC limits its measurement of health care quality to eight indicators. Ex. 5, Stern Rep. at 1; Ex. 43, HALLC Medical Services Contract, July 19, 2012, Ex. C. By entering into a contract with these limitations, MDOC has practically guaranteed that there will be no meaningful oversight of its health care vendor, since it is not possible to effectively monitor the quality of care with only eight standards. Ex. 5, Stern Rep. at 1. Further, the eight standards are poorly chosen and MDOC fails to even evaluate all eight. *Id.*

MDOC's failure to provide oversight of the health care system for which it is responsible is a cause of the system-wide problems observed. Ex. 30, LaMarre Rep. at 7. For example, in

[27] CQI is a means of identifying deficient processes and outcomes, developing solutions to address those deficiencies, and determining the degree to which those solutions were successful. *See* National Commission on Correctional Health Care, Standards for Health Services in Prisons 12-16 (2014).

the case of a patient who died in December 2013, Dr. Stern found a "tragic, callous, and outrageous neglect of basic human needs" that "went beyond any deliberate indifference I have seen in my entire career." Ex. 5, Stern Rep. at 2. In their formal review of the death, however, EMCF health care staff did not find a single problem or misstep with the care provided to the patient, and concluded that the 'treatment' appears to have been 'appropriate.'" *Id*. at 3; Ex. 44, HALLC EMCF Mortality/Death Review, December 23, 2013. The failure to acknowledge even one of the myriad obvious dangerous deficiencies in this patient's care suggests a deliberate refusal to recognize that staff repeatedly failed in their responsibility to the patient. Like each of the individual deficiencies identified by Plaintiffs' experts, the gross failure of Defendants to monitor or hold its health care vendor accountable is systemic and subjects each member of the EMCF class to substantial risks of serious harm in violation of the Eighth Amendment. Ex. 5, Stern Rep. at 3.

III. DEFENDANTS' FAILURE TO PROVIDE A FUNCTIONING MENTAL HEALTH CARE SYSTEM AT EMCF SUBJECTS ALL PRISONERS WITH SERIOUS MENTAL HEALTH NEEDS TO RISK OF SEVERE HARM.

EMCF is the primary MDOC facility for housing prisoners with serious mental illness, yet MDOC has failed to provide a functioning system for the delivery of basic mental health care for the more than 1,000 seriously mentally ill prisoners housed at EMCF. Ex. 4, Kupers Rep. at 30. The availability and quality of care fall far short of what is minimally required to meet the needs of EMCF's mentally ill population; on a systemic basis, regardless of diagnosis, acuity, or history, MDOC denies patients the care necessary to meet their mental health needs. *Id.* at 54; Ex. 35, Abplanalp Rep. at 23-24. Mental health care at EMCF is so pervasively deficient that it subjects all prisoners with serious mental health needs to significant risks, including psychiatric deterioration, worsening prognoses, permanent psychiatric damage, and extreme suffering. Ex. 4, Kupers Rep. at 3. 30.

A case in point is that of a 43-year-old male with a history of serious mental illness, suffering from severe cardiac conditions, including damaged heart tissue and congestive heart failure, asthma, high blood pressure, anemia, and schizophrenia, who recently died in an isolation cell confinement in EMCF. Ex. 5, Stern Rep. at 2. Dr. Stern describes this case (Stern Patient #1) as follows:

> The patient spent several months in the medical observation unit at EMCF and then, incredibly, he was discharged back to an isolation cell in Unit 5 – where he died, a month later. Fifteen days before his death, a Mental Health Counselor saw him and noted that he was having hallucinations and said he had "nothing to live for." The counselor observed that he "was trying to cut himself with a small dull object and he had a long rope tired around his neck" and was asking for medical and mental health assistance. The counselor's conclusion was that the patient "did not appear to be in any distress" after which the counselor simply walked away. Despite his history of severe mental illness and the fact that he was supposedly under close monitoring by the mental health team due to his very high risk of deterioration, and after this searing encounter, he was not to be seen by any mental health professional again for nine more days. This event went beyond any deliberate indifference I have seen in my entire career; it is the definition of intentional patient abandonment.

Id. at 2

A. A Pervasive Pattern of Meaningless Clinical Encounters and Dangerous Over-Reliance on Psychotropic Medications Results in Systemic Risk of Serious Harm.

The overwhelming majority of clinical mental health encounters at EMCF are essentially meaningless and of virtually no diagnostic or therapeutic value. Ex. 35, Abplanalp Rep. at 14. A patient at EMCF may be seen by a clinician several times in a single month, yet there is no evidence in the patient's medical record of any actual mental health care being provided. Merely laying eyes on a patient and exchanging a few words or cataloging a patient's complaints in a note does not constitute a clinical encounter. *Id.* Although all of the mental health treatment plans at EMCF include a rote recommendation of individual and group therapy, individual

therapy is practically non-existent and group therapy is either not offered or so rare as to be of no therapeutic value. *Id.* at 13-14.

In the absence of virtually any meaningful talk therapy, there is an over-reliance on psychiatric medications at EMCF. Ex. 35, Abplanalp Rep. at 7, 8, 14; see also Ex. 4, Kupers Rep. at 41. When psychotropic medications are given in the absence of a mental health treatment program, they merely tranquilize the patients, resulting in long-term worsening prognoses. Ex. 4, Kupers Rep. at 43. A security captain at EMCF described the scene in the housing units as reminding him of "One Flew Over the Cuckoo's Nest," with psychotic prisoners banging their heads against the wall, self-mutilators harming themselves, and prisoners who are hallucinating. Ex. 7, Naidow Dep. at 65-66.

Most mental health staff at EMCF functions as mere note-takers who may or may not record a patient's complaint but take no action to ensure that he receives necessary mental health care. Ex. 35, Abplanalp Rep. at 4. For example, a prisoner who reported hearing voices repeatedly asked to see a psychiatrist. Even though staff collected co-pays[28] from him for his sick call slips, and he was apparently referred for an appointment, he did not get to see a psychiatrist. When the prisoner continued to ask for help, the mental health staff simply offered another sick call slip. *Id.* at 4-5 (Abplanalp Patient #1). In a number of cases, mental health counselors recorded that prisoners had no mental health problems at the same time that other staff documented symptoms of severe mental illness. Ex. 4, Kupers Rep. at 25 (Kupers Patient #3), 39-40, 50 (Kupers Patient #29); Ex. 35, Abplanalp Rep. at 4 (Abplanalp Patient #1).

[28] At EMCF, inmates are charged a fee of $6.00 for communicating their needs to mental health providers. Often inmates must pay the fee for simply informing the provider that their medication is causing painful side effects. Although charging inmates a co-pay for mental health services is not unconstitutional *per se*, the practice of charging a prisoner for even submitting a sick call request with no action taken as a result creates unnecessarily barriers to access to care. Ex. 35, Abplanalp Rep. at 9.

The widespread practice by mental health staff of ignoring obvious mental and other health needs by prisoners is staggering and can have life-threatening or even fatal results, as in the case of Stern Patient #1, described above, and Abplanalp Patient #4, in which multiple mental health staff documented that the patient was threatening to swallow a battery, but took no effective action to intervene. After Patient #4 swallowed two batteries, an x-ray was sought, but not on an emergency basis. Not until the x-ray results returned and Patient #4 was experiencing physical symptoms was he sent out for treatment. Ex. 35, Abplanalp Rep. at 9. Abplanalp Patient #8, who seemed to be under the delusion that he was an animal, was given an appointment for three months in the future. After this patient told staff that he took someone else's medication, he was not taken seriously. About two weeks later, while in psychiatric observation, Patient #8 developed severe abdominal pain that was ignored by medical staff for about three weeks. When he finally received an examination by a nurse, he was found to have a red area the size of a baseball on his abdomen, the result of an infection with fever. Not only did Patient #8 not receive any significant mental health treatment while in observation, staff ignored his serious and obvious medical problems. *Id.* at 11-12. Similarly, Abplanalp Patient #9 was placed on suicide precautions because of a hunger strike. Two days later, the patient had still not received a suicide risk assessment. The patient was left in an observation cell but suicide precautions were discontinued. Approximately one week later, Patient #9 told staff that he had taken an overdose of psychotropic medications, but staff kept him in his cell. The next day, while being transported back to his housing unit, Patient #9 was disoriented and unsteady. When Patient #9 was finally sent to the hospital, he was diagnosed with neuroleptic malignant syndrome, a life-threatening illness consistent with overdosing on the psychotropic medications. *Id.* at 13.

A large number of prisoners with serious mental illness are confined in isolation, essentially without treatment. For example, Kupers Patient #2 suffers from an ongoing psychosis involving hallucinations and is housed in Unit 5 where he is confined almost 24 hours a day behind a solid metal door in a cell that lacks a working light. Other than his prescribed psychotropic medication, he is receiving no apparent mental health treatment; while the psychiatric nurse practitioner describes his various mental health crises, his mental health counselors describe him as having no problems. Ex. 4, Kupers Rep. at 26. This case is one of many examples of prisoners being abandoned in isolation cells that resemble medieval dungeons while mental health staff deny them any treatment other than medication. *See id.* at 25-29 (describing Kupers Patients #5, #7, #8, #10, #11); *see also id*. at 39-40 (Kupers Patient #29).

B. None of the Minimally-Required Components for a Functioning Mental Health Care System Are in Place at EMCF, Resulting in Significant Risk of Harm for All Inmates with Serious Mental Health Needs.

None of the minimally-required components for a functioning mental health care system are in place at EMCF. As a result, from the time of admission to the time of release, any inmate at EMCF with serious mental health needs is at significant risk of harm. Ex. 35, Abplanalp Rep. at 3. Mental health care is structurally deficient in essentially every aspect, staff performance, medical record maintenance, risk screening, crisis intervention services, in-patient care, intermediate level of care, outpatient care, and informed consent. Ex. 4, Kupers Rep. at 3; Ex. 35, Abplanalp Rep. at 11, 21. In addition, the staffing levels at EMCF are grossly inadequate, whether measured by a standard formula for staff-to-prisoner ratios or by evaluating the quality of mental health care provided. Ex. 4, Kupers Rep. at 30-31.

1. EMCF Has an Insufficient Number of Qualified Mental Health Clinicians.

There are 844 patients at EMCF who are currently prescribed psychiatric medication, yet MDOC employs only one psychiatrist who works two days a week at EMCF plus one full-time psychiatric nurse practitioner. The American Psychiatric Association recommends a ratio of one psychiatrist per 150 patients on medication; even if one were to double this recommendation, coverage at EMCF would still be seriously deficient. Ex. 4, Kupers Rep. at 31. Virtually the only modality of mental health treatment available at EMCF is psychotropic medication. With the availability of newer medications offering fewer side effects but requiring more tailoring to individual patients, *see id.* at 40-42, this lack of psychiatric coverage to ensure proper pharmacological monitoring is particularly dangerous. Even in Unit 3C, which supposedly offers the most intensive mental health services available at EMCF, there is little meaningful mental health treatment. *Id.* at 31. Mental health staff, with extremely limited exceptions, is not trained or supervised and fails to provide competent services. Ex. 35, Abplanalp Rep. at 21. Security staff lacks the enhanced qualifications and training needed to manage prisoners with mental illness. Ex. 3, Kupers Rep. at 30-32.

