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

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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, Mft Repor. 12, 20140 Td[(t)- accheft

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

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

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10 *See infra* Section III.

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

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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.

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."

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.

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 o

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

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 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 analysi(r)3(i44 0 Td[(u)2(r)3(3 Td[(of

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.

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 bar 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.

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[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.

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

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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]

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 Tw 11 Tw 0.33 0 Td[(r)eea1(t)-2(r)32CBDC ii6e9-2(un 0.33 0 Td Tdti4(r)3Tc 0.96 428.

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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-following note appeared *verbatim* in a patient's chart on

> 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.

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 psychi0(ai)-16(nTc 0.22 Twp)*-6(h)-4(eal)-6te.si..t.Twp4(t)]TJ07BD-6(tl)-2(l)-or ond he k-7(e)4(d)-1hmsp,2(n)-

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

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.

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

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-

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,bNU.[(9;)-2( )]Td[Ex2,.3 T7((2,p-0.002 Tpn 2( )],l

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

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[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.

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 [illegible]

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

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

20. Prisoners must bang on their doors to try to obtain medical attention in case of a medical or

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

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.*

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[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. MohiTw - 201-0.002TdS/TT0 1 Tf36.76 0 Tdm8 0 Td[(KM)-3(T
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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 "

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

- 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 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 absenteill f0eruTc 0 dcif 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 relictei, s7aae1(,)105ppo6(me)4(n)-elin-elgedeclaao1(a)-4 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) (h)ac6 -21-6(o)-

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- 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;

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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'