Exhibit 2

Expert Report of Eldon Vail

***Dockery et al. v. Fisher et al.*, No. 3:13-cv-00326-TSL-JMR**

Submitted: December 29, 2016

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I. ASSIGNMENT

1. Plaintiffs' counsel retained me to evaluate and offer my opinion regarding the safety and security of prisoners confined at the East Mississippi Correctional Facility (EMCF), in Meridian, Mississippi.

II. QUALIFICATIONS

2. I am a former correctional administrator with nearly 35 years of experience working in and administering adult institutions.

3. Before becoming a corrections administrator, I held various line and supervisory level positions in a number of adult prisons and juvenile facilities in the State of Washington, in addition to serving as a Juvenile Parole Officer and pre-release supervisor. I have served as the Superintendent (Warden) of three adult institutions, including facilities that housed maximum, medium, and minimum-security inmates.

4. I served for seven years as the Deputy Secretary of the Washington State Department of Corrections (WDOC), where I was responsible for the operation of prisons and community corrections. I briefly retired, but was asked by the then-Governor of Washington, Chris Gregoire, to come out of retirement to serve as the Secretary of the Department of Corrections in the fall of 2007. I served as the Secretary for four years, until I retired again in 2011.

5. As a Superintendent, Assistant Director of Prisons, Assistant Deputy Secretary, Deputy Secretary, and Secretary, I was responsible for the safe and secure operations of adult prisons in the State of Washington, a jurisdiction that saw and continues to see a significant downward trend in prison violence.

6. As the Superintendent of McNeil Island Corrections Center, and as a result of legislation, then-Secretary Chase Riveland charged me with designing and opening a new program for mentally ill inmates within the WDOC. I did so in collaboration with leaders from a number of departments from the University of Washington (UW) who informed the design and operation of the two units, one medium security and one maximum security, devoted to this population.

7. That collaboration continued for nearly 20 years as UW staff came to assist the Department in improving our treatment of mentally ill inmates throughout the system. Our focus was on moving inmates out of high security bed placement whenever possible.

8. As Assistant Director for Prisons, my responsibilities included oversight of mental health programs for all prisons in the State of Washington. Part of this assignment was to oversee the design of a capital project that more than doubled the size of Washington's largest program for the mentally ill. Taking what I had learned from my experience on McNeil Island, my primary focus was to design a housing

continuum for the mentally ill that did not rely on over-classifying individuals as maximum security, and instead moved them through less restrictive levels of prison housing. We developed a design that allowed inmates to move through progressive custody levels from maximum to minimum security and to avoid segregation whenever possible.

9. During my tenure as the Deputy Secretary, we created a specialized high-security treatment unit for the mentally ill inmates, where the inmates could be safely housed without significant levels of isolation and also receive robust treatment from mental health professionals. This unit was separate and apart from regular segregation units.

10. As Deputy Secretary and later as Secretary, I focused on providing proper treatment for the mentally ill in prison on a system-wide basis.

11. My opinions are based upon my substantial experience running correctional institutions and presiding over a statewide prison system for more than a decade. I have spent considerable time working to provide for the proper custody and care of the mentally ill sentenced to prison. I am experienced in sound correctional practice.

12. Since my retirement I have served as an expert witness and correctional consultant for cases and disputes over 40 times in multiple jurisdictions—state, local and federal. As an expert witness and consultant I have been called upon to address security issues and conditions of confinement in adult prisons and jails across the country. Many of those cases involved the care, custody and conditions of confinement for mentally ill inmate patients, including in the states of California, Arizona, Delaware, New Jersey, and Illinois.

13. I recently completed an assignment for the United States Department of Justice, investigating the treatment of gay, lesbian, and transgender inmates in the Georgia Department of Corrections. Earlier this year, I completed a report for the Sacramento County Sheriff, making recommendations for the improved treatment of mentally ill prisoners and the overuse of segregation in their jails. I am also working for the New York ACLU and their pro bono partners, tracking compliance with a settlement agreement achieved with the New York Department of Corrections and Community Service regarding the conditions of confinement and overuse of segregation in that state's prison system.

14. A true and correct copy of my current resume is attached as **Exhibit 1** to this report, which lists my work experience, publications in the last 10 years, and service as an expert witness and correctional consultant, including prior trial and deposition testimony given in the last four years.

III. COMPENSATION

15. My billing rate for work on this case is $150 per hour.

IV. FOUNDATION FOR EXPERT OPINIONS

16. In forming my opinions I considered documents provided by the parties including over 100 videos and/or photographs related to use of force (UOF) events and/or incidents of violence within EMCF; over 500 Management and Training Corporation (MTC) Extraordinary Occurrence Reports (EORs) documenting UOF events, contraband findings, self-inflicted wounds, as well as inmate fights and assaults; monthly reports submitted by MTC to the Mississippi Department of Corrections (MDOC); correspondence and emails from the MDOC Contract Monitor; a sample of unit log books from EMCF; grievance records; records of inmates' treatment while in segregated confinement; and, a variety of additional documents submitted by the parties. The vast majority of these documents date from 2014 – 2016.

17. A complete list of the materials I relied upon in this matter is attached hereto as **Exhibit 2**, and may be referred to in footnotes and/or other references within this report.

18. In addition to the documents reviewed, I visited EMCF on June 22 and June 23, 2016 where I inspected the living units and had private interviews with 16 inmates. I spoke with several other inmates at their cell fronts.

19. In June 2014, I authored my first report regarding the safety and security of prisoners in EMCF. A true and correct copy of that report, which I have reviewed and relied upon, is attached hereto as **Exhibit 3**. That report was based upon a 4-day inspection of the facility that took place between March 31, 2014 – April 3, 2014, as well as a review of documents relevant to that time. My primary conclusion in that report was, "East Mississippi Correctional Facility is an extraordinarily dangerous prison. All prisoners confined there are subjected on a daily basis to significant risk of serious injury."[1]

20. Based upon my review of more recently produced documents, interviews with inmates, and another tour of the EMCF facility, two years after my first report was written, my opinion regarding the security and corrections environment at EMCF has not changed. My current report is consistent with, validates, and extends, the findings of my previous report. EMCF remains an extraordinarily dangerous prison where prisoners are subjected to significant risk of serious injury or harm on a daily basis.

21. My work on this matter is ongoing. This report summarizes my current opinions given the available information I have reviewed to date. It is my understanding that a number of relevant documents requested by Plaintiff's counsel have either just been received or have yet to be received. I reserve the right to modify or supplement my analyses and opinions if additional information becomes available.

[1] *Dockery v. Fisher*, Expert Report of Eldon Vail (June 16, 2014), at ¶19

V. SUMMARY OF OPINIONS

22. EMCF is and remains a very dangerous prison. Inmates housed there are at significant risk of serious harm.

23. MTC has received a steady stream of information from the MDOC Contract Monitor documenting deficiencies in the operation of EMCF yet there has been very little follow up by MTC to correct these deep and systemic problems. Despite having knowledge that MTC fails to correct the problems, MDOC has failed to hold MTC accountable in a manner that would result in improvements to the operation of EMCF and would make it a reasonably safe facility.

24. EMCF authorities are not in control of the institution. There are too few staff for employees to feel safe, and they have insufficient training and experience to manage a population of mentally ill or close custody inmates, many of whom belong to prison gangs. To a large extent inmates control the facility. Violence, often driven by the power and influence of gangs, is widespread.

25. The prevalence of contraband in the prison is alarming, creating substantial risk for both inmates and the staff.

26. Inmates in segregation (and in other parts of the prison) are subjected to avoidable use of force events. The resulting uses of force that should never have occurred create a climate that is extremely stressful for both staff and inmates and risks triggering ongoing cycles of violence.

27. Conditions in the segregation units do not meet contemporary standards. MTC fails to meet some of the most basic elements of MDOC segregation policy and as a result, the risk of harm to the inmates is increased.

28. EMCF makes little or no effort to keep mentally ill inmates out of segregation despite overwhelming evidence that such placement exacerbates the symptoms of the mentally ill. Too often the mentally ill simply languish in segregation, committing acts of self-harm, acts for which they are frequently punished. In effect, inmates are punished for their mental illness.

29. EMCF is primarily a prison for mentally ill inmates. In my experience as a corrections administrator, and based on the documents I have reviewed related to the provision of mental healthcare at EMCF, my inspection of EMCF, and my interviews with inmates, very little mental health treatment is being provided to the mentally ill population beyond medication.

VI. OPINIONS

A. Deficiencies in the Operation of EMCF are Significant, Persistent, and Well Known to Prison Administrators

30. EMCF has had an on-site Monitor from the MDOC since before I wrote my first report in 2014. The Monitor is an MDOC employee who, by state statute, "shall be responsible for monitoring all aspects" of privatized facilities.[2] From the records available, the Monitor appears to have had unfettered access to the operation of EMCF.[3] The Monitor has produced a steady stream of reports regarding EMCF's performance.