2. EMCF Fails to Provide the Essential Levels of Mental Health Care.

The basic levels of care for any mental health system are inpatient care, intermediate care, and outpatient care. Ex. 4, Kupers Rep. at 32; Ex. 35, Abplanalp Rep. at 10-11. Inpatient care is the equivalent of care provided by a psychiatric hospital in the community; it is care for people so psychiatrically impaired that they cannot function on their own. Ex. 4, Kupers Rep. at 32; Ex. 35, Abplanalp Rep. at 10. Intermediate care is designed for higher-functioning patients who still need greater supervision and care than they could receive in a general population housing unit. Ex. 4, Kupers Rep. at 32; Ex. 35, Abplanalp Rep. at 13. Outpatient mental health

care provides care for patients who can function well on their own but who require periodic or regular treatment that can be provided in a general population setting. Ex. 4, Kupers Rep. at 32; Ex. 35, Abplanalp Rep. at 11. At EMCF, there is no meaningful access to any of these levels of care. Ex. 4, Kupers Rep. at 32- 37; Ex. 35, Abplanalp Rep. at 11.

a) Inpatient care

There is no inpatient level of care at EMCF and no indication that psychiatric patients are ever transferred to psychiatric facilities outside of EMCF for inpatient care. Ex. 4, Kupers Rep. at 32; Ex. 35, Abplanalp Rep. at 22. An adequate inpatient unit must be able to provide intensive treatment, with several hours a day of structured programming and treatment. Mere psychiatric observation does not constitute an inpatient level of care. Ex. 4, Kupers at 33; Ex 35, Abplanalp Rep. at 10.

The most intensive mental health services are offered in Unit 3, the housing unit designated for seriously mentally ill patients, but Unit 3 does not qualify as inpatient care. Apart from medication – sometimes by forced injections of powerful sedating drugs – mental health services in Unit 3 are almost nonexistent. Ex. 4, Kupers Rep. at 33. The prisoners housed there are entirely idle. Practically no group or individual therapy is available, and the few groups that are purportedly offered rarely take place. There are few if any programmatic activities such as vocational rehabilitation or any other form of psychiatric rehabilitation. Patients in Unit 3 are simply warehoused with no specific admission or discharge criteria, meaning that mentally ill inmates languish in isolation, ignored for weeks or months at a time, which frequently results in decompensation of their mental status. *Id.* Furthermore, many of the most severely mentally ill are not housed in Unit 3; it is routine for acutely psychotic prisoners to be housed in segregation or in general population. Ex. 7, Naidow Dep. at 206.

b) Intermediate care

Intermediate care is a crucial component in any correctional mental health program because it allows mentally ill inmates an opportunity to be in a less restrictive (and consequently more challenging) environment while still providing greater oversight and monitoring than is available in a general population setting. Ex. 35, Abplanalp Rep. at 11. The safety and support provided in intermediate care (sometimes referred to as a "step-down program") helps prisoners remain infraction-free, avoid victimization, and avoid punitive or long-term segregation. Ex. 4, Kupers Rep. at 33, 34.

The intermediate level of mental health care is almost entirely lacking at EMCF. Ex. 4, Kupers Rep. at 33. EMCF refers to Unit 2A as a "therapeutic community" that offers more programming than in other parts of the facility, but this unit still falls short of an adequate intermediate level of care. *Id.* at 35. In addition, Unit 2A houses only minimum- and medium-security prisoners who are near their time of release from prison; prisoners with serious mental illness are not admitted to Unit 2A. *Id.* Thus, not only is the closest approach to an organized therapeutic program at EMCF not available to the many prisoners who do not qualify for medium security, it also excludes those prisoners who need it most. *Id.* Other than Unit 2A, there are no mental health treatment programs at EMCF that could possibly qualify as intermediate mental health treatment. *Id.*

c) Outpatient care

Outpatient mental health care at EMCF is entirely inadequate. In general population units, outpatient care consists solely of medication, along with the possibility of movement to observation status during suicide or other crises. The multiple modalities of mental health

treatment that are needed, including individual and group psychotherapy as well as psychiatric rehabilitation programs, are absent except in Unit 2A.[29] Ex. 4, Kupers Rep. at 36-37.

Outpatient mental health treatment in the segregation pods at EMCF is even more deficient. Ex. 4, Kupers Rep. at 36. Many prisoners in the segregation pods suffer from acute and disabling mental illness; some suffer from psychosis. Ex. 4, Kupers Rep. at 36; Ex. 7, Naidow Dep. at 69-70. The vast majority of mental health encounters for prisoners in segregation occur in brief cell-front interactions, lasting perhaps less than a minute, where confidential communication between prisoner and clinician is impossible. Virtually no office visits or other private encounters occur except in response to a crisis. Ex. 35, Abplanalp Rep. at 16; Ex. 4, Kupers Rep. at 36-37. Cell-front interviews are entirely unacceptable except as a method for mental health clinicians to attempt to identify those who need to be taken to a private location for a confidential clinical encounter. Ex. 4, Kupers Rep. at 37. It is impossible to perform a full mental status exam, let alone provide mental health care, through a one-inch-thick solid metal door, where the only way to communicate with the patient is shouting through a narrow crack so that no confidentiality exists. Ex. 35, Abplanalp Rep. at 16. This lack of privacy thus acts as a barrier to accessing care. *Id.* at 22-23. Not surprisingly, the overwhelming majority of notes by mental health staff in the prisoners' medical records reflect superficial interactions in a chaotic environment that makes reliable or accurate assessments all but impossible. *Id.* at 22.

[29] As noted above, the programming in Unit 2A does not meet prisoner needs because most prisoners at greatest need are excluded from eligibility for it. Ex. 6, Kupers Rep. at 34.

3. There is no Minimally Adequate Program for Crisis Intervention and Suicide Prevention.

Every mental health care system must have a program for intervening with and stabilizing patients in acute psychiatric crisis as well as an active suicide-prevention program. These programs must include a number of components, such as training of mental health and security staff to recognize and intervene with patients at risk; screening for suicide risk upon admission to the prison and to segregation; evaluating inmates based on their history of past suicidal and self-harm crises and current stressors; assessing ongoing suicide risk; monitoring at-risk prisoners, which means not only intensive observation during an immediate crisis but also at less frequent intervals as the patient demonstrates diminishing risk of self-harm; providing meaningful talk therapy; and reviewing the program so that structural deficiencies or lapses in staff performance can be noted and corrected. Ex. 4, Kupers Rep. at 17.

Meaningful crisis intervention and suicide prevention programs do not exist at EMCF. Ex. 4, Kupers Rep. at 37, 38; Ex. 35, Abplanalp Rep. at 17. Suicide assessments are non-existent: although there are hundreds of incidents of suicidal or self-harm statements and actions in the records Plaintiffs' experts reviewed, not a single instance included any kind of suicide risk assessment or addressed the underlying issues with the inmate. Ex. 35, Abplanalp Rep. at 17. There is a near total lack of follow-up. *Id.* Despite the fact that patients at EMCF decompensate and experience psychiatric crises with alarming frequency, staff passively respond to these crises and fail to provide the necessary continuity of care. *Id.* at 12-13; Ex. 4, Kupers Rep. at 38-41.

For example, Abplanalp Patient #11 has been diagnosed with schizophrenia and substance dependence. He has a history of suicide, psychotic symptoms, including command hallucinations that tell him to set fires, and a family history of mental illness. His time at EMCF has been characterized by multiple psychiatric crises and episodes of self-mutilation. Yet time

after time, in encounters with mental health staff, no suicide or self-harm assessment is documented, and there are only cookie-cutter mental health notes in the chart, with no specific intervention planned or follow-up noted. Ex. 35, Abplanalp Rep. at 18-19.

When prisoners complain that they are suicidal, they are often transferred to an "observation cell," often in the prison infirmary. After a few days, they are transferred back to prison housing, sometimes to the segregation cell where they were confined prior to the suicidal crisis, without any treatment plan or follow-up. The result is that the patient cycles in and out of the observation cell for weeks and months at a time. Ex. 4, Kupers Rep. at 38-41. These frequent and sometimes long-term stays in the observation cell are psychiatrically dangerous, since the observation cell is simply another kind of isolation cell. The prisoner is alone 24 hours every day; no provision is made for any meaningful activity; staff scarcely talks to him; he does not leave his cell, even for recreation; he is stripped of his clothes except for a suicide-proof gown, and of all possessions and amenities. These deprivations might be necessary for safety while a patient is being stabilized, but they are problematic when imposed for extended periods of time. *Id.* at 38-39. Kupers Patient #29 is an example of a prisoner whose psychosis was exacerbated by isolated confinement in an observation cell without necessary treatments. The combined effect of isolation and idleness in the cell and the shortfalls in treatment made his psychotic condition more persistent and disabling and his prognosis much worse. *Id.* at 40-41.

4. There are Systemic Failures in the Management of Psychiatric Medications at EMCF.

Patients on psychotropic medications must have periodic monitoring and follow-up at intervals based on the patient's individual needs. At EMCF, it appears that there is no individualized determination of the necessary intervals for follow-up. Ex. 4, Kupers Rep. at 43. Failure to perform this standard monitoring can be catastrophic.

For example, Kupers Patient #64 was placed on a psychotropic medication that had the potentially fatal side effect of lowering his white blood cell count. When a patient's white cell count begins to fall it must be monitored closely; a slight drop may herald a plummeting white count, a medical emergency that can be fatal. Ex. 4, Kupers Rep. at 44. Patient #64's white blood cell count did, in fact, drop below normal levels. For six months, however, the psychiatrist failed to monitor the issue even after the medical doctor brought it to his attention, and thus the psychiatrist failed for six months to document a clinically adequate risk/benefit analysis, that is, an analysis of whether the risk of a continuing rapid fall in the white cell count outweighed the benefit of a medication that had proved capable of controlling the patient's severe psychotic condition. *Id.* at 44.

Another major deficiency in medication management at EMCF is the failure to consistently obtain patients' informed consent for treatment with psychotropic medications. Informed consent is a fundamental ethical consideration in the practice of medicine, including psychiatry, and it applies in prisons just as it does in the community. MDOC's own policy, MDOC #125-04-A, "Offender Right to Refuse Medical Treatment," spells out the prisoner's right to refuse treatment, including psychiatric treatment. Ex. 4, Kupers Rep. at 45. However, at EMCF, the requirement of obtaining informed consent to treatment is frequently ignored. *Id.* at 44-46.

Little talking or reasoning occurs before forcible injections; rather, if a prisoners refuses to take his medication orally, or becomes agitated, a team of officers grabs him, forces him to the floor, and holds him down while a nurse pulls down his pants and gives him an injection in his gluteal muscle. Ex. 4, Kupers Rep. at 46-47. This may entail an extremely brutal use of force and the risk of serious physical injury besides the humiliation of such public exposure. *Id.*

Based on the absence of documented adequate informed consent, the failure to try less intrusive interventions, the coercion implicit in frequent "take-downs" conducted in view of other patients, and the poor documentation of the reasons for the injections, it appears that the use of involuntary medication by injection is not uncommon at EMCF.

For example, Kupers Patient #21, who has been diagnosed with paranoid schizophrenia, is prescribed Haldol Decanoate by injection every 28 days. Haldol can have dangerous and potentially permanent crippling or fatal neurological and other side effects. Ex. 4, Kupers Rep. at 41, 42. Patient #21 says that he does not want the shots, and has told staff that he is willing to take pills instead, but is not given an opportunity to refuse the shots. He sees other prisoners being taken down by a "goon squad" to be injected, and this frightens him into cooperating when staff tell him that it is his turn to get a shot. *Id.* at 47.

In some limited circumstances, it may be clinically appropriate to administer medication in the absence of consent. The National Commission on Correctional Health Care standard for Emergency Psychotropic Medication calls for a "protocol for emergency situations when an inmate is dangerous to self or others due to medical or mental illness and when forced psychotropic medication may be used to prevent harm, based on a provider's order." Ex. 4, Kupers Rep. at 46 (citing Standards for Mental Health Services in Correctional Facilities (2008) (essential standard MH-I-02)). The standard "supports the principle that psychotropic medication may not be used simply to control behavior or as a disciplinary measure." *Id.* The provider must document in the inmate's record the inmate's condition; the threat posed; the reason for forcing medication; other treatment modalities attempted, if any; and goals for less restrictive treatment alternatives as soon as possible. *Id.* At EMCF, the required documentation regarding consent and forced medication is far from adequate. *Id.* at 46-48. Documented

consideration of alternative interventions is lacking; in fact, practically no significant alternative treatment modalities exists at EMCF. *Id.* at 46. Often there is insufficient documentation in the chart to enable a reviewer to understand the reason for an involuntary injection of psychotropic medications, or even whether it is in fact involuntary. *Id.*

5. EMCF's Mental Health Records Have Systemic Deficiencies.

Accurate, complete and reliable records are the foundation for adequate mental health treatment (and indeed, for all medical treatment). Ex. 4, Kupers Rep. at 49. It is virtually impossible to provide meaningful mental health care without accurate, complete and reliable records. Ex. 35, Abplanalp Rep. at 20. Information such as assessments, contacts with prisoners, laboratory reports, patient history and reported symptoms, diagnoses, prescriptions, and changes in health status must be accurately recorded. In addition, there must be a current treatment plan in the chart, and changes in the treatment plan must be documented along with an explanation of the reason for the changes. Ex. 4, Kupers Rep. at 49.

The records of prisoners with serious mental health needs at EMCF are grossly incomplete, unreliable, and in many cases contain apparently fabricated entries. Ex. 35, Abplanalp Rep. at 20. They typically contain boiler-plate, cut-and-paste entries with identical information for different patients and verbatim repetitions that are not specific to the patient's mental health symptoms. The records lack any type of assessment, evaluation, or individual plan for care. *Id.* One of the most egregious failings of the mental health records at EMCF is the almost complete absence diagnoses and problems, which are the foundation upon which inmate treatment and care must be based. Even the most basic elaboration or explanation of inmate complaints is overwhelmingly absent. *Id.* at 21.

The large gaps and missing documentation in MARs are also dangerous, particularly with regard to psychotropic medications, which must be given in a consistent and continuous manner

to prevent the risk of serious harm to the mental and physical health of the patient. Ex. 4, Kupers Rep. at 49. There are also gaps in the record between quarterly reviews and treatment plans for many inmates, and numerous examples of critical observations not entered into the record until long after they occurred. This lack of adequate documentation places inmates at increased risk of harm. Ex. 35, Abplanalp Rep. at 21.

No one is performing any meaningful oversight or quality control of the mental health system at EMCF, and no one in MDOC management has been paying attention to the mental health crisis at EMCF. Ex. 35, Abplanalp Rep. at 23. The system, in short, is in free-fall.

IV. FILTHY AND DANGEROUS ENVIRONMENTAL CONDITIONS IN UNITS 5 AND 6 AND DEFENDANTS' FAILURE TO PROVIDE ADEQUATE FOOD TO PRISONERS CONFINED THERE SUBJECT THEM TO RISK OF SERIOUS HARM.

Although Defendants knew well in advance that Plaintiffs' experts would be visiting EMCF, Plaintiffs' environmental expert still found filthy and dangerous conditions throughout Units 5 and 6.[30] Ex. 45, Expert Report of Diane Skipworth ("Skipworth Report") at 8-18.[31]

[30] Numerous prisoners also confirm that environmental conditions in Units 5 and 6 have been and remain deplorable. Ex. 60, Declaration of Isaiah Sanders, Jan. 7, 2014, ¶¶ 1, 5-9; Ex. 61, Declaration of Terry Pierce, Jan. 7, 2014, ¶¶ 1, 4-6, 8; Ex. 62, Declaration of Demetrias Reed, Feb. 20, 2014, ¶¶ 4, 6,8, 9, 12; Ex. 63, Declaration of Leo Laurent, Mar. 20, 2014, ¶¶ 2-12, 14; Ex. 64, Declaration of DeAngelo Elmore, Feb. 19, 2013 ¶¶ 1-8; Ex. 65, Declaration of Rotheleo Dixon, Feb. 19, 2013, ¶¶ 1, 4-6, 9; Ex. 66, Declaration of L. Walker, June 11, 2013, ¶¶ 2-3; Ex. 67, Declaration of Marcus Lewis, July 1, 2014. Staff continue to ignore prisoner requests for assistance, leaving prisoners no choice but to set fires, flood their cells, and engage in self-harm to have their basic needs met. Ex. 68, Declaration of Johnny Ailes, July 8, 2014; Ex. 66, Declaration of Larry Walker, June 11, 2013, ¶ 2; Ex. 65, Declaration of Rotheleo Dixon, Feb. 19, 2013, ¶ 8; Ex. 62, Declaration of Demetrias Reed, Feb. 20, 2014, ¶ 8.

[31] Ms. Skipworth is employed by the Dallas County Sheriff's Department as Director of Detention Services. In that capacity, she oversees the management of the Support Services of her Division, with a yearly budget of 10 million dollars and 57 employees. She performs inspections that include the jail housing units, the food production facility and warehouse, the laundry and related areas, in order to ensure compliance with relevant law and regulations. She has also performed inspections of immigration detention facilities and correctional facilities on behalf of the U.S. Department of Justice and the U.S. Department of Homeland Security. Ms. Skipworth is a licensed sanitarian and licensed dietician and has also obtained certification in

Plaintiffs' corrections expert, Eldon Vail, was so confounded by the conditions of these units, even though the prison knew of his impending visit, that he concluded that "EMCF lacks the ability to get their segregation units clean and maybe even the understanding of how important cleanliness is for safety and security." Ex. 6, Vail Rep. at 10, 11. These conditions are hazardous to both prisoners' health and security; "facility cleanliness is fundamental to prison safety and security." *Id.* at 10.

The levels of dust, dirt, spillage, debris, and residue in the isolation units show that basic cleaning procedures are not routinely performed and inmates there do not have access to adequate cleaning supplies. Ex. 45, Skipworth Rep. at 9; Ex. 6, Vail Rep. at 9, 11; Ex. 4, Kupers Rep. at 19. The floor of the unit's dayroom is filthy, with large puddles of standing water mixed with excrement or blood and littered with used styrofoam food trays. Ex. 4, Kupers Rep. at 19; Ex. 6, Vail Rep. at 9. Given that the prisoners in the segregation units are almost never in those common areas except when passing through in restraints, there is no excuse for these areas not to be routinely cleaned. Ex. 6, Vail Rep. at 9. A pillar wall in the unit was caked with food or feces that had been there for some time. *Id.*

The showers in the segregation units are in disrepair and extremely dirty, caked with soap and grime and with standing water on the floor. Some showers are without functional lights; others have exposed lighting and plumbing fixtures. Ex. 6, Vail Rep. at 9, 10. Security staff sometimes leave prisoners in the shower stalls for hours at a time, a practice for which they have no justification. Ex. 7, Naidow Dep. at 46-47, 110, 138. The flush controls on many toilets in

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laundry and line management and as food protection management instructor. She also serves as an adjunct faculty instructor at Brookhaven College, preparing students for Food Protection Management Certification, where she was designated as a Distinguished Adjunct Faculty. Ms. Skipworth was also recognized by the Commissioners Court of Dallas County and the Dallas County Sheriff's Department. *See* Ex. 45, Skipworth Rep. at 87.

the isolation units are broken and there is evidence of repeated sewage back-ups outside the facility. Ex. 45, Skipworth Rep. at 15; 70-72 (cell plumbing); 73 (sewage back-up). Prisoners may be left for days or weeks in cells with nonfunctioning toilets and sinks. *Id.* at 15, 70. Dysfunctional toilets may go unrepaired for weeks at a time. Ex. 6, Vail Rep. at 10. Staff may tell prisoners to defecate into a trash bag. Ex. 7, Naidow Dep. at 151.

Photographs from these units in the facility show conditions more consistent with the 19th than the 21st century. *See, e.g.,* Ex 45, Skipworth Rep. at 22-24 (dirty cell walls promoting disease transmission); 30 (filthy cell); 31 (dirty cell with food trash promoting disease transmission); 32 (dirty shower; floor not maintained); 33 (shower with apparent blood spill next to discarded bag of medication); 34-37 (cell with walls, floor and cell window covered with blood from self-injury incident days earlier); 38 (cleaning cart in use by prisoner worker to clean housing unit; no cleaning chemicals on cart); 39-43 (cells with poor sanitation promoting disease and covered ventilation grilles); 54 (mouse droppings); 70 (in-cell toilets that did not work properly); 76 (mold in showers);[32] Ex. 6, Vail Rep. at 7-12. The conditions observed by Plaintiffs' environmental and corrections experts were not an aberration: when Plaintiffs' experts returned three weeks later, they found the same filthy and dangerous conditions. *See* Ex. 4, Kupers Rep. at 16-17, 19; Ex. 35, Abplanalp Rep. at 3.