31. For my previous report, I did not receive many documents related to the Monitor's work. For this report, I received and reviewed much more information and documentation about the work of the Monitor, including some weekly inspection reports, a complete set of monthly inspection checklists completed by the Monitor that date from March 2014 – March 2016, and emails sent by the Monitor to MTC and MDOC administrators.[4] I attach as **Exhibit 4**, an example of the checklist used by MDOC as part of their monthly report, which is used to evaluate MTC and EMCF's compliance with policies, including those related to staffing and inmate supervision.[5] It is clear that the Monitor has consistently pointed out some of the issues and problems that make EMCF a dangerous prison. What is rare in the documents I have received is any written follow up to the findings of the Monitor by MTC, or any consistent progress to correct those problems.

32. As I outline in detail below, the Monitor's reports to MDOC and MTC officials have consistently documented serious problems in EMCF's general population and segregation units, including many that are longstanding and persistent ones. But, the problems go unfixed.

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[2] MS Code § 47-5-1223 (2015)

[3] I believe there has been a single Monitor in place at EMCF, but the person serving that function has changed once during the time this report covers.

[4] The Monthly Inspection Checklists are referenced throughout this report and can be found at: MDOC-CON-00000332–347 (March 2014); MDOC-CON-00000396–411 (April 2014); MDOC-CON-00000490–506 (May 2014); MDOC-CON-00000549–564 (June 2014); MDOC-CON-00000614 –629 (July 2014); MDOC-CON-00000679–695 (August 2014); MDOC-CON-00000743–758 (September 2014); MDOC-CON-00000788–803 (October 2014); MDOC-CON-00000855–870 (November 2014); MDOC-CON-00000933–949 (December 2014); MDOC-CON-00004927–4914 (January 2015); MDOC-CON-00005002–5018 (February 2015); MDOC-CON-00005104–5169 (March 2015); MDOC-CON-00005223–5237 (April 2015); MDOC-CON-00005321–5340 (May 2015); MDOC-CON-00005393–5410 (June 2015); MDOC-CON-00005481–5494 (July 2015); MDOC-CON-00005575–5591 (August 2015); MDOC-CON-00005681–5695 (September 2015); MDOC-CON-00005787–5863 (October 2015); MDOC-CON-00005969–5984 (November 2015); MDOC-CON-00006038–6053 (December 2015); MDOC-CON-00000023–38 (January 2016); MDOC-CON-00000096–111 (February 2016); MDOC-CON-00000195–210 (March 2016)

[5] *See* MDOC-CON-00000195–210

33. The Monitor's reports from December 2014 and July 2015 are illustrative. In December 2014, for example, the Monitor sent MDOC officials a list of problems that she had been reporting to MTC administrators since September 2014, but that were still ongoing.[6] Some highlights from that list for Units 1–4, the general population units, included:

- Windows/doors covered
- Count not being conducted according to policy
- Security checks not being conducted
- Pods not being monitored by staff
- Offenders are issuing the trays in the pods
- Case managers are not seeing offenders according to policy
- Disciplinary not being conducted according to policy
- Offenders are not getting chemicals to clean cells/pods daily
- Showers not being cleaned
- Maintenance issues not being completed

Some of the items on the list for Units 5 and 6, which include the segregation units, were similar:

- Windows/doors covered
- Recreation not being conducted according to policy
- Counts not being conducted according to policy
- Security checks not being conducted according to policy
- Staff not manning pods
- Offenders not having access to case managers according to policy
- Supervisors/Wardens/unit managers making rounds but not addressing any offender issues

The Monitor ended the list with the comment: "I have been advised monthly that these issues would be taken care of but as of today, 12/30/14, we still have the same issues, when will they be taken care of[?]"

34. In July 2015 the Monitor similarly wrote to the Warden, again expressing concern about the number of issues she had identified that had not yet been addressed by prison staff. She began her email by saying: "I have address [sic] these serious issues on several occasion without a positive response other than 'I [will] take care of it.' Well it has not been taken care of and I don't think the issues will take care of themselves."[7] Among the unresolved issues listed by the Monitor were:

- Gang members working in the segregation units . . . I am being told they can control the units

[6] MDOC-CON-00002261–2262
[7] DEF_ESI_0006171

- Staff assigned to the units are not remaining on their posts; leaving the pod unsupervised
- Security checks are not being conducted
- Offenders are running the units as they wish

The Monitor noted: "These issues are all over EMCF but the [segregation] units are the worst." She ended her note by saying: "Please be advised this is not personal[;] it is part of my job to report when policy is not being followed and I have been talking [about] these issues for weeks."

35. Whether provided by the reports from the Monitor or in letters from inmates, many of the deficiencies in the operation of EMCF have been called out time and again to MTC and MDOC administrators. As I document in this report, those known deficiencies create dangerous conditions for the inmates (and sometimes for the staff) at EMCF.

1. Counts at EMCF are Not Conducted Properly

36. There is not much that is more fundamental in corrections than accurately and correctly counting inmates. The primary responsibility of any prison is to make sure the inmates stay confined inside the secure perimeter of the institution. You make sure the inmates are still confined by regularly and accurately counting them to make certain they are still there. To quote MTC's own training materials regarding counts:

- The primary responsibility of the institution is to protect the citizenry by maintaining custody and control of the inmates/detainees confined within the facility.
- Inmate/detainee counts ensure that all inmates/detainees are alive, in their proper place and no one has escaped.[8]

37. But inmates at EMCF are not always counted properly. In the monthly MDOC On-Site Monitoring Worksheet for August 2014,[9] in a finding of non-compliance, the Monitor said: "Count being conducted improperly, inmates are in the wrong cell."[10] The finding was emphasized by the Monitor twice more in the same report where she says: "Offenders are in the wrong cell."[11]

38. Unfortunately, the problem of counts not being conducted properly is a recurring one at EMCF. In fact, this very same problem was identified by the Monitor on every checklist from May 2014 – March 2016, meaning that it was not being corrected by MTC, despite being identified by the Monitor every month for nearly two years. Incredulously, each time the Monitor identified MTC's non-compliance

[8] MTC077100
[9] MDOC-CON-00000630 - 00000695
[10] MDOC-CON-00000684
[11] MDOC-CON-00000684

with conducting counts properly, the comment came with either a specific due date for correction or just "ASAP." But as far as I know, the problem has not yet been fixed.[12]

39. Specifically, the Monitor has regularly found that EMCF is non-compliant in having staff "conduct formal count at least once per 8 hour shift/3x per day." A formal count is defined by MDOC policy as "Scheduled Institutional counts that are logged in Unit Registers for forwarding to the Area Control Centers".[13]

40. Similarly, since April 2014 through March 2016, the Monitor's inspection sheets also show non-compliance with respect to two other ways counts should be conducted:

- Face to photo count as necessary
- Each offender positively identified during count

41. But as the Monitor noted on the April 2015 checklist, among others, the ability to make these necessary identifications is impeded by the fact that "staff do not take items down that are hanging therefore they cannot see in the cell to verify offenders."[14] I address the issue of obstructed cell windows later in this report, but it is important to note here that if officers aren't regularly and routinely looking into inmates' cells, something that has to be done during counts, they may not be able to detect that the correct inmates are not in their assigned cells, a problem that persists at EMCF.

42. Finally, during my inspection of the facility in June 2016, inmates I interviewed informed me of one other way counts are not properly conducted at EMCF, telling me sometimes the inmates conduct them. Inmates told me that since officers do not routinely stay in the units and supervise the inmates, it is their opinion that many officers do not feel comfortable actually being in the units and therefore rely on the inmates to keep the peace. It was not a question I asked, but an observation that was offered to me by the inmates as a concern about the operation of the prison and their own safety. It was also an observation made by the Monitor in July 2015 when she wrote to the Warden: "Offenders are running the units as they wish."[15]

43. Typically, the inmates explained, during count time the officers come into the unit and ask the inmates if everyone is there. The officers then report the results given to them by the inmates as the accurate count. The inmates informed me that this was a routine occurrence, but also said the practice depended on the shift, with the officers working afternoons and nights more reliant on inmates to help with the counts. It is confirmed from the analysis of shift rosters that I address later in this report that the

[12] MDOC-CON-00000792
[13] AG 4705
[14] MDOC-CON-00005223–5237
[15] DEF_ESI_0006171

afternoon shift sometimes has fewer staff to supervise the units than does the day shift.

44. The problem of inmates conducting the counts was further documented in a letter dated July 23, 2015, and sent by an inmate to Commissioner Fisher. In that letter the inmate said (among several other concerns he was attempting to bring to the attention of the Commissioner): "EMCF officials are allowing inmates to operate this Facility, including inmate body counts – EMCF officials just haven't given inmate[s] the [roster] and a pair of handcuff[s], (yet!) I assume."[16]

45. One consequence to which EMCF's lax attitude towards counts contributes was described to me during my private interviews with inmates, when some of them told me that inmates are sometimes able to control cell assignments. One inmate told me "nobody is in the right cell." Another told me "cell assignments come from the gangs." Another told me that inmates make the cell assignments. Yet another told me you can change your cell assignment in the general population units without staff approval. The claims were verified in some examples made available, as I document later in this report. If inmates believe that staff are not always in control of and/or knowledgeable of correct cell assignments, it is yet another message to the inmate population that authority in the institution is based on the power of the inmate population and not the authority of prison officials. Proper control of the prison is once again eroded, placing inmates and staff in danger.