One harrowing example of the effects of the failure to maintain minimal sanitary conditions involved an incident in which a prisoner in segregation had feces thrown into his cell by another prisoner. In order to try to obtain staff attention so that he could leave this cell, the prisoner cut himself, which then led to a use of force by staff. Staff claimed to give the prisoner

[32] As noted above, Plaintiffs' psychiatric expert, in nearly forty years of monitoring correctional facilities, does not recall witnessing a prison with the same level of neglect by the staff as EMCF. Ex. 4, Kupers Rep. at 19. The conditions in Units 5 and 6 are so harsh that they are incompatible with mental health. *Id.* at 53.

cleaning supplies, but the prisoner could not have used them because he had no running water in his cell. According to staff, the water could not be fixed until the next day, so the prisoner was left in the cell. The escalating incident ultimately led to the prisoner being restrained on a gurney in his contaminated cell. Ex. 6, Vail Rep. at 39, 40.

Spilled blood is a frequent occurrences at EMCF due to the frequency of inmate-on-inmate violence and self-cutting, *see* Ex. 4, Kupers Rep. at 18, 20, 23-27; Ex. 6, Vail Rep. at 18-25, 31-43, yet prison staff do not employ even the most elementary safety precautions necessary to prevent prisoners and staff from exposure to blood-borne pathogens, including HIV and hepatitis. Ex. 6, Vail Rep. at 9-10; *see also* Ex. 45, Skipworth Rep. at 33-36. Plaintiffs' environmental expert observed a major blood spill in a cell that had occurred days earlier, yet the cell was still smeared with blood, an enormous puddle of blood remained on the floor, and bloody bandages filled the sink. *See* Ex. 45, Skipworth Rep. at 34-36. Even when Plaintiffs' expert called this serious biohazard to the attention of security staff, the prisoner worker who was first assigned to remove the spill was not provided with necessary personal protection equipment until the expert expressed concern. *Id.* at 35. After the clean-up was officially complete and the prisoner workers left, a trail of blood was still running out of the cell toward the common area. *Id.* at 37.

Multiple electrical hazards exist throughout Units 5 and 6, including exposed live wires in shower stalls and cells and charred light sockets, all of which create fire and electrical shock hazards. Ex. 45, Skipworth Rep. at 6, 8, 26-27, 56. Many areas are so poorly lit that they do not meet safety standards, and many showers and cells have no operable lighting, posing particularly serious health and safety concerns. *Id*. at 6-7; Ex. 6, Vail Rep. at 8, Ex. 4, Kupers Rep. at 15-16.

The grossly inadequate lighting is also profoundly detrimental to mental health. Ex. 4, Kupers Rep. at 17.

The ventilation system in Units 5 and 6 is not maintained; ventilation grilles throughout the facility are plugged or blocked. Ex. 45, Skipworth Rep. at 10; *see also id.* at 39-43. This shortcoming is particularly dangerous to health and safety in light of the lack of fire safety at the facility. Prisoners openly keep wicks[33] in their cells, which are often placed in ventilation grilles, compromising the ventilation system even further. *Id.* at 10. At the time of Plaintiffs' expert inspections in March and April 2014, there was a strong smell of smoke throughout the housing areas, and fires were smoldering in some of the segregation units. *Id.* at 9; Ex. 6, Vail Rep. at 9; Ex. 35, Abplanalp Rep. at 3; Ex. 4, Kupers Rep. at 24. The failure to follow fire protection and safety practices and the unreasonable level of exposure to fire and smoke places all prisoners and employees at EMCF at serious risk of injuries, including burns and smoke inhalation. Ex. 45, Skipworth Rep. at 17.

Defendants' failure to maintain the facility encourages infestation by vermin and promotes the growth of disease-causing microorganisms. Ex. 45, Skipworth Rep. at 7; *see also* Ex. 7, Naidow Dep. at 134-6. Indeed, prisoners reported to Plaintiffs' experts that their cells were full of rodent droppings, *see* Ex. 4, Kupers Rep. at 18; Ex. 6, Vail Rep. at 9, and Plaintiffs' sanitation expert found droppings in cells randomly chosen for inspection. Ex. 45, Skipworth Rep. at 11-12. Mice are effective agents for spreading diseases among humans including salmonellosis. *Id.* at 12, 54, 56-58, 60, 66, 70-72, 74. The prison laundry does not operate effectively to supply prisoners with clean clothes and linens. *Id*. at 11, 52-53.

[33] Wicks are contraband homemade devices constructed by tightly wrapping flammable material, such as toilet paper, and then placing it in the dayroom microwave so that a spark will ignite the paper.

The filthy conditions that Plaintiffs experts observed, including the barbaric conditions in the segregation units, have been known to Defendants for years yet have not been remedied. *See e.g.*, Ex. 81, AG_013406, Email from Tyeasa Evans to Frank Shaw, Aug. 13, 2012 (email from facility's contract monitor to the facility warden requesting that he remedy sewage spill that had been running from a pipe into two inmates' cells for three days despite staff knowledge of the issue); Ex. 46, AG_008915, Email from Tyeasa Evans to Michael White, June 20, 2013 (email from facility's contract monitor to facility administrators noting that she visited Unit 6 and did not observe "any cell sanitation, showers or recreation being conducted"; she visited Unit 5, but only "some cells on 5b" received sanitation); Ex. 27, MTC_ESI_0000285, Email from Tyeasa Evans to Norris Hogans, June 23, 2014 (email from facility monitor to facility administration noting that pods on Unit 5 need general cleaning and that in the kitchen several areas and appliances need cleaning); Ex. 47, AG_014096, Email from Tony Compton to Federico Ovalle, Sept. 20, 2012 and Ex. 48, AG_008991, Email from Tyeasa Evans to Frank Shaw, Oct. 11, 2012 (noting that the facility's hot water heater remained broken for three months after MTC took over); Ex. 49, MTC_ESI_0000173, Email from Christopher Epps to Odie Washington, RS Marquardt, and Harold Pizzetta, June 16, 2014 (email from Defendant Epps responding to a report of an attempted escape, noting that "inmate cells on unit 5 were dark and most of them did not have light fixtures at all and the ones that did have light fixtures, the lights did not work"); Ex. 50, MTC_ESI_0000283, Email from Tyeasa Evans to Norris Hogans, June 23, 2014 (email from facility's contract monitor to facility administrators noting that, during her walk-through of the housing units, she observed four prisoners in Unit 5B who had no lights in their cells); Ex. 51, MTC_ESI_0000286, Email from Tony Compton to Derrick Smith and Norris Hogans, June 10, 2014 (noting that 15 prisoners on Unit 5 D did not have light in their cells and 3 prisoners

had cells with exposed wiring); Ex. 52, MTC_ESI_0000669, Email from Frank Shaw to Tyeasa Evans, May 23, 2013 (noting that offender request forms had been forwarded to the warden alleging that food had been exposed to blood but was nonetheless served to inmates); Ex. 6, Vail Rep. at 12 (citing MTC Security Minutes from November 14, 2012, which stated that living conditions in the segregation units were "awful" and "very concerning" and that the showers throughout the units needed attention); Ex. 53, MTC_ESI_0000293, Email from Tyeasa Evans to Jerry Buscher, June 2, 2014 (noting that Units 5 and 6 are in need of a "good general cleaning").

There are pervasive deficiencies in the safety and sanitation of food preparation at EMCF. Ex. 45, Skipworth Rep. at 14. Neither the kitchen nor its equipment is properly cleaned, sanitized, or maintained. *Id*. at 14, 17. The kitchen fails to prevent cross-contamination of food items with microorganisms and contains dirty equipment that promotes infestation with disease-causing rodents and cockroaches. *Id*. at 14. The ceiling is in such disrepair that debris falls on food preparation surfaces as well as on the food itself. *Id.*

There is evidence that not enough food is supplied to meet prisoners' needs. The various weekly menus posted for use over a four week period claim to provide 2900 calories per day for prisoners. This would be sufficient – if this were the food actually provided. Ex. 45, Skipworth Rep. at 78-80. The meals actually served, however, depart substantially from the posted weekly menu. During the inspection by Plaintiffs' environmental expert, items of lesser nutritional value were repeatedly substituted for the items listed on the posted menus. *See id.* at 81-85. For example, on April 2, 2014, EMCF's menu called for dinner to include, among other things, ½ cup of carrots, ½ cup of gelatin, and potato salad. Instead, prisoners were served corn chips, cookies, and two additional slices of bread. *Id*. at 82.

The food that prisoners at EMCF are provided is in many cases insufficient to maintain a healthy body weight. Many prisoners at EMCF have body mass indices ("BMIs") below 18.5, a level that creates risks of health complications, including anemia, nutrient deficiencies, bone loss, osteoporosis, heart irregularities, blood vessel diseases, increased vulnerabilities to infection and other disease, and delayed healing. Ex. 54, Diane Skipworth Report Addendum at 2-3.

V. THE EXTRAORDINARILY DANGEROUS, HARSH, AND DEGRADING CONDITIONS IN THE SOLITARY CONFINEMENT UNITS AT EMCF SUBJECT ALL PRISONERS CONFINED THERE TO EXCESSIVE RISK OF SERIOUS HARM.

In the segregation units at EMCF, MDOC has created a totality of conditions so harsh and extreme that they are incompatible with mental health. Prisoners are isolated, forced to live in abject filth and darkness, subjected to violence and danger, and denied care for their most basic human needs. Ex. 4, Kupers Rep. at 54. They degrade mentally, emotionally and behaviorally. Ex. 7, Naidow Dep. at 76. Each of these conditions, individually and taken together, inflicts tremendous psychological suffering and places each prisoner at significant risk of serious harm.

A. The Effects of Prolonged Solitary Confinement, Particularly on Persons With Mental Illness, Is Well Known Generally and by MDOC.[34]

At EMCF there are approximately 120 prisoners in long-term (longer than three months) segregation in Unit 5 and approximately 30 prisoners in shorter-term segregation in Unit 6D.[35]

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[34] For purposes of Plaintiffs' claims, "isolated confinement" or "solitary confinement" refers to prisoners who are segregated from the mainstream prisoner population, involuntarily confined in their cells for 22 hours a day or more, given only extremely limited or no opportunities for direct and normal social contact with other persons, and afforded extremely limited, if any, access to meaningful programming of any kind. Ex. 4, Kupers Rep. at 10.

[35] Isolated confinement also occurs in any housing unit at EMCF that is on lock-down status. Lockdowns occur when prison officials deem that a security problem requires round-the-clock cell confinement of all prisoners in a housing unit or units. During lockdowns, prisoners are almost entirely isolated and idle and often are not even permitted to go to the yard for

Some prisoners have languished in solitary confinement for years. *See* Ex. 55, Defendants' Responses to Plaintiffs' First Set of Requests for Admission at 2. A large proportion of the prisoners consigned to long-term segregation at EMCF suffer from serious mental illness. Ex. 4, Kupers Rep. at 15, 16, 17. Security and mental health staff at EMCF are aware that there are many seriously mentally ill prisoners in these units. Ex. 6, Vail Rep. at 14; Ex. 7, Naidow Dep. at 69-70. Inmates in the isolation units are subjected to unremitting isolation and idleness, an environment that puts great stress on almost all inmates and especially those with pre-existing mental illness. Ex. 6, Vail Rep. at 8.

It is well-established that long-term confinement (greater than three months) in isolation causes severe psychiatric morbidity, disability, suffering and mortality. Ex. 4, Kupers Rep. at 11 (citing to the literature).[36] As early as 1890, the U.S. Supreme Court found that, in isolation units, "[a] considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community." *Id.* (quoting 4 *In re Medley*, 134 U.S. 160 (1890)). Every study of the effects of solitary or supermax-like confinement for periods longer than 60 days has found evidence of negative psychological effects. *Id.* at 14 (citing *Wilkinson v. Austin*,

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recreation. Lockdowns occur frequently at EMCF and can last weeks or even months at a time. Ex. 4, Kupers Rep. at 11.

[36] For reviews of this research, see Peter Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*, 34 Crime and Justice 441 (2006); Bruce A. Arrigo & Jennifer L. Bullock, *The Psychological Effects of Solitary Confinement on Prisoners in Supermax Units: Reviewing What We Know and Recommending What Should Change*, 52 International Journal of Offender Therapy & Comparative Criminology 622 (2008).

No. 04-495, Brief of Professors and Practitioners of Psychology and Psychiatry as Amicus Curiae in Support of Respondent, 2005 WL 539137 (Mar. 3, 2005)).

Long-term consignment to segregation is a major factor in the high suicide rate among prisoners, which is approximately twice as prevalent in prison as in the community. Of all successful suicides in correctional systems, approximately 50% involve the 3 to 8% of prisoners who are in some form of isolated confinement. Ex. 4, Kupers Rep. at 12.

Long-term isolated confinement similar to that in the segregation pods on Units 5 and 6 at EMCF causes psychiatric symptoms such as severe anxiety, depression and aggression in relatively healthy prisoners, and psychotic breakdowns, severe affective disorders and suicide crises in prisoners with histories of serious mental illness or who are prone to mental illness. Ex. 4, Kupers Rep. at 12. The known detrimental effects of long-term isolation include anxiety, headaches, troubled sleep, lethargy or chronic tiredness, nightmares, heart palpitations, obsessive ruminations, confused thinking, irrational anger, chronic depression, fear of impending nervous breakdown, hallucinations and perceptual distortions, and suicidal ideation. *Id.* at 13 (citing sources); Ex. 6, Vail Rep. at 15-16 (same).

There is broad consensus in the corrections and mental health community that housing mentally ill inmates in segregation subjects them to a heightened risk of serious harm. Ex. 6, Vail Rep. at 15; Ex. 4, Kupers Rep. at 13-14; Ex. 7, Naidow Dep. at 76. The stark isolation and idleness of segregation will predictably cause prisoners already prone to psychotic episodes to suffer a "breakdown." Ex. 4, Kupers Rep. at 13. Every form of mental illness is typically exacerbated by long-term isolated confinement like that on Units 5 and 6 and during lockdown on other units. *Id.* at 13-14. A large proportion of the prisoners in isolated confinement at EMCF are prescribed relatively high doses of psychotropic medications, often by injection and in

some cases over their objection. *Id.* at 17-18. Drugged and sedated, they spend their days in a dark cell, sleeping much of time, and unable to engage in productive activities of any kind. *Id.* at 18. The possibility of adjusting to life in general population or in the community at the end of a prisoners' time in isolated confinement is greatly diminished by the conditions of this confinement. *Id.*

MDOC has long been aware of the damaging effects of solitary confinement in general and especially on people with mental illness. Plaintiffs' expert, Dr. Kupers, testified regarding these effects in 2003 in a Mississippi death row trial, *Russell v. Epps*, and again in 2006 in *Presley v. Epps*, a case that challenged the conditions of confinement in Mississippi's super-maximum security prison, Unit 32 at Mississippi State Penitentiary. Ex. 4, Kupers Rep. at 14. The *Presley* case resulted in a consent decree that reduced MDOC's solitary confinement population by 85% and created a mental health step-down unit. An article jointly authored by Dr. Kupers, Emmett Sparkman, MDOC's Deputy Commissioner, and MDOC's mental health providers recounted the need for and the success of these reforms. *Id.* (citing Terry A. Kupers et al., *Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs*, Criminal Justice and Behavior (2009)).

MDOC has likewise long been aware of the negative effects of solitary confinement on mentally ill prisoners at EMCF. In 2011, Dr. Kupers met with and made recommendations to MDOC's Deputy Commissioner and the Regional Medical Director for Psychiatry for GEO, the contractor responsible for EMCF at that time, concerning the mental health effects of solitary confinement on prisoners at EMCF. Dr. Kupers recommended that no prisoner be consigned indefinitely to the solitary confinement units; that all prisoners be provided with a series of brief

incremental phases by which to transfer out of segregation; and that prisoners with serious mental illness should be removed from long-term segregation on Unit 5. Ex. 4, Kupers Rep. at 15. There was consensus among all parties to that discussion that no prisoner should be consigned indefinitely to Unit 5; that incremental rewards and advancement to greater freedom and eventually general population should be built into each phase of the program on Unit 5; and that the incremental phases should be relatively short. *Id.* Yet despite this consensus, the situation at EMCF has deteriorated since 2011. *Id.* During an extended state-wide lock-down in June 2013, MTC's Regional Vice President, Marjorie Brown, notified MDOC Commissioner Christopher Epps and Deputy Commission Archie Longley of the serious effects the lock-down was having on the mentally ill prisoners at EMCF:

> The concern lies more with East MS and the mentally ill offenders. They usually begin to decompensate with the lockdowns for extended periods of time. We have in the past allowed out of cell time for four hours per tier in order to reduce the stress on the offenders . . . Today East MS had two incidents on Unit 3 . . . Both incidents were resolved without force, but is indicative of some of the issues with the Mental Health inmates' struggles to cope with the lockdown.

Ex. 56, MTC_ESI_0000231, Email from Marjorie Brown to Archie Longley, cc: Christopher Epps, June 18, 2013.

B. The Conditions in Isolated Confinement at EMCF Are Shockingly Harsh and Inhumane.

The toll that isolated confinement takes on prisoners is exacerbated by the shockingly harsh, filthy and squalid conditions in the isolation units at EMCF. Ex. 4, Kupers Rep. at 16. While environmental conditions throughout the facility present an unreasonable risk to prisoners' health and safety, the conditions are especially deplorable and dangerous in the segregation housing in Units 5 and 6. Ex. 45, Skipworth Rep. at 8. Plaintiffs' corrections expert characterized these conditions as "the worst I have ever seen in 35 years as a corrections

professional" and opined that "all inmates confined to the segregation units at EMCF, and most especially those with serious mental illness, are subjected to an ongoing substantial risk of serious harm from the dangerous, filthy and degrading conditions there." Ex. 6, Vail Rep. at 7.

Prisoners in the isolation units at EMCF are confined to a cell the size of a small bathroom behind a solid metal door with a narrow glass window and a narrow port for passing food trays. Ex. 6, Vail Rep. at 8. Human contact is limited to a few times a day, when staff come to deliver food or during brief mental health or medical rounds. *Id.* Conversation with inmates in other cells is possible only by shouting. *Id.* Inmates do not have access to telephones for calls to family. *Id.* at 14; Ex. 4, Kupers Rep. at 18. It is common that prisoners are deprived of the opportunity to leave their cell, even to shower, for days at a time. Ex. 6, Vail Rep. at 8. Although national correctional standards and MDOC policy requires that prisoners in solitary confinement have access to out-of-cell exercise five days a week, prisoners in solitary confinement at EMCF may receive only one hour of exercise a week, or none at all. *Id.* at 12, 13-14. Prisoners may not receive their allotted recreation time for weeks on end, Ex. 4, Kupers Rep. at 21; Ex. 7, Naidow Dep. at 60, 61, which is harmful to their physical and mental well-being. Ex. 6, Vail Rep. at 13.

The level of neglect by staff of prisoners in the segregation pods on Units 5 and 6D is far beneath all standards of correctional care and decency. Ex. 4, Kupers Rep. at 20. As in other units in the prison, emergency call buttons often do not work. Ex. 5, Stern Rep. at 6; Ex. 30, LaMarre Rep. at 9; Ex. 4, Kupers Rep. at 20-21; Ex. 6, Vail Rep. at 20. Staff rarely come by to check on prisoners, who cannot obtain attention to their basic needs, whether for a light bulb for a dark cell, cleaning supplies, toilet paper, repair of a toilet that is flooding their cell with excrement, or an appointment to see a doctor or mental health clinician. Ex. 4, Kupers Rep. at

20. Prisoners must bang on their doors to try to obtain medical attention in case of a medical or other emergency – often a futile effort, because no staff may be in the isolation pods. Ex. 23, MTC_ESI_0000076, Memorandum from Tyeasa Evans to Tony Compton, May 2, 2014 (stating that in Unit 6D "no staff was present"); Ex. 7, Naidow Dep. at 110-113 (security staff leave their mandatory posts uncovered, without authorization and without telling their supervisors). These prisoners can only obtain attention for their basic human needs by setting fires, flooding their cells, cutting themselves, or refusing to remove their arms from the food slots in their cell doors, which may subject them to pepper spray. The result is an overwhelming number of unnecessary and dangerous use-of-force events, putting prisoners at significant risk of injury. Ex. 6, Vail Rep. at 6.

A strong odor of smoke permeates the isolation housing units from fires set by the inmates, which is often the only way to summon assistance from officers. Ex. 45, Skipworth Rep. at 17. For example, a prisoner who suffered from severe heart disease, hypertension, and anemia as well as schizophrenia set a fire in his segregation cell the day before he died; a nurse noted in his chart that he set the fire "in order to get medical attention." Ex. 4, Kupers Rep. at 23. Plaintiffs' experts observed fires actively burning in the housing units during their tours. Ex. 6, Vail Rep. at 9; Ex. 45, Skipworth Rep. at 17. Fires are sometimes not extinguished for long periods of time or simply left to burn themselves out. Ex. 7, Naidow Dep. at 141-142. Prisoners and staff with asthma can have trouble breathing because of the smoke, which places both at serious risk of harm. *Id.* at 142-143; Ex. 45, Skipworth Rep. at 17.

As discussed in Section IV *supra*, Plaintiffs' experts observed horrifically dirty conditions in the segregation units during their tours of EMCF. Facility cleanliness is fundamental to prison safety and security; to allow such filth to linger unattended creates inmate

unrest and makes the unit much more dangerous. Ex. 6, Vail Rep. at 10. The levels of dust, dirt, spillage, debris, and residue in the isolation units show that basic cleaning procedures are not routinely performed and inmates there do not have access to adequate cleaning supplies.

One of the most shocking conditions in the isolated confinement cells in Units 5 and 6D is the deprivation of light. Ex. 4, Kupers Rep. at 16. Depression and paranoid thinking are severely exacerbated by excessive darkness. Living in excessive darkness also results in loss of diurnal rhythm, the alternation of day and night that provides orientation as to time, which human require to maintain their sanity. *Id.* at 17. Cells in the segregation units are dark, with only a small window to the outside and a narrow slit in the door looking into the dayroom. Lighting fixtures are nonfunctional in many cells, and thus it is common for prisoners in segregation to be in almost total darkness, 24 hours a day, for weeks or months at a time. Ex. 6, Vail Rep. at 8, 10; Ex. 4, Kupers Rep. at 16-17; Ex. 35, Abplanalp Rep. at 3 (noting "lack of adequate (or any) lighting"); Ex. 45, Skipworth Rep. at 6. Plaintiffs' corrections expert noted, after viewing the lighting in segregation, that "I have never, in my forty years touring prisons, seen anything like this." Ex. 4, Kupers Rep. at 17.

MDOC's highest leadership has been aware of these conditions in the solitary confinement units for years. A year before filing this lawsuit, Plaintiffs' counsel brought these conditions to the attention of Commissioner Epps in a letter offering to assist MDOC in remedying the conditions. Ex. 57, Letter from Margaret Winter to Christopher Epps, May 15, 2012. MDOC's leadership is also aware that these dangerous and unacceptable conditions have continued unabated to the present day. *See, e.g.,* Ex. 58, MTC_ESI_0000471, Email from Archie Longley to Christopher Epps, June 16, 2014 (quoting report from MDOC's contract monitor that inmates' cells in Unit 5 were dark; most had no light fixtures at all, and the rest had

light fixtures that did not work); Ex. 59, MTC_ESI_0000287, Email from Tyeasa Evans to Norris Hogans, June 6, 2014 (reporting that 15 of the cells observed during a tour of Unit 5D had no working light); Ex. 6, Vail Rep. at 12.

Adding enormously to the dangers and stress experienced by those confined to the segregation units at EMCF is the fact that custody officers do not have basic control of the units. Ex. 6, Vail Rep. at 16. The doors to the individual cells are not secure. *Id.* Prisoners are well aware that other inmates can and sometimes do escape their cells and assault other inmates. *Id.* at 19; *see also* Ex. 23, MTC_ESI_0000076, Memorandum from Tyeasa Evans to Tony Compton, May 2, 2014 ("offenders continuously manipulate there [sic] cell doors on Unit 6 and come out [of their cells]"; on Unit 5 "various doors were unsecure;" "various inmates out of their cells and "Staff informed me she was not sure why they were out").

These conditions press the outer bounds of what most humans can psychologically tolerate, subject all prisoners housed in EMCF's solitary units to a significant risk of serious psychiatric symptoms and breakdown, and subject the less healthy prisoners to significant risk of severe and possibly irreversible psychiatric consequences, including psychosis, mania or compulsive acts of self-abuse or suicide. Ex. 4, Kupers Rep. at 3; Ex. 6, Vail Rep. at 15 ("The barbaric conditions of confinement in the segregation units at EMCF are particularly injurious to the many prisoners in segregation who suffer from severe mental illness.").

ARGUMENT

When prisoners seek injunctive relief from the conditions of their confinement, they need not prove that the challenged conditions have resulted in actual injury; it is the unreasonable *risk* of harm to which they are subjected that entitles them to prospective relief under the Eighth Amendment. *See Farmer v. Brennan*, 511 U.S. 825, 837 (1994) (holding that prison officials violate the Eighth Amendment when they have actual knowledge of a substantial risk of serious

harm to prisoners and fail to act reasonably to address that risk). The Fifth Circuit has explicitly applied that principle to class action claims, affirming injunctions in a prisoner class action requiring MDOC to remedy filthy cells and excessive heat on death row, even though no evidence was offered of medical injuries resulting from exposure to those conditions. *Gates v. Cook*, 376 F.3d 323, 339 (5th Cir. 2004) (holding that plaintiffs "[do] not need to show that death or serious illness has yet occurred to obtain relief. [They] must show that the conditions pose a substantial risk of harm to which MDOC officials have shown a deliberate indifference.").

Ten years after *Gates v. Cook*, there can be no doubt that it is proper to certify a class seeking injunctive relief pursuant to Rule 23(b)(2) when pervasive, system-wide deficiencies threaten an entire class of prisoners. Recently, in *Brown v. Plata*, 131 S. Ct. 1910 (2011), the Supreme Court affirmed a grant of relief to a state-wide class of tens of thousands of prisoners in multiple prisons, based on "systemwide deficiencies in the provision of medical and mental health care that, taken as a whole, subject sick and mentally ill prisoners in California to a *substantial risk of serious harm* and cause the delivery of care in the prisons to fall below the evolving standards of decency that mark the progress of a maturing society." *Id.* at 1926 n.3 (internal quotation marks and citation omitted) (emphasis added).

In the same term that it decided *Plata*, the Supreme Court also decided *Wal-Mart Stores, Inc. v. Dukes*, 131 S. Ct. 2541 (2011). In *Dukes*, the plaintiffs sought to certify a nationwide class on behalf of 1.5 million employees in over 3400 local stores alleging employment discrimination under Title VII. *Id.* at 2549-50. The Court refused to certify the class under Rule 23 (b)(2) because the plaintiffs had alleged no discriminatory employment policy or practice uniting the class. *Id.* at 2554. In contrast, Plaintiffs here present a traditional Rule 23(b) class: like the plaintiffs in *Plata*, they seek only injunctive relief from common policies and

practices that subject all prisoners to substantial risks of serious harm, relief that is equally applicable to all class members.

Post-*Dukes*, courts in the Fifth Circuit and elsewhere have certified classes of institutionalized persons in a variety of contexts. *See M.D. v. Perry,* 675 F.3d 832, 847 (5th Cir. 2012) ("*Perry I*") (noting that a case seeking only prospective relief for deliberate indifference may be certified under Rule 23(b)(2) if there are common questions of law or fact that do not require determination of entitlement to individualized relief, such as a claim that "the State engages in a pattern or practice of agency action or inaction – including a failure to correct a structural deficiency within the agency, such as insufficient staffing[.]"). Plaintiffs' claims fall squarely within the long line of institutional reform cases, including many post-*Dukes* cases, which the federal courts have found amenable to class treatment. *See, e.g., Parsons v. Ryan*, 754 F.3d 657, 678 (9th Cir. 2014) (approving certification of a state-wide class of prisoners regarding medical and mental health claims), *aff'g* 289 F.R.D. 513 (D. Ariz. 2013); *Stukenberg v. Perry*, 294 F.R.D. 7, 35 (S.D. Tex. 2013) ("*Perry II*") (certifying, on remand, class of foster children); *Jones v. Gusman*, 296 F.R.D. 416 (E.D. La. 2013) (certifying a settlement class of New Orleans jail detainees); *Kenneth R. ex rel. Tri-County CAP, Inc./GS v. Hassan*, 293 F.R.D. 254 (D.N.H. 2013) (certifying class of persons with serious mental illness institutionalized in state hospitals); *Henderson v. Thomas,* 289 F.R.D. 506 (M.D. Ala. 2012) (certifying class of HIV-positive prisoners certified regarding discrimination in prison conditions); *Butler v. Suffolk Cnty.*, 289 F.R.D. 80 (E.D.N.Y. 2013) (certifying class of jail detainees regarding conditions of confinement); *Olson v. Brown,* 284 F.R.D. 398 (N.D. Ind. 2012) (certifying a class of jail detainees); *Connor B. ex rel. Vigurs v. Patrick,* 278 F.R.D. 30, 34 (D. Mass. 2011) (rejecting a motion to decertify a class of children in state custody and finding that *Wal-Mart Stores, Inc. v.*

Dukes, 131 S. Ct. 2541 (2011) was "easily distinguishable"); *D.G. ex rel. Strickland v. Yarbrough*, 278 F.R.D. 635, 639 (N.D. Okla. 2011) (refusing to decertify a class of foster children in legal custody of state following *Dukes*); *Logory v. Cnty. of Susquehanna*, 277 F.R.D. 135, 143 (M.D. Pa. 2011) (certifying a class challenging a procedure routinely subjecting incoming jail detainees to delousing).[37]

As show below, Plaintiffs meet all the requirements for certification pursuant to Rule 23(b)(2).

I. Plaintiffs Satisfy the Numerosity Requirement of Rule 23(a)(1).

To meet the numerosity requirement of Rule 23(a), a class "must be so numerous that joinder of all members is impracticable." Rule 23(a)(1). A class with 40 or more members raises a presumption that the numerosity requirement has been satisfied. William B. Rubenstein, et al., Newberg on Class Actions, § 3.12 (5th ed. 2011). A district court has wide discretion to determine numerosity and the practicality of joinder. *See, e.g., In re Rodriguez,* 695 F.3d 360, 365 (5th Cir. 2012) (approving certification of class with approximately 125 class members); *Jones v. Diamond*, 519 F.2d 1090, 1100 (5th Cir. 1975) (approving certification of class comprised of 48 current jail detainees where class included future jail detainees); *Jack v. Am.*

[37] There are also numerous recent unpublished decisions certifying classes in institutional cases. *See, e.g., Decoteau v. Raemisch,* No. 13-cv-3399-WJM-KMT, 2014 WL 3373670 (D. Colo. July 10, 2014) (class of prisoners in administrative segregation); *Redmond v. Bigelow*, No. 2:13CV393DAK, 2014 WL 2765469 (D. Utah June 18, 2014) (class of prisoners); *Ashker v. Governor of California,* No. C 09-5796 CW, 2014 WL 2465191 (N.D. Cal. June 2, 2014) (class of prisoners confined in isolation); *Lyon v. United States Immigration and Customs Enforcement*, No. C-13-5878 EMC, 2014 WL 1493846 (N.D. Cal. Apr. 16, 2014) (class of immigration detainees at several facilities); *Hughes v. Judd*, No. 8:12-cv-568-T-23MAP, 2013 WL 1821077 (M.D. Fla. Mar. 27, 2013) (class of juveniles in custody); *Chief Goes Out v. Missoula Cnty*., No. CV 12-155-M-DWM, 2013 WL 139938 (D. Mont. Jan. 10, 2013) (class of juveniles, both pre-trial and convicted, confined in jail); *Indiana Protection & Advocacy Servs. Comm'n v. Comm'r, Indiana Dep't of Corr.*, No. 1:08-cv-01317-TWP-MJD, 2012 WL 6738517 (S.D. Ind. Dec. 31, 2012) (class of mentally ill prisoners confined in segregation at multiple prisons); *Rosas v. Baca*, No. CV-12-00428 DDP (SHx), 2012 WL 2061694 (C.D. Cal. June 7, 2012) (class of jail detainees challenging practice and custom of use of excessive force).

Linen Supply Co., 498 F.2d 122, 124 (5th Cir. 1974) (approving certification of class of 51 when class included "unnamed, unknown future" members).

Plaintiffs easily meet the numerosity requirement. The EMCF Class, defined as "all persons who are currently, or who will be confined at the East Mississippi Correctional Facility, ECF No. 1, Complaint ¶ 284, includes 1,197 prisoners.[38] The Mental Health Subclass, which consists of all persons who are currently, or will be, subjected to Defendants' mental health care policies and practices at EMCF, *id.* ¶ 300, includes at least 844 prisoners.[39] The Isolation Subclass, defined as "all persons who are currently, or will be, subjected to Defendants' policies and practices of confining prisoners in conditions amounting to solitary confinement at the East Mississippi Correctional Facility," *id.* ¶ 293, includes, at a minimum, approximately 150 prisoners at any one time.[40] The Unit 5 and 6 Subclass, defined as "all persons who are currently, or will be housed in Units 5 and 6 at the East Mississippi Correctional Facility," *id.* ¶ 307, includes considerably more than 150 prisoners at any given time.[41]

Accordingly, the EMCF class and each subclass satisfies the numerosity requirement for class certification.

II. Plaintiffs Satisfy the Commonality Requirement of Rule 23(a)(2).

To meet the commonality requirement, there must be questions of law or fact common to the class. Fed. R. Civ. P. 23(a)(2). It is not enough that class members suffer the same type of

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38 Ex. 1, Mississippi Department of Corrections, *Daily Inmate Population,* http://www.mdoc.state.ms.us/Research%20and%20Statistics/DailyInmatePopn/2014DIP/2014-09%20Daily%20Inmate%20Population.pdf (last accessed Sept. 12, 2014).

39 Ex. 2, Patients on Psych Meds. Because it is possible that not all Mental Health Subclass members are prescribed psychotropic medication, the actual size of the subclass may be larger than 844. Ex. 4, Kupers Rep. at 30 (estimating number of seriously mentally ill inmates at over 1,000).

40 Ex. 4, Kupers Rep. at 10.

41 Ex. 3, McGinnis/Roth Rep. at 7-8.

injury or have been subject to a violation of the same law; rather, a plaintiffs must identify at least one common contention for which a "determination of its truth or falsity will resolve an issue that is central to the validity of each one of the claims in one stroke." *Dukes*, 131 S. Ct. at 2551 (citations and quotation marks omitted). Post-*Dukes*, the federal courts have repeatedly certified 23(b)(2) classes in prison and other institutional reform cases. *See supra*.

For example, in *Parsons v. Ryan,* Plaintiffs brought a statewide class action on behalf of 33,000 prisoners alleging unconstitutional medical care, mental health care, and solitary confinement at ten separate prisons throughout Arizona. 754 F.3d at 662. As in the present case, the plaintiffs in *Parsons* alleged that the state's systemically deficient policies and practices subjected putative class members to a substantial risk of harm. The Court of Appeals for the Ninth Circuit, affirming class certification, held that these policies and practices presented questions common to all members of the class and subclass because "each of the policies and practices is unlawful as to every inmate or it is not." *Id.* at 678. Whether or not those policies and practices subjected putative class members to an unconstitutional risk of harm would be determined "in one stroke" without the need to make any individualized assessment of whether a potential class member had suffered any particular injury; commonality rested in the finding that *"*every inmate suffers exactly the same constitutional injury when he is exposed to a single statewide ADC [Arizona Department of Corrections] policy or practice that creates a substantial risk of serious harm." *Id.* Whether the state employed enough health care staff was a common question readily amenable to determination in one stroke: "Either ADC employs enough nurses and doctors to provide adequate care to all of its inmates or it does not do so; there is no need for an inmate-by-inmate inquiry to determine whether all inmates in ADC custody are exposed to a

substantial risk of serious harm by ADC staffing policies." *Id.* at 679-680 (citing *Perry II*, 294 F.R.D. at 45).

Similarly, on remand from the Court of Appeals' decision in *Perry I*, the district court certified a class of foster children in custody. *Perry II*, 294 F.R.D. at 35. The court noted that a potential class plaintiff must identify a common policy, practice or course of conduct that is the source of the alleged injury; absent official sanction, a policy can be identified on the basis of custom or consistent practice, or it can be based on the defendant's deliberate indifference. "The critical question here is whether the government has failed to respond to a need . . . in such a manner as to show 'deliberate indifference' to the risk that not addressing the need will result in constitutional violations." *Id.* at 26 (citations and internal quotation marks omitted). The court held that the plaintiffs were entitled to class certification because they had alleged a deprivation of a legally protected right (the defendants' deliberate indifference to or conscious disregard of a known and excessive risk to the plaintiffs' health or safety); identified a common policy or practice on the part of the defendants (caseworkers' overburdened workloads); presented evidence that this policy or practice might impair that legally-protected right; and identified common questions of law or fact that would resolve their claim (to what extent caseworkers were overworked; whether this overwork was significant enough to subject the class members to an unreasonable risk of harm; whether the State had sufficient mechanisms in place to mitigate those risks). *Id.* at 45.

All of Plaintiffs' claims readily meet the commonality requirement because each is based on systemic failures or structural deficiencies in policies and practices at EMCF which subject all members of the class or relevant subclass to a risk of serious harm. Determination of the truth or falsity of each claim of a systemic deficiency will resolve in one stroke an issue that is central to

the validity of each such claim. There is no need for an inmate-by-inmate inquiry to determine whether all inmates at EMCF are exposed to a substantial risk of serious harm by MDOC's policies.

Given that Plaintiffs' claims are based entirely on systemic, structural deficiencies in various conditions of confinement at EMCF, common questions of law and fact abound. Although the over-arching common question with respect to each claim is whether Defendants are deliberately indifferent to systemic deficiencies in the conditions of confinement that subject all class members and subclass members to a risk of serious harm, the common questions specific to each claim of the class and subclasses include, but are not limited to, the following:

Failure to protect and excessive force

- Whether a systemic defect in cell-door locking mechanisms subjects all class members to an unreasonable risk of serious harm (Ex. 6, Vail Rep. at 16-18); and
- Whether inadequate policies and practices on use of force subject all class members to an unreasonable risk of serious harm (Ex. 6, Vail Rep. at 19-53).

Deficiencies in sanitation and nutrition

- Whether systemic failure to make adequate cleaning materials available subjects all members of the class to an unreasonable risk of serious harm (Ex. 6, Vail Rep. at 10-12);
- Whether substandard lighting that fails to meet health and safety standards subjects all members of the class to an unreasonable risk of serious harm (Ex. 45, Skipworth Rep. at 6-7; Ex. 4, Kupers Rep. at 16-17; Ex. 6, Vail Rep. at 8);
- Whether failure to maintain the ventilation system subject all members of the class to an unreasonable risk of serious harm (Ex. 45, Skipworth Rep. at 10, 39-43);
- Whether failure to follow fire protection and safety practices subject all members of the class to an unreasonable risk of serious harm (Ex. 45, Skipworth Rep. at 6, 8, 26-27, 56);
- Whether failure to maintain effective pest control subjects all members of the class to an unreasonable risk of serious harm (Ex. 45, Skipworth Rep. at 12, 54-58, 60, 66, 70-72, 74); and

- Whether failure to ensure safety and sanitation of food preparation subjects all members of the class to an unreasonable risk of serious harm (Ex. 45, Skipworth Rep. at 14, 17, 78-80).

Deficiencies in medical policies and practices

- Whether failure to restrict clinicians to practice within the limits of their licensure subjects all class members to risk of serious harm (Ex. 30, LaMarre Rep. at 25);

- Whether failure to require daily screening of sick call requests for all prisoners, regardless of housing unit, to ensure triage for degree of urgency, subjects all class members to risk of serious harm (Ex. 5, Stern Rep. at 5-8; Ex. 6, Vail Rep. at 20; Ex. 30, LaMarre Rep. at 9-13).

The mental health subclass

- Whether failure to provide sufficient staffing levels for psychiatric coverage and adequate numbers of qualified mental health staff subjects all members of the mental health subclass to unreasonable risk of serious harm (Ex. 4, Kupers Rep. at 30-32);

- Whether failure to provide adequate supervision of mental health staff subjects all members of the mental health subclass to unreasonable risk of serious harm (Ex. 4, Kupers Rep. at 49-52);

- Whether inadequate training for security staff interactions with prisoners with mental illness subjects all members of the mental health subclass to unreasonable risk of serious harm (Ex. 4, Kupers Rep. at 52-54);

- Whether inadequate monitoring of patients on psychotropic medications subjects all members of the mental health subclass to unreasonable risk of serious harm (Ex. 4, Kupers Rep. at 43); and

- Whether systemic failures in maintaining mental health records subjects all members of the mental health subclass to risk of serious harm (Ex. 4, Kupers Rep. at 49; Ex. 45, Abplanalp Rep. at 20-21).

The isolation subclass

- Whether confining prisoners to prolonged solitary confinement in unremitting isolation and idleness subjects all members of the isolation subclass to risk of serious harm (Ex. 6, Vail Rep. at 8-9; Ex. 4, Kupers Rep. at 10-18);

- Whether failure to provide prisoners confined to isolation units with regular access to out-door exercise and showers subjects all members of the isolation subclass to risk of serious harm (Ex. 6, Vail Rep. at 8, 12-14; Ex. 4, Kupers Rep. at 21);

- Whether confining inmates in the isolation units in cells without functioning emergency call buttons subjects all members of the isolation subclass to unreasonable risk of harm (Ex. 30, LaMarre Rep. at 9; Ex. 4, Kupers Rep. at 20-21; Ex. 6, Vail Rep. at 20); and

- Whether systemic failure to perform 30-minute security checks on each inmate in the isolation units subjects all members of the isolation subclass to unreasonable risk of serious harm (Ex. 6, Vail Rep. at 19).

The Units 5 and 6 subclass:

- Whether systemic failure to meet minimum sanitation standards in Units 5 and 6 subjects all members of the isolation subclass to an unreasonable risk of serious harm (Ex. 6, Vail Rep. at 7-12).

III. Plaintiffs Satisfy the Typicality Requirement of Rule 23(a)(3).

To meet the typicality requirement, the claims of the named representatives must be "typical of the claims or defenses of the class." Fed. R. Civ. P. 23(a)(3). The typicality requirement is satisfied when the named representative's legal injury arises from the same practices affecting the rest of the class, even if factual differences exist. The test for typicality is not whether the claims of the named representatives are identical to the claims of other class members, but rather whether the named representatives' claims "have the same essential characteristics" as those of the putative class, *Stirman v. Exxon Corp.*, 280 F.3d 554, 562 (5th Cir. 2002), and whether they "possess the same interest and suffer the same injury" as other class members. *Gen. Tel. Co. of the Sw. v. Falcon*, 457 U.S. 147, 156 (1982), citing *East Texas Motor Freight Sys. Inc., v. Rodriguez,* 431 U.S. 395, 403 (1977); *see also Dukes,* 131 S. Ct. at 2552 (requiring that class members have suffered the same injury in the sense that their claim involves a common contention that is capable of class-wide resolution).

Each of the named plaintiffs for the EMCF Class and for each subclass is subject to the same conditions that affect all other class members. Thus the claims of the named Plaintiffs are typical of the claims of the class as whole. *See Perry II*, 294 F.R.D. at 45 ("The State's

caseworker policies and practices affect all children in the Texas PMC, including the named plaintiffs. Their claims are therefore typical of the class.").

IV. Plaintiffs Will Fairly and Adequately Represent the Interests of the Class.

The final requirement of Rule 23(a) is that the representative parties will fairly and adequately represent the interests of the class. Fed. R. Civ. P. 23(a)(4). Satisfying this requirement requires a consideration of "[1] the zeal and competence of the representative[s'] counsel and . . . [2] the willingness of the representatives to take an active role in and control the litigation and to protect the interest of absentees." *Stirman v. Exxon Corp.,* 280 F.3d 554, 563 (5th Cir. 2002); *accord Berger v. Compaq Computer Corp.*, 257 F.3d 475, 479 (5th Cir. 2001). Plaintiffs meet these requirements.

The named representatives in this case will fairly and adequately represent the class and subclasses. They are represented by highly competent counsel who have and will continue to represent them and the class and subclasses with zeal and competence. *See* Section VI *infra.* The named representatives themselves are willing and able to take an active role in the litigation and to protect the interests of the absentees. *See* Ex. 69, Declaration of Jermaine Dockery, Mar. 29, 2014, ¶ 13; Ex. 70, Declaration of Jeffery Covington, Sept. 10, 2014, ¶ 4; Ex. 71, Declaration of Joseph Osborne, Sept. 11, 2014, ¶ 10; Ex. 72, Declaration of Phillip Fredenburg, Sept. 11, 2014, ¶ 9; Ex. 73, Declaration of John Barrett, Sept. 11, 2014, ¶ 7; Ex. 74, Declaration of Derrick Hayes, Sept. 10, 2014, ¶ 9; Ex. 75, Declaration of Alvin Luckett, Sept. 11, 2014, ¶ 4; Ex. 76, Declaration of James Vann, Sept. 11, 2014, ¶ 6. Plaintiffs for the class and for each of the subclasses share with other putative class members a common interest in ensuring that prisoners confined at EMCF are protected from the dangerous and inhumane conditions described in the Complaint. There is no suggestion of collusion between the named representatives and any of

the Defendants, nor are there other conflicts that could hinder the named representatives' ability to pursue this lawsuit vigorously on behalf of the class.

V. The Requirements of Rule 23(b)(2) are Satisfied Because Defendants Have Acted, or Failed to Act, on Grounds that Apply Generally to the Class, so that Final Injunctive Relief Is Appropriate to the Class as a Whole.

In addition to satisfying Rule 23(a), a class action must meet the requirements of one of the provisions of Rule 23(b). This case fits squarely within Rule 23(b)(2), which authorizes class certification where "the party opposing the class has acted or refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class as a whole."

Plaintiffs have alleged an unreasonable risk of harm to all class and subclass members from the conditions of confinement at EMCF due to systemic defects in Defendants' policies and practices to which all class members are subjected. All members of the proposed class and subclasses here are confined in the same facility, in the custody of the same institutional policy-makers, and subjected to the same injurious institutional policies and practices. Plaintiffs seek no individual relief for themselves or for any other individual class member; they seek only to require Defendants to reform their defective policies and institution-wide practices at EMCF to meet minimal constitutional standards and thereby remediate the risk of serious harm to which all members of the class and the subclasses are subjected. Thus, the same final injunctive relief would be appropriate for all members of the class and for all members of relevant subclass on the issues for each subclass.

Plaintiffs' claims are clearly susceptible to common specific relief so that final injunctive relief would be appropriate for the class as a whole. In fact, the Fifth Circuit has approved the very kind of class-wide relief that Plaintiffs seek here for each of their claims. *See, e.g, Gates*, 376 F.3d at 328, 338 (affirming injunctions against MDOC on behalf of inmates on death row,

requiring, among other things, that all inmates be provided cleaning supplies and with electric fans, ice water, and daily shower during hot weather; mosquito eradication efforts; the repair of window screens and of toilets; upgrade of lighting in cells; ensuring that private medical services vendor complies with the ACA and MCCHC medical and mental health standards; and ordering that inmates with severe mental health illnesses be housed apart from other inmates).

The Court need not, at this stage, determine what remedy Plaintiffs will be entitled to if they prevail on the merits of their claim. *Perry II*, 294 F.R.D. at 48. "Rather, the Court must determine that the Plaintiffs' claim is one that is susceptible to common, specific relief." *Id.* at 47. The Court may, of course, consider equitable remedies other than those suggested by Plaintiffs: equitable relief is flexible and is intended to be tailored to the circumstances. *Id.* at 48, citing *Lemon v. Kurtzman*, 411 U.S. 192, 199–201 (1973); *Hecht Co. v. Bowles,* 321 U.S. 321, 329–30 (1944). The following proposals, accordingly, are merely examples of the remedies that the Court might determine to be appropriate if Plaintiffs prove their claims at trial:

Deficiencies in correctional practices (excessive force and failure to protect)

- Require replacement of cell doors with defective locking mechanisms, or prohibit the housing of inmates in cells with defective locking mechanisms;
- Provide training to correctional staff on interaction with seriously mentally ill inmates;
- Revise the policy regarding use of force and require retraining of security staff on use of force;
- Require video recording of all planned use of force; and
- Require prompt decontamination of prisoners subjected to pepper spray.

Deficiencies in sanitation and nutrition

- Require that housing units be cleaned on a regular basis;
- Prohibit confinement prisoners in cells with broken toilets;

- Require use of standard safety precautions to clean blood spills;
- Require upgrades of lighting levels to meet health and safety standards and eliminate electrical hazards;
- Require regular maintenance of the ventilation system;
- Require adherence to standard fire protection and safety practices;
- Require effective pest control;
- Implement policies to ensure safety and sanitation of food preparation; and
- Require the provision of food that supplies adequate nutrition and is sufficient to maintain healthy body weight.

Deficiencies in medical policies and practices

- Restrict clinicians to practice within the limits of their licensure;
- Require daily screening and prompt triage of sick call requests for all prisoners;
- Ensure access to the range of necessary outside medical services;
- Ensure access to infirmary-level care, chronic care, urgent care, and emergency care;
- Develop a policy to ensure accurate and complete records of medication administration; and
- Require development of a meaningful quality assurance program.

Deficiencies in mental health policies and practices

- Upgrade staffing levels for psychiatric coverage;
- Upgrade supervision of mental health staff;
- Provide adequate training for security staff who manage prisoners with mental illness;
- Ensure access to in-patient, intermediate, and out-patient levels of mental health care;
- Implement a program for psychiatric crisis intervention and suicide prevention;
- Ensure adequate monitoring of patients on psychotropic medications;
- Implement a policy to ensure informed consent for treatment with psychotropic medications;

- Implement a policy to ensure accurate complete mental health records are maintained; and

- Prohibit the housing of prisoners with serious mental illness in the isolation units.

Conditions affecting the isolation subclass

- Ensure that minimum environmental standards are adhered to in the isolation unit;

- Ensure that inmates in isolation have adequate access to medical and mental health care;

- Implement a program to ensure that prisoners who must be confined apart from others are not relegated to prolonged unremitting isolation and idleness;

- Require that prisoners confined to isolation be provided regular access to daily out-door exercise and at least thrice-weekly showers;

- Revise and implement relevant policy to require that inmates in the isolation units have regular access to telephones for calls to family;

- Prohibit confining inmates to cells in the isolation units that do not have functioning emergency call buttons; and

- Enforce the policy requiring security checks every 30 minutes on each inmate in the isolation units.

VI. The Court Should Designate Plaintiffs' Counsel As Class Counsel.

Rule 23(g) requires that the district court appoint class counsel for any class that is certified under Rule 23. The lawyers appointed to serve as class counsel must "fairly and adequately represent the interests of the class." Fed. R. Civ. P. 23(g)(1)(B). The appointed class counsel is to be listed in the Court's class certification order. *Id.* Plaintiffs request that if the Court certifies this case as a class action, it appoint as class counsel the attorneys who are currently representing them in this litigation: The American Civil Liberties Union National Prison Project, the Southern Poverty Law Center, the Law Offices of Elizabeth Alexander, and Covington and Burling LLP. One attorney for each of the organizations and firms serving as counsel in this action has filed a declaration with this motion attesting to the facts set forth

below. *See* Ex. 77, Declaration of Margaret Winter; Ex. 78, Declaration of Jody E. Owens, II; Ex. 79, Declaration of Elizabeth Alexander; Ex. 80, Declaration of Mari K. Bonthuis.

The rule identifies four factors that the Court must consider in appointing class counsel: (1) "the work counsel has done in identifying [and] investigating potential claims in the action;" (2) "counsel's experience[ing] in handling class actions, other complex litigation, and the types of claims asserted in the action;" (3) counsel's knowledge of the applicable law; and (4) "the resources that counsel will commit to representing the class." Fed. R. Civ. P. 23(g)(1)(A). Plaintiffs' counsel fully satisfy these criteria.

Plaintiffs' counsel have worked for over four years to identify and investigate the claims in the action. Ex. 78, Declaration of Margaret Winter ¶ 7. They have conducted multiple expert tours of EMCF, interviewed scores of putative class members and other potential fact witnesses, reviewed court records and medical records, and engaged in extensive legal research. *Id.* With regard to the second and third factors, Plaintiffs' counsel have extensive experience in handling class actions on behalf of prisoners and institutionalized persons, including a number of successful class action lawsuits on behalf of Mississippi prisoners, as well as other complex litigation, and they are knowledgeable with regard to the applicable law. Finally, Plaintiffs' litigation team has committed and will continue to commit to the representation of this class significant staffing and material resources, including the retention of highly qualified experts. Plaintiffs' counsel fully satisfy the criteria for class counsel set forth in Rule 23(g), and Plaintiffs respectfully request that the Court appoint them in its class certification order.

CONCLUSION

For the above reasons, Plaintiffs request that the Court find that Plaintiffs' proposed class and subclasses meet the requirements of Fed. R. Civ. P. 23(a) and 23(b)(2); certify the

designated class and subclasses; and, pursuant to Fed. R. Civ. P. 23(g), appoint current counsel for Plaintiffs as counsel for the class and subclasses.

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