46. Another consequence is that if officers are not looking into cells and inmates are sometimes doing the counts, the likelihood of the security of the cells being breeched increases exponentially. That's exactly what happened on July 5, 2015, when at 7:30 a.m., it was discovered during the morning inner perimeter check (a security check on the grounds of the prison) that a window had been cut out of Cell 102 in Unit 6A. On investigation, an inmate was found occupying Cell 102, even though that inmate was actually assigned to Cell 201 and should have been in that cell all night. There is no detail in the incident memo documenting exactly how long that inmate had been in Cell 102 before he was discovered, though report does cite the inmate saying that "[t]he offenders on the pod asked him to moved [sic] downstairs last night to ensure no one else moved inside cell 102 and also promised [him] a bag of tobacco."[17] That the inmate was not discovered until the morning is only understandable if the officers are not checking to see if the inmates are in the right cell. If officers are not looking into cells and inmates are sometimes doing the counts, the likelihood of the security of the cells being breeched increases exponentially. Security was in fact breeched in this case, to the extent that a window had actually been cut out of the cell.

47. MTC has some reasonably good curriculum to instruct officers in how to do counts which emphasizes the critical point of why counts must be conducted correctly.[18]

[16] MDOC-CON-00001042
[17] DEF_ESI_0008921
[18] *See* MTC077099–77125

But more than just how counts are conducted, with respect to who conducts them, in all my years working in corrections, I have never heard of a prison where control by the staff has been so eroded that the inmates are doing the counts. This is a very serious problem reflecting several concerns, not the least of which is the accountability of those charged with managing the prison and their charge to do all they can to keep inmates, staff, and the community safe.

2. Officers' Views Into Cells At EMCF Are Often Obstructed

48. MTC has a handbook for inmates, describing the rules for daily living at EMCF and the general operation of the prison.[19] Every Monitor's checklist, from March 2014 – March 2016, reports that MTC is non-compliant with the item, "Staff aware of handbook content and follow procedures." This is usually followed by a comment such as, "Rules according to inmate handbook are not followed."[20]

49. Two related rules in the Handbook that I believe are very important state:

- Inmates will not be allowed to tape, glue, or otherwise affix any item to housing unit doors, windows, walls, bunks, lockers, or other fixtures.
- Clothing, towels, etc., will not be hung on any fixture or block any exterior window or cell door window. No items are to be hung so as to block the view of housing officers.[21]

50. It is critical for officers to be able to quickly and routinely identify what is going on with inmates in their cells. When a rule this fundamental is not regularly enforced, it sends the message to the inmates that rules do not matter and that they are left to fend for themselves since the officers cannot control the basic expectations for inmates in the living units. Again, I emphasize that this issue is critical because, if officers aren't regularly and routinely looking into the cells, they may not detect inmates who have been assaulted or inmates who are engaged in acts of self-harm (later in this report, records I discovered document relevant examples of this problem). Nor as I described above, will they be able to conduct an accurate count.

51. Despite these facts, it is clear that officers' blocked views into inmates cells is a persistent and ongoing problem at EMCF that creates danger for both staff and inmates. From at least October 2014 – March 2016, the Monitor has continually reported this problem in the basic operation of the living units at EMCF, often with the comment: "Staff do not take items down that are hanging therefore they cannot see into the cell to verify offenders."[22]

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[19] *See* MDOC-CON-00004036–4097
[20] MDOC-CON-00000205
[21] MDOC-CON-00004044
[22] *See, e.g.*, MDOC-CON-00000792

52. During my inspection of EMCF in June 2016, I also witnessed the problem of obstructed cell views when I attempted to look into inmates' cells. In both the general population units and in the segregation units, I was unable to see into some inmates' cells. This violation is so fundamental that I was somewhat shocked to find it during my expert inspection. Typically, such obvious problems are addressed and eliminated before outside visitors arrive. The fact that it was not addressed reveals the depth of dysfunction at EMCF. It is clear that it is a persistent and ongoing problem at EMCF that creates danger for both staff and inmates.

3. Significant Problems with Locking Mechanisms at EMCF

53. Until mid-September 2016, when the facility was closed, MTC operated another prison in Mississippi for the MDOC, called Walnut Grove Correctional Facility ("Walnut Grove"). That facility, which was placed under a Consent Decree in 2012, had a problem with unsecure cell doors. In June 2015, Judge Carlton Reeves said the following on the issue:

> - Often a topic of concern, the locking mechanism on the cell doors at Walnut Grove were easily compromised by inmates, which thwarted staff's ability to secure and protect. It is impossible for Defendant to provide protection from harm in a facility where inmates are aware that they can freely escape their cells.
> - It is foreseeable that inmates will continue to unlock cell doors at their own liberty. Instructing guards to check doors each time they open and close is only a short-term and impracticable solution that does not rectify the problem. It also places too much responsibility, in an area where mistakes can be fatal, on human error. The only guaranteed remedy is to fix the doors, and to date, Defendant has only done so in *some* of the units.[23]

54. But even as the very dangerous problem of unsecure cell doors was being highlighted for MDOC and MTC with respect to another one of their jointly operated facilities, it was being ignored, or at least left uncorrected on a systemic level, at EMCF.

55. In fact, in my June 2014 report in this case, I wrote about this very problem at EMCF:

> Adding enormously to the dangers and stress experienced by those confined to the segregation units at EMCF—and also the dangers and stress experienced by those who work in the units—is the fact that the doors to the individual cells in the

[23] *Depriest, et al. v. Walnut Grove Correctional Authority, et al*., Civil Action No. 3:10-cv-663-CWR-FKB, Order at 26–27 (S.D. Miss. June 10, 2015) (Reeves, J. presiding)

> segregation units are not secure. Inmates can successfully block their full closure.[24]

Records generated since that report was written demonstrate the point that unsecure cell doors and locks on recreation cages create significant risk to inmates and officers in the form of assaults and unnecessary and completely avoidable use of force events. Inmates at EMCF, in the segregation units, and also elsewhere in the prison, are successfully and too easily able to manipulate, or "rig," their cell doors to prevent their full and secure closure. While the examples offered below do not and should not excuse the behavior of the inmate (or any inmate) who attempts to "rig" his cell door, it is inexcusable for MTC to fail to take the steps necessary to correct this long-standing problem at EMCF. As Judge Reeves noted with respect to the doors at Walnut Grove, it asks too much to rely on officers to check doors each time inmates are placed in their cells to ensure that the cell door lock has not been manipulated. Instead, the solution is to fix the doors.

56. On August 25, 2014, officers were escorting an inmate out of the segregation pod and into the octagon outside of the pod. When they opened the door to the pod, another inmate in segregation was able to "manipulate his cell door and exit his cell," enter the octagon (the center hub that connects each of the four pods on a housing unit) and assault a Sergeant.[25] With proper cell locks on the cell doors, this incident would have been avoided.

57. On September 19, 2014, officers were escorting an inmate in restraints inside Unit 5B, a segregation pod. Another inmate "was able to manipulate his cell" and exit that cell and assault the inmate who was in restraints.[26] This resulted in the use of force against both inmates, another situation that was completely avoidable if EMCF had functioning locks on the doors in their segregation units.

58. About three months later, on December 10, 2014, the same inmate who was able to manipulate and exit his cell in the September 2014 incident, was able to do so again in an attempt to assault another inmate.[27] Notably, the cell the inmate manipulated in December 2014 was different from the one he manipulated in September 2014, but still on Unit 5B. The medical examination of an officer involved indicated that the top of the forehead and the back of the neck was red. The inmate who was attacked had redness to his right brow, shoulder and hand. The related EOR says there would be further investigation of how the inmate was able to manipulate his cell door, but if there was, it was not included in the materials I received.

59. Also in December 2014, yet another inmate in segregation came out of his cell, which had an "unsecured" door. He was able to assault a Lieutenant and an Officer.

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[24] Expert Report of Eldon Vail (June 16, 2014), at ¶47
[25] DEF-026423 - 026426
[26] DEF-026696 - 026711
[27] DEF-027401 - 027412

They were forced to go "hands on" with the inmate to get him back into this cell.[28] The EOR said the incident was being further investigated, but if there was such an investigation it also was not part of the materials I received.

60. On January 15, 2015, an inmate was taken out of his segregation cell in restraints to be taken to medical for his monthly shot. Another inmate "breeched his cell door . . . and attacked" the inmate in restraints with a homemade weapon "causing multiple injuries." The victim "sustained 3 lacerations to his abdomen area, 2 lacerations to his right arm, 3 lacerations to his facial area, 1 laceration to left side of his neck, and [] 1 deep laceration between the 3rd and 4th finger on his left hand." He was transported by ambulance to the hospital.[29]

61. In August 2015, an inmate was being escorted in restraints from the recreation cage back to his cell. Another inmate "was able to manipulate the lock on the cage he was placed in" and assaulted the inmate in restraints. Chemical agents were used to gain control of the situation, because the officer feared for the inmates' and staff's safety.[30] Again, this was a situation that was totally avoidable, but for the non-working locks.

62. In November 2015, an inmate was being escorted from his cell to a recreation cage, two inmates "were able to manipulate the locks on the recreation area doors and exit the recreation areas." The two inmates then entered the pod and attempted to assault the inmate being escorted by the officers. The officers used a chemical spray, exposing all three inmates, and were able to get the potential inmate victim off the pod before he could be injured. All three inmates' exposure to the chemical spray was completely avoidable, had the locks on the recreation are doors been properly functioning.[31]

63. Interspersed through these exemplar incidents are occasional instances where MTC and MTC officials take notice of the problem of unsecure cell doors at EMCF, but ultimately, do not address the problem on a systemic level.

64. For example, a series of emails between MTC and MDOC officials discusses the September 2014 incident where the inmate in segregation had "rigged" his cell door and exited his cell to assault another inmate who was under escort. One of the parties to the email was Tony Compton, who I understand supervises the MDOC Monitors. His contribution to the email string was to say:

> This needs to be discussed with the Warden and staff need to do their jobs and go back to the basics.[32]

[28] DEF-027433 - 027442
[29] DEF-027588–27603
[30] DEF-029688 –029701
[31] DEF-030967–030984
[32] DEF_ESI_0013752

65. In July 2015, Mr. Compton wrote an email to the EMCF, once again addressing the issue of the non-secure cell doors, but apparently still unaware of the systemic problem. He said:

> I was just informed that while conducting pill call on the Segregation Unit at EMCF, the offenders "Popped" their cell doors and came out while nurses from Centurion Medical were passing out medication. Is there an issue with the locks on offenders cell doors and what was the procedure prior to the new vendor taking over? . . . Please review and investigate these allegations and advise me of your findings.[33]

What is surprising about this email from Mr. Compton is that it sounds as if he had just become aware of the problem with the cells doors, despite the fact it had been implicated over time in incidents like those described above.

66. It is clear that MTC is and has been well aware of this very dangerous situation for some time and has not begun to address it at EMCF. Neither has MDOC and they are equally culpable in exposing staff and inmates to this extraordinary and highly unusual risk at EMCF.

67. Of additional concern are the defective controls to the cell doors in the Unit 1 picket, the control booth elevated above the four pods of the housing unit. During my inspection of EMCF in June 2016, MTC staff, including the MTC Vice President Marjorie Brown, acknowledged that the electronic controls in the picket were not working. Instead of the officer in the picket being able to release or secure the cells doors from the picket, officers had to release or secure the cell doors with keys. During my interviews at EMCF in June 2016 inmates expressed concern for their own safety should there be a fire or other emergency that would require them to be quickly released from their cells. Inmates informed me this problem has existed in Unit 1 for months. I can confirm ongoing problems with the electronic controls in that unit as far back as October 2014 when the Monitor included reference to it in her monthly checklist: "Staff is in the picket on one/controls do not work."[34] The failure to fix this physical plant problem with cell door locks also creates an ongoing risk to the safety of inmates at EMCF.

68. In my last report in 2014 I documented how long some of the physical plant problems have existed at EMCF. In 2012, the Occupational Safety and Health Administration (OSHA) identified serious safety problems at EMCF. OSHA directed that the following remedial actions, among others, were required:

- Repair or replace defective cell door lock systems throughout the facility.

[33] DEF_ESI_0008500
[34] MDOC-CON-00000788

- Repair or replace defective picket door indicator system in the housing unit(s).
- Assure continued maintenance of all door lock systems throughout the facility. Institute a policy prohibiting inmates from placing items on cell doors that obstruct corrections officers' view into cells.[35]

69. In 2014 I opined:

> It is astonishing to me that a full two years later these problems have yet to be addressed. As an experienced corrections administrator, I would have treated them as a life-threatening emergency. It is clear that MDOC is indifferent to the safety of the prisoners at EMCF and unresponsive to the previous direction they have received from the United States government. Once again, I do not believe they have the capacity or the willingness to address the multitude of problems at EMCF.[36]

70. It has now been four years since MDOC has been put on notice by the federal government of these problems, and two years since it was reminded of the problems by my first report in this case, yet the problems still have not been corrected. I do not have a stronger word to offer than that I continue to be "astonished."

4. Inmates At EMCF Pass Out Food In the Living Units During Meal Times

71. During my June 2016 interviews with inmates, I was informed of another way control over operation of the living units has been ceded to the inmates: inmates pass out the food in the living units during meal times. Again, this was not a question I affirmatively asked of the inmates, until they began to tell me about the situation, at which point I did ask how the feeding process worked. The inmates' general response was that it depended on which inmate was passing out the food, and that it was generally a powerful gang member who performed this function. If the gang member was "righteous," he made sure everyone got fed. But in some circumstances, inmates who owed debts to other inmates were sometimes punished by not being fed.

72. Food is a commodity in prisons. It has obvious value for the health of individual inmates but its value can also be used to trade or barter to create and/or pay off debts among the inmate population. For that reason, supervision of food service is a critical security concern and is important to safe and secure prison operation. Certainly, at other prisons, while inmates do sometimes push the food carts to the

[35] Occupational Saftey and Health Administration, *Citation and Notification of Penalty to the GEO Group*, Inspection No. 315306357 (June 11, 2012), at 8
[36] Expert Report of Eldon Vail (June 16, 2014), at ¶67

housing unit and deliver the food directly to the inmates, this is an activity that must be closely supervised by officers. It appears that such supervision is lax at EMCF. In fact, in December 2014, the Monitor noted as an on-going problem in Units 1–4 since September 2014: "Offenders are issuing the trays in the pods."[37] And in July 2015, in response to a letter from an inmate complaining about this, the Contract Monitor wrote: "I have observed staff observing feed, trays to be handle[d] by staff only."[38]

73. The fact that the Monitor raised this issue as a problem makes it an obvious issue that MTC should have been aware of and acted upon it in order to make certain that all inmates were regularly fed and that no inmate could be victimized by another stronger inmate or group of inmates.

5. EMCF Staff Fail to Respond to Issues Raised by Prisoners

74. From September 2015 – March 2016, in response to the item, "Offender requests answered within MDOC requirements," the Monitor commented, "Not written in offender trak, offenders state no response."[39] Whoever created the checklist understands that timely responses to legitimate issues raised by inmates are important to the overall safety and security of the institution.

75. In my experience when inmates raise legitimate issues with the staff and those issues are not addressed, inmates are much more likely to act out and express their frustration through acts of misbehavior. Inmates in prison are near totally dependent on the assistance of staff to meet their basic human needs. When systems don't function to help inmates get answers to their questions and resolve issues, it is predictable they will search for other ways, such as engaging in misconduct, to try and bring attention to their concerns.

76. In my opinion, the sheer volume of letters received by the Monitor, as well as the subjects of those letters, reveals a profound frustration on the part of the inmates at EMCF at getting answers to their questions by MTC staff. If MTC was responding to the issues in the letters appropriately, the inmates would not feel the need to go to the Monitors for everything as mundane as trying to get their clothing issues sorted out to such serious concerns as alerting the Monitor that they feel their lives are in danger, examples of which I offer later in this report.

6. MTC Administrators Often Fail To Respond To The Deficiencies in Prison Operations That are Brought to Their Attention

77. As the many Monitor reports and checklists make clear, the problems described above were explicitly communicated by the Monitor to MDOC officials and MTC administrators. On the other hand, there is no clear and consistent record of how

[37] MDOC-CON-00002261
[38] MDOC-CON-00001035
[39] MDOC-CON-00000096

MTC administrators on the ground at EMCF respond to the issues raised by the Monitors, other than that the persistence of the identified problems suggests that they do not do so in any meaningful way. That said, there are a few documents in the material that was disclosed to me that shed light on the issue more concretely. They also suggest that the Monitor's identification of basic problems at the prison is ignored by MTC.

78. For example, beginning on June 30, 2014 there are a series of emails between the Monitor and EMCF's Deputy Warden Norris Hogans.[40] In an email in that series, dated August 22, 2014, the Deputy responds to some of the issues raised by the Monitor, but his responses are not convincing. For example, in response to the concern that "Staff conducting count improperly," the Deputy said: "Supervisors have been instructed to pay more attention to staff counts, staff have been advised of the proper way to count." But given that this email exchange occurred over two years ago and that the same problem persisted at least through March 2016 according to the Monitor, and at least until June 2016 based on my interviews with inmates during an inspection of the facility in that month, it is clear that this problem was not actually resolved.

79. Nearly a year later, in May 2015, there is a memo from the Warden to the Monitor addressing the Weekly Report of April 19, 2015.[41] Four times in that Weekly Report, the Monitor pointed out that windows into the cells were covered and that staff had not corrected the problem. The Warden responded: "All unit officers and offenders have been advised to remove all items covering their windows and doors. Inmates have also been advised they will receive a RVR (Rule Violation Report) if [their] cell is not in compliance." It is clear from the Monitor's records through March 2016, and through my own observations in June 2016, that the Warden's communication was not effective, and that this problem was not actually corrected.

80. Ultimately, I am very impressed with the work of the Monitor in identifying the right issues. I am not impressed with the lack of effective follow-up by MDOC to correct those problems. The items I list above are fundamental to the operation of a safe and secure prison. But I am deeply distressed that neither MTC, the Monitor, or MDOC administrators could bring the necessary focus to resolve these known issues, many of which persist to the present day, as documented by the file material made available for this report as well as my own inspection of the prison in June 2016. MTC has failed to heed the guidance offered by the Monitor, and MDOC administrators have failed to hold MTC accountable for these failures. As the examples above show, this failure has, and will continue to place the safety and security of inmates at serious risk.

[40] DEF_ESI_0000544
[41] MDOC-CON-00002335–2338

B. Staffing Levels at EMCF are Insufficient and Contribute to Deficiencies in the Operation of the Prison and Create an Unnecessary Risk of Harm to Inmates and Staff

1. There is Insufficient Staffing in the General Population Units

81. EMCF is designed to house inmates in six housing units, 1–6, each consisting of four pods, A–D, and a picket, or a control booth that sits above the four pods in a housing unit so as to provide additional observation of what is going on in the unit. Each unit/pod houses inmates of different security classifications. Units 1A–1C, and Units 6A–6C, house "close custody" inmates, "the highest risk general population inmate" who according to MDOC policy, "requires closer supervision where the offender must be under positive security control at all times." Unit 1D and Units 2–4 house general population inmates. Units 5 and 6D house inmates in segregation.

82. It is crucial to the safe and orderly operation of the prison that each of these units/pods and their corresponding picket are adequately staffed. The lack of appropriate numbers of staff makes it very difficult to supervise and control any inmate population. The result is that the rules for inmate conduct are not enforced which erodes the authority of the institution. Moreover, an understaffed prison is an unsafe one, for both inmates and officers.

83. But, understaffing is the reality at EMCF. The Monitor's checklists and reports, details the fact of this problem in a number of ways. For example, in October 2014, the Monitor said: "There is not enough staff to properly supervise the units."[42] From November 2014 – January 2015, the checklist reported: "Personnel is considering hiring more staff for coverage."[43] In February 2015 the Monitor reported: "Staffing is short most evenings/nights. Only 2 staff in units 1–4." [44] This same comment is repeated in June and July 2015.[45] And from September 2015 – March 2016 the checklist simply reports: "More staff needed."[46]

84. The Monitor correctly identified a staffing problem at EMCF. With respect to the general population units, Units 1–4, each living unit consists of four pods, separate and apart from each other, that require officers and inmates to get through a locked door to enter or exit the pod, there should be four floor officers assigned to each of these units to ensure some level of supervision of the inmates. Put differently, staffing levels should be such that there is at least one officer in each pod, and one in the picket.[47] Failing to do so means the inmates are frequently left to their own devices to protect personal safety. In many cases, the result is that the inmate seeks

[42] MDOC-CON-00000788
[43] MDOC-CON-00000855, 933, 4927
[44] MDOC-CON-00005002
[45] MDOC-CON-00005393, 5481
[46] MDOC-CON-00005681, 5787, 5969, 23, 96, 195
[47] As I explain below, there should be 2 officers in each close custody pod, including Units 1A–1C.

the protection of more powerful inmates, often represented in the organization of prison gangs.

85. The staff rosters made available to me through discovery confirm the reality of a staff shortage at EMCF, and demonstrate a pattern of insufficient staff assigned to the general population living units at EMCF.

86. What follows is a sample of the shift rosters I have received and reviewed, and the numbers of officers assigned to work on the floor in the general population units during those shifts.[48] The rosters cover the years 2014, 2015, and 2016 revealing the persistence of EMCF's staff shortage problem.

87. For example, in 2014[49]:

Date	Shift	Total Number of Officers			
		Unit 1	Unit 2	Unit 3	Unit 4
6/6/14	Afternoon	2	2	2	2
6/10/14	Afternoon	3	3	3	3
6/11/14	Afternoon	2	2	2	2
6/13/14	Afternoon	2	2	2	2
6/14/14	Afternoon	3	3	3	3
6/15/14	Afternoon	2	2	2	3
7/29/14	Day	2	2	2	2
8/11/14	Day	3	2	2	2
8/12/14	Day	4	2	2	2
8/13/14	Day	2	2	3	2
8/14/14	Day	2	2	2	2
8/14/14	Afternoon	2	3	2	2
8/22/14	Afternoon	2	2	2	2

[48] Day shift is 7 a m. – 3 p m. and the afternoon shift is 3 p m. – 11 p m.
[49] DEF_ESI_0000233 (6/6/2014); DEF_ESI_0000229 (6/10/2014); DEF_ESI_0000231 (6/11/2014); DEF_ESI_0000227 (6/13/2014); DEF_ESI_0000225 (6/14/2014); DEF_ESI_0000212 (6/15/2014); DEF_ESI_0000373 (7/29/2014); DEF_ESI_0000740 (8/11/2014); DEF_ESI_0000728 (8/12/2014); DEF_ESI_0000726 (8/13/2014); DEF_ESI_0000708 (8/14/2014); DEF_ESI_0000710 (8/14/2014); DEF_ESI_0000371 (8/22/2014); DEF_ESI_0000535 (8/23/2014); DEF_ESI_0000529 (8/23/2014); DEF_ESI_0000526 (8/24/2014); DEF_ESI_0000398 (8/28/2014); DEF_ESI_0000365 (8/30/2014); DEF_ESI_0000362 (8/30/2014); DEF_ESI_0000339 (9/2/2014); DEF_ESI_0000329 (9/2/2014); DEF_ESI_0000271 (9/3/2014); DEF_ESI_0000236 (9/4/2014); DEF_ESI_0000238 (9/5/2014); DEF_ESI_0000219 (9/6/2014); DEF_ESI_0000110 (9/9/2014); DEF_ESI_0000108 (9/11/2014)

8/23/14	Day	2	2	2	2
8/23/14	Afternoon	2	2	2	2
8/24/14	Day	2	2	2	2
8/28/14	Day	2	2	2	2
8/30/14	Day	2	2	2	2
8/30/14	Day	2	2	2	2
9/2/14	Day	2	2	2	2
9/4/14	Day	2	2	2	2
9/2/14	Afternoon	2	2	2	2
9/3/14	Afternoon	2	2	2	2
9/5/14	Day	1	2	2	2
9/6/14	Afternoon	2	2	2	2
9/9/14	Day	2	2	2	2
911/14	Afternoon	2	2	2	2

88. This pattern continues in 2015[50]:

Date	**Shift**	**Total Number of Officers**			
		Unit 1	**Unit 2**	**Unit 3**	**Unit 4**
4/6/15	Day	2	2	2	2
4/6/15	Afternoon	2	2	2	2
4/8/15	Day	2	2	2	1
4/8/15	Afternoon	2	2	2	2
4/11/15	Day	2	2	2	2
4/11/15	Afternoon	2	2	2	2
4/25/15	Day	2	2	2	2
4/25/15	Afternoon	2	2	2	2
12/5/15	Day	2	2	2	2

[50] DEF_ESI_0006925 (4/5/2015); DEF_ESI_0006925 at 2 (4/6/2015); DEF_ESI_0006925 at 8 (4/8/2015); DEF_ESI_0006925 at 9 (4/8/2015); DEF_ESI_0006925 at 16 (4/11/2015); DEF_ESI_0006925 at 17 (4/11/2015); DEF_ESI_0006893 at 16 (4/25/2015); DEF_ESI_0006893 at 17 (4/25/2015); DEF_ESI_0010151 (12/5/2015); DEF_ESI_0010031 (12/15/2015); DEF_ESI_0009876 (12/31/2015)

12/15/15	Day	2	2	2	2
12/31/15	Day	2	2	2	2

89. The same staffing levels are also present in 2016[51]:

Date	Shift	Total Number of Officers			
		Unit 1	Unit 2	Unit 3	Unit 4
1/17/16	Day	2	2	2	2
1/17/16	Afternoon	2	2	2	2
1/18/16	Day	2	2	2	2
1/18/16	Afternoon	2	2	2	2
1/19/16	Day	2	2	2	2
1/19/16	Afternoon	2	2	2	2
1/20/16	Day	2	2	2	2
1/20/16	Afternoon	2	2	2	2
1/21/16	Day	2	2	2	2
1/21/16	Afternoon	2	2	2	2
1/22/16	Day	2	2	2	2
1/22/16	Afternoon	2	1	2	2
1/23/16	Day	2	2	2	2
1/23/16	Afternoon	2	2	2	2
7/10/16	Day	2	2	2	2
7/10/16	Afternoon	3	2	2	2
7/11/16	Day	2	2	2	2
7/11/16	Afternoon	2	2	2	2

[51] DEF-211685 (1/17/2016); DEF-211691 (1/17/2016); DEF-211700 (1/18/2016); DEF-211706 (1/18/2016); DEF-211716 (1/19/2016); DEF-211722 (1/19/2016); DEF-211732 (1/20/2016); DEF-211738 (1/20/2016); DEF-211748 (1/21/2016); DEF-211754 (1/21/2016); DEF-211764 (1/22/2016); DEF-211770 (1/22/2016); DEF-211779 (1/23/2016); DEF-211785 (1/23/2016); DEF-212012 (7/10/2016); DEF-212018 (7/10/2016); DEF-212028 (7/11/2016); DEF-212033 (7/11/2016); DEF-212043 (7/12/2016); DEF-212049 (7/12/2016); DEF-212060 (7/13/2016); DEF-212066 (7/13/2016); DEF-212076 (7/14/2016); DEF-212082 (7/14/2016); DEF-212092 (7/15/2016); DEF-212098 (7/15/2016); DEF-212108 (7/16/2016); DEF-212114 (7/16/2016); DEF-212125 (9/18/2016); DEF-212130 (9/18/2016); DEF-212140 (9/19/2106); DEF-212150 (9/19/2016); DEF-212154 (9/20/2016); DEF-212159 (9/20/2016); DEF-212168 (9/21/2016); DEF-212177 (9/22/2016); DEF-212182 (9/22/2016); DEF-212192 (9/23/2016); DEF-212197 (9/23/2016); DEF-212208 (9/24/2016); DEF-212213 (9/24/2016)

7/12/16	Day	2	2	2	2
7/12/16	Afternoon	2	2	2	2
7/13/16	Day	2	2	2	2
7/13/16	Afternoon	2	2	2	2
7/14/16	Day	2	2	2	2
7/14/16	Afternoon	2	2	2	2
7/15/16	Day	2	2	2	2
7/15/16	Afternoon	2	1	2	2
7/16/16	Day	2+ 2 Cadets	2	2	2
7/16/16	Afternoon	2	1	1	1
9/18/16	Day	2	2	2	2
9/18/16	Afternoon	2	2	2	2
9/19/16	Day	2	2	2	2
9/19/16	Afternoon	1	1	2	2
9/20/16	Day	2	2	2	2
9/20/16	Afternoon	2	2	2	2
9/21/16	Day	2	2	2	2
9/22/16	Day	2	2	2	2
9/22/16	Afternoon	2	2	2	2
9/23/16	Day	2	2	2	2

90. What this staffing pattern means is that with rare exception, there are only two officers to supervise four separate pods of inmates in the general population at EMCF. As the Monitor noted in the October 2014 checklist, this staffing pattern is "not enough," because while there are "2 staff on the floor and one in the picket . . . there are four pods on each unit."[52]

91. To be clear, two officers to supervise four pods of inmates in the general population units at EMCF is the level of staffing that MTC defines, and MDOC authorizes as "mandatory staffing." But at this staffing level, at best, an officer could be in the pod only half the time, assuming the officer is diligent about splitting his/her time between two different pods. This staffing pattern is unsafe for the inmates as, too frequently, no officer is available to detect conflict and resolve issues before they escalate. When there are not enough officers assigned to staff at least one to each of

[52] MDOC-CON-00000789

the pods where the inmates reside, compliance with basic rules is not achieved and the inmates are left to fend for themselves and do what they must to ensure their own safety.

92. This staffing pattern is also unsafe for officers for the same reason—problems escalate before the officer gets a chance to intervene and perhaps head off conflict and/or violence before it has a chance to occur. MTC's mandatory staffing level for the units is not sufficient to keep the staff or the officers safe.

93. Video evidence and the written reports of EMCF officer and inmate interactions in the general population units help demonstrate the point.

94. In Unit 3A, a medium/minimum security unit,[53] a video from July 20, 2015 shows an inmate being stabbed and chased around the unit for over a minute.[54] It takes an officer almost two minutes from the time the stabbing began to enter the unit. Had an officer been in the unit when the assault began, it is highly likely that the incident would have gone on as long as it did and may not have even happened. The day shift roster, during which this assault occurred, shows there were only two officers assigned to supervise the four pods of Unit 3.[55]

95. In an EOR from June 22, 2015, it is described that a spontaneous use of force (SUOF) occurred when multiple inmates assaulted another inmate who was being escorted by officers out of the pod.[56] What is not in the EOR is revealed on the video.[57] The video opens with flames coming out of the cell of the inmate who is ultimately escorted out of the unit by officers. The video also reveals that it takes an officer nearly four minutes to enter the pod and respond to the cell that is burning. The EOR does not mention the fire or mention any concern that it took so long for an officer to respond to a cell that was burning. This example illustrates that failing to maintain an officer in the pod at all times creates unnecessary risk.

96. One video, dated November 24, 2014,[58] is from Unit 3C, a unit identified as a mental health unit by MTC.[59] It is clear from watching the video that tension is accelerating between one inmate and several others for at least about one minute. Eventually, multiple inmates begin to attack a single inmate with punches and kicks. There is no indication that any officers are in the unit to intervene when the tension became obvious, or to act to break up the assault once it started. The shift roster for this day shows that there were only two officers assigned to supervise the four pods in Unit 3.[60] It takes about 40 seconds before an officer enters the unit and uses a chemical spray to stop the assault. Had an officer actually been in the unit it is

[53] DEF_ESI_0000249
[54] DEF-029524A; DEF-029524
[55] DEF-212321
[56] DEF-029294
[57] DEF-029294A
[58] DEF-027096A
[59] DEF_ESI_0000249
[60] DEF_ESI_0010229

likely the assault could have been prevented or stopped after a punch or two was thrown. The related incident report itself acknowledges that officers entered unit only after the assault began.[61] The inmate who was assaulted is described as "acting abnormally" (no surprise in that this is a mental health unit), and after the assault was over, received a PRN shot—likely medication for his mental illness.[62]

97. On November 4, 2014, 2 inmates were fighting in a general population unit. One of the inmates received a laceration to the back of his head when he was struck with a food tray. The EOR describes how other inmates had to pound on the door of the pod to get the attention of the officers so that the injured inmate could get medical treatment. The EOR also says that no staff witnessed the assault. Since the inmates had to pound on the door to get the officers' attention, there is no way the officers could have witnessed it. The injured inmate received five stitches.[63]

98. It is completely irresponsible for MTC to fail to make certain there is at least one officer at all times in each and every housing unit at EMCF, and the above incidents illustrates this failure. Moreover this failure is particularly dangerous because EMCF is primarily a facility that houses the mentally ill. Yet not even in this particularly high-risk setting has MTC taken the most basic steps to ensure institutional order and security.

2. Insufficient Staffing in Close Custody

99. In close custody, Unit 1, Pods A–C, there should be even more staff per pod. Close custody inmates are those who are considered to be the most dangerous in the general inmate population (excluding those housed in segregation). The MDOC Classification Plan policy defines close custody inmates as:

> The highest risk general population inmate and has one or more of the below risk factors:
>
> - Risk of escape
> - Periodic demonstrated as a threat to staff/inmates
> - Recent or serious disciplinary record
>
> This custody requires closer supervision where the offender must be under positive security control at all times.[64]

100. In a close custody setting, even with staffing by experienced and well-trained correctional officers, working alone endangers staff and inmates alike, as officers sometimes need immediate backup in working with close custody inmates. In my

[61] DEF-027095
[62] A "PRN" prescription involves a medication that is to be administered whenever it is needed by the patient.
[63] DEF-027210–27213
[64] AG 5844-5845

opinion there should be two officers assigned to work inside each close custody pod, meaning there should be a total of seven floor officers in Unit 1 per shift (two officers in each of Units 1A, 1B, and 1C, one officer in Unit 1D, and one additional officer assigned to the picket). But such a staffing pattern is not consistent with the MTC rosters cited above. Rather, of the staff rosters I have reviewed, only on the August 12, 2014 day shift were there enough officers assigned to put even one officer in each pod. The officers working on that shift, the one with the most staffing I have seen in the records, were three shy of the minimum I believe necessary to appropriately supervise these units and necessary for inmate and officer safety.

101. Here is a sample of the kind of problems that have occurred in the close custody pods in Units 1A – 1C from 2014 and 2015, and which demonstrate why sufficient staffing, at the level of two officers per close custody pod, and one in the picket, is necessary:

- Weapons confiscated from inmates;[65]
- Inmate(s) assaulted, outside transport for medical treatment called;[66]
- Inmate(s) assaulted, no outside transport for medical treatment called;[67]
- Inmate(s) assaulted officer(s), outside transport for medical treatment of officer called;[68]
- Inmate(s) assaulted officer(s), no outside transport for medical treatment of officer called;[69]
- Use of Force against inmate required;[70]
- Inmate accessed outside of building to retrieve contraband.[71]
- Inmate set fire to his cell.[72]
- Inmate found with weapon; he said he had it because he was assaulted by multiple inmates the previous night[73]
- Inmate reported being raped; required offsite transport for medical treatment[74]

[65] DEF-028781 (8 weapons found); DEF-029055 (4 weapons found); DEF-029912 (3 weapons found); DEF-026569 (3 weapons found); DEF-029927 (3 weapons found); DEF-031560 (2 weapons found); DEF-030833 (2 weapons found); DEF-029117 (2 weapons found); DEF-030825 (1 weapon found); DEF-028814 (1 weapon found); DEF-028796 (1 weapon found); DEF-028971 (1 weapon found);
[66] DEF-029875; DEF-030097; DEF-030103; DEF-027041; DEF-028419; DEF-029117;
[67] DEF-026617; DEF-026302; DEF-026302; DEF-028933; DEF-032113; DEF-029294; DEF-026165; DEF-026189; DEF-027443
[68] DEF-030065;
[69] DEF-029527; DEF-029543; DEF-026879;
[70] DEF-029194; DEF-030251; DEF-028331; DEF-029308; DEF-030953; DEF-026359
[71] DEF-027306
[72] DEF-028099
[73] DEF-029773
[74] DEF-026663

102. These are extreme problems to have in a prison. The examples cited above are only some of those available and I selected them to illustrate the extent of problems including numerous weapons being found in the unit; multiple inmates attacking individual inmates, sometimes identified as gang-related incidents (likely always gang-related), sometimes with weapons involved; assaults against staff; inmates trying to escape from the unit because they are not safe and believe their lives are in danger if they stay in the pod; and assaults so serious that they required trips to the hospital.

103. Again, the units being discussed here are designed to be direct supervision units—meaning that the officers need to be in the pod interacting with inmates and detecting problems and heading them off before they occur. The notion that you can supervise these units indirectly with insufficient levels of staffing is completely bankrupt from a competent correctional perspective, and poses an obvious and serious risk to inmates confined in those units.

104. Videos provided to Plaintiffs by MTC further illustrate the point. For example, in September 2015, shortly after 3 a.m., two inmates were assaulted by other inmates in close custody Unit 1A. Both inmates were stabbed and taken to an outside hospital for treatment. In a review of this event it was identified that the unit was not locked down at 10 p.m. the previous evening as required by policy, allowing these serious assaults to occur.[75] This event, like many others, could and should have been avoided. This particular example illustrates that inmates were out of their cells well after they should have been and staff were inattentive to the point where a stabbing could occur.

105. On March 16, 2015, an inmate from a close custody unit submitted a sick call slip reporting that he had been stabbed multiple times and burned on the neck with scalding water. The inmate was brought to medical for an examination and the inmate "had multiple older puncture wounds, a burn on his shoulder from hot water, and several facial injuries." The inmate reported that the stabs wounds were received on March 9, 2015 and the scalding was from March 13, 2015. He also identified the inmates who stabbed him, scalded him, and beat him with a stick. There were six inmates involved in the assaults.[76] It is incomprehensible to me that staff failed to be aware that this week-long assault was occurring and/or that the inmate had suffered serious injury, except when I consider that there are rarely sufficient staff to make sure there is at least one officer in the pods with the inmates at all times. This is what happens when staffing levels are insufficient—actual harm can and does occur.[77]

[75] DEF_ESI_0005996, at 3-5
[76] DEF-028172 - 028177
[77] The inmate was housed in Unit 6C. During this time there were no officers assigned to this unit on the day shift on March 10 (DEF-211366) and March 13, (DEF-211374).

106. To offer another example from Unit 1C, a close custody pod,[78] on December 8, 2014, an inmate who was accused of stealing food from other inmates was targeted and beaten with mop and broom handles. It took officers nearly 10 minutes before they entered the unit and stopped the violence against the individual inmate. The victim was described in the incident report as having "multiple wounds and lacerations to head and face."[79]

107. In my opinion the evidence is overwhelming of what predictably happens when you place close custody inmates, some of whom are mentally ill and some of whom are gang members, into a living unit without sufficient staff to provide adequate supervision to keep them safe. Violence and increased risk for inmates as well as the staff has and will continue to occur until the staffing issues are corrected.

3. Officers Fail to Stay at Their Assigned Posts

108. In my first report I wrote about the problem of officers staying in their assigned post in the pods in the segregation units. I said:

> The lack of these routine checks on the welfare of each inmate in the segregation units is a source of constant concern by the prisoners. Repeatedly, prisoners told me that officers often are not on the zones. Inmates are well aware that other inmates can and sometimes do get out of their cells due to the problem with the cell doors and, as a result, assaults have occurred.[80]

It is clear this problem has continued since my first report.

109. On September 26, 2015, an inmate lit a fire in Unit 6D. It was reported, "No staff response to the unit until 10 minutes after the incident."[81] The report also noted that the officers failed to respond with a fire extinguisher. If officers are in the unit actually supervising the inmates, there is no way this issue would have taken ten minutes for an appropriate response.

110. During my private interviews in June 2016 with inmates from segregation and from general population, they reported that when officers are on duty they are often not in the living units. One inmate said: "They come around every couple hours." Other comments included: "Officers are in the zone every now and then;" "Officers don't stay on the zone;" and "Officers are hardly on the zone at night."[82] One inmate told me that officers are absent from the zone for three or four hours at a time. One inmate described a fight that had occurred the previous day and that the officer watched the fight through the window outside of the unit and did not

[78] DEF-027443A
[79] DEF-027443
[80] Expert Report of Eldon Vail (June 16, 2014), at ¶55
[81] DEF_ESI_0005994
[82] Inmates and some staff at EMCF call each pod a "zone".

intervene. Another said the officers can't keep the inmates safe because there are not enough of them.

111. I asked one of the inmates I interviewed in segregation in 2016 why he was in segregation. He explained he had been charged with escape. I asked him to tell me what that was about. He recounted that it was not actually an escape. He had accessed the pipe chase in his living unit and had found a way to exit the building and get outside of the unit so he could pick up contraband that had been thrown over the fence. He was caught outside the building when viewed on a camera. I asked him how he was able to get out of the unit without being detected by the staff and he explained it was easy since officers were so rarely in the unit.

112. During my inspection of 2016, I traveled throughout the institution for two days. Frequently, as I walked passed living unit pods I observed there were no officers present in the pods. The lack of a sufficient number of officers and the expectations for where the officers are to station themselves are so ingrained at EMCF that I was able to observe their actual practice during my inspection—the pods are often left with no physical presence of a correctional officer, a problem that was similarly identified for MTC by the Monitor in December 2014 when she wrote that "[s]taff [are] not manning pods,"[83] and in July 2015 when she wrote that "[s]taff assigned to the units are not remaining on their posts; leaving the pod unsupervised."[84]

113. I do not fault the officers for failing to be in the units. First and foremost there are not enough officers assigned to put even one in each pod, and as I have noted above, it is my opinion that one officer alone is not sufficient for inmates and staff to feel safe in a close custody unit. It is also my opinion that the EMCF officers' level of training and competency to manage close custody or seriously mentally ill inmates is far from adequate to keep themselves or the inmates safe. I do fault the administration of MTC for failing to provide sufficient staff and training to keep officers and inmates safe, and I fault MDOC for failing to insist that MTC follow these basics of prison management.

C. <u>The Numbers of Weapons at EMCF are Extreme</u>

114. In my experience as a correctional administrator and as an expert in corrections and prison safety, when inmates do not feel that the officers can protect them, they necessarily will seek ways to protect themselves. One of those ways is to arm themselves and seek access to a weapon. As I said in my report from 2014, "This is a prison awash in contraband and easily accessible weapons."[85] Unfortunately, two years later, this still appears to be an all too prevalent problem at EMCF.

[83] MDOC-CON-00002261–2262
[84] DEF_ESI_0006171
[85] Expert Report of Eldon Vail (June 16, 2014), at ¶21

115. MTC is required to provide a monthly report to MDOC itemizing several critical performance measures for the institution. Records for EMCF show the following numbers of weapons were discovered from July 2014 – January 2016:[86]

Month	Weapons Discovered
July 2014	128
August 2014	4
September 2014	7
October 2014	7
November 2014	8
December 2014	27
January 2015	19
February 2015	52
March 2015	12
April 2015	12

Month	Weapons Discovered
May 2015	41
June 2015	52
July 2016	121
August 2015	59
September 2015	34
October 2015	23
November 2015	27
December 2015	42
January 2016	67

116. There were 742 weapons discovered at EMCF in the 19-month period, July 2014 – January 2016. Taken as a simple average, that means that over 39 weapons were discovered in EMCF per month over a nineteen-month period.[87] That is more than one weapon discovered in the prison every day.[88] In my experience these numbers are startling and alarming. It is also my experience that correctional staff never discovers all of the contraband in an institution. Thus, the prevalence of weapons in the prison is probably much higher.

117. There is also evidence from those same records of those weapons being used during that same time period:[89]

Month	Used on Inmate	Used on Staff	Monthly Total
July 2014	1	1	2
August 2014	2	2	4
September 2014	0	0	0
October 2014	0	0	0
November 2014	1	1	2
December 2014	0	0	0
January 2015	2	2	4
February 2015	3	3	6
March 2015	5	5	10

[86] DEF-024658 and 024675
[87] There are 2 sets of numbers reported by MTC on their monthly reports. One set of those numbers equates to an average of 34 weapons per month, the other to 39. Whichever number is correct, this is a high numbers of weapons to be found each month in a single prison—still more than 1 per day.
[88] In fact, I understand that Plaintiffs' sanitation and nutrition expert, Diane Skipworth, discovered weapons on both of her inspections of the facility.
[89] DEF-024649 - 024663

April 2015	2	2	4
May 2015	2	2	4
June 2015	3	3	6
July 2015	4	1	5
August 2015	4	0	4
September 2015	3	0	3
October 2015	1	0	1
November 2015	1	1	2
December 2015	1	1	2
January 2016	1	0	1

As I have already referenced in this report, some of these weapons produce injuries so serious that they require transport to the hospital for medical treatment. Whether staff or inmate, the risk of becoming a victim to the use of a weapon is ever present. On average, it happens to someone in EMCF over 3 times a month.[90] This creates a climate where inmates do not feel safe in the prison they are confined in, and where the officers do not feel safe in the prison they are meant to administer.

118. Concern about one's own safety is also a theme in the correspondence the Monitors regularly receive from the inmates that indicates they feel their lives are in danger.

119. For example, on June 17, 2015, an inmate wrote the Monitor upset that he had been "assaulted, stabbed and robbed" on the 20th of the previous month and nothing was being done about it. He quotes the EMCF handbook and says he has a right to protection from harm.[91]

120. On May 21, 2015, another inmate wrote the Monitor. This inmate said he had already been stabbed and was worried he was about to be placed in the same unit as the inmates that had stabbed him. He was asking the Monitor to help him and said, "I feel like my life is in danger."[92]

121. On March 3, 2015, an inmate wrote a letter to the MDOC Monitor. In that letter he begins by saying: "My life is really in danger." He then, acknowledging that he was once member of the Vice Lords gang, describes a gang-related assault that happened at another prison that he failed to participate in, even though he was expected to. Because he did not participate, he was targeted by the gang for assault and was stabbed. He was then transferred to EMCF. The danger from the gang followed him to EMCF when one of the inmates who had stabbed him arrived at the facility. Shortly thereafter, some of the gang members at EMCF threatened his life, then chased him into his cell while one of them brandished a knife. When he wrote to the Monitor he had been in his cell since the gang members had chased him. They would not allow him to receive a food tray so he had not eaten for a few days.

[90] Even removing the seeming outlier of 10 weapon-involved incidents in March 2015, the average is still more than 2 per month.
[91] MDOC-CON-0001575
[92] MDOC-CON-00001427

He ends the letter admitting he too had a knife (and a cell phone) but would willingly give both up if the Monitor could help find him protection.[93] On that same day, before the Monitor probably even received the letter, the inmate was driven to actions that could have led to his death. According to the incident report, the inmate:

> Placed a small foreign object inside the keyhole of his cell door lock to prevent staff from being able to access the cell door. The offender then set his mattress and clothing items on fire inside the cell using the wiring from the cell light fixture to start the fire. Staff immediately attempted to put the fire out and remove the offender from the cell but were unsuccessful, as the offender had barricaded the cell door. . . . Captain Dykes then retrieved the necessary tools from the EMCF armory to remove the locking device from the door and gain access to the inside of the cell. Staff entered the cell and extinguished the fire and [the inmate] was found to be unresponsive. The offender was removed from the cell and a code blue was called. Medical staff responded and the offender was taken to the EMCF medical department where it was determined the offender would need to be transported to the Rush hospital emergency department for further evaluation via Metro ambulance.[94]

The video available for the incident tells a more complete story.[95] The video begins with officers at the front of the inmate's cell. Smoke is pouring out. I assume the video did not capture the use of the fire extinguisher that put the fire out. The officers are not able to get the cell door open until the video has been running for 22 minutes and 40 seconds. During that time, the officers had not yet called for medical to respond. Once the cell door was opened medical was called for and they arrived on the scene about 4 minutes later. The inmate was unresponsive. He lay on the floor of the unit while medical attempted to treat him for another 6 minutes when he was then placed on a gurney and taken to EMCF medical. Ten minutes after his arrival in medical oxygen is administered. The video ends 48 minutes after it began with the inmate still unresponsive, having engaged in an act of self-harm likely because of, at least in part, his fear of gang members' continued threats against him.

122. On January 18, 2015, another inmate wrote to the Monitor saying he had, "refused housing," meaning that he directly refused to accept the cell assignment he had been given. In my experience this means the inmate did not feel safe in the cell or living unit assignment the staff had given him. The inmate had been in segregation for about 4 months. The inmate he was afraid of was then put into the same unit as

[93] MDOC-CON-00001202–1203
[94] DEF-028100
[95] DEF-028099A

him and he was afraid he would be "stabbed to death." He asked the Monitor for an emergency transfer to a different prison.[96]

123. On July 8, 2014, an inmate wrote the Monitor telling her the Gangster Disciples and the Vice Lords had put a hit on him. He told the Monitor that if he stayed at EMCF, he was afraid he was going "to get stabbed or something worse." He was asking to be transferred to a different prison "as soon as possible" so he could be safe.[97]

124. On April 4, 2014, another inmate wrote the Monitor, reminding her of his previous stabbing and asking for her help getting to protective custody because he believed his life to be "in serious danger" and did not "want to die in prison."[98]

125. On March 14, 2014, an inmate wrote a very detailed letter to the Monitor describing multiple threats from the same inmate, one time while the aggressor was brandishing a knife. He recounted how he was able to disarm the aggressor with the knife and take it from him. When the staff responded to the incident scene, the inmate who wrote the letter was in possession of the knife and he received a RVR. He was writing the Monitor asking for help getting the RVR corrected.[99]

126. On November 19, 2013, an inmate living in Unit 4 wrote the Monitor and said, "I am being held at knifepoint and extorted. . . . My life is in immediate danger and I need your help."[100] The Monitor responded in March 2014 telling the inmate she had forwarded his safety issues to the Warden.[101]

127. On November 20, 2013, another inmate wrote the Monitor. This inmate said, "I was assaulted with weapons by several inmates that belong to a gang. I fear for my life in a major way."[102] He was asking to be placed in protective custody.

128. There is a pattern of inmates reaching out to the Monitor for help, feeling like their lives are in danger. As I discussed earlier in this report, inherent in many of these inmates' notes to the Monitor is an expression that the inmate has no other alternative but to hope the Monitor can help them. Implicit in their pleas for help is a distinct lack of confidence that MTC staff can or will help them. When inmates feel that staff cannot or will not protect them they are likely to do what they feel they need to do in order to stay safe, which in my opinion explains the prevalence of weapons at EMCF.

129. And sometimes the threats are even against the staff, as was the case in January 2015, when the Laundry Supervisor, a staff person, submitted an Unusual

[96] MDOC-CON-00001292
[97] MDOC-CON-00004740–4741
[98] MDOC-CON-00002903
[99] MDOC-CON-00002875–2883
[100] MDOC-CON-00003435
[101] MDOC-CON-00003434
[102] MDOC-CON-00003436

Occurrence Report saying that an inmate had threatened to pay someone $500 to "take me out." She also said the inmate made the same threat on an officer.[103]

130. Also significant, in May 2014, an inmate wrote to the Monitor twice saying he was in danger from the Gangster Disciples because he had refused an order to stab the Unit Manager. In one of his letters he said: "I refuse to carry out the hit. Now the Gangster Disciples is trying to stab me and the high ranking member of the gangsters got a hit on me."[104] The inmate also wrote: "[T]he warden know all about [the] situation but it seem like it don't matter about my safety in this prison. My life is really in danger."

131. There are many other letters written to the Monitor saying that the inmates' "life is in danger" and asking for help either getting transferred or placed into protective custody. While that also happens in other prisons, in my experience, the frequency of it at EMCF is far higher than what is typically seen at a well-functioning prison. The sheer numbers of weapons discovered at the prison, the fact that the documentation shows they are used with some frequency, and the letters from the inmates to the Monitors asking for help, combined with insufficient staffing and lack of attention to basic correctional activities like inmate counts, all lead me to conclude that EMCF is a very dangerous prison that presents an ongoing risk of serious harm to the prisoners.

D. Staff are Poorly Trained and Engage in Unnecessary Uses of Force

132. The Monitor's reports reveal a serious concern in the repeated finding of non-compliance to the checklist items regarding use of force. The language from the checklist describing specific items where non-compliance has repeatedly been found since September 2015 is:

- Policy governing immediate/calculated use of force consistent with MDOC
- All use of force incidents documented and reviewed
- Use of Force consistent with law and MDOC, incident report prepared and MDOC notified ASAP by phone/fax, contract monitor notified
- Incident reports, other than critical, furnished [within] one week
- Videotapes of incidents preserved/catalogued as per MDOC
- Offender is seen by medical immediately after incident
- Facility subscribes to prescribed confrontation avoidance procedures

[103] MDOC-CON-00001358
[104] MDOC-CON-00002686 and MDOC-CON00004733–4735

- Medical staff consulted prior to calculated use of force situations[105]

One comment that frequently follows the item regarding confrontation avoidance is: "Need training in how to conduct."[106]

133. What the Monitor is pointing out here is that MTC is not following MDOC policy regarding use of force; that use of force events are not being documented properly either in writing or by video; that medical is not being involved in planned use of force situations; and, that inmates are not being seen by medical immediately after a use of force event. All of these items are important to make sure force is not used unnecessarily or excessively and that inmates receive medical care after a use of force event.

1. Spontaneous Uses of Force are Unnecessarily Used at EMCF in Situations That Should be Planned

134. A spontaneous use of force (SUOF) is appropriate when the inmate presents an immediate or imminent risk of harm, for example when an inmate is assaulting someone and will not respond to verbal orders to cease his actions. A planned use of force (PUOF) is appropriate when there no immediate risk of harm, for example when an inmate is refusing orders to submit to handcuffs and come out of his cell. In this example the inmate is confined to a cell and presents no immediate or imminent risk of harm. This gives the officers the advantage of time and circumstance and allows the opportunity for staff to attempt to create a dialogue with the inmate and de-escalate the situation so that use of force might be avoided. This is especially true for inmates who are mentally ill.

135. A little over two years ago I was asked to opine about the use of force on mentally ill prisoners confined in a very large jail. My report contained five findings, one of which was that the jail staff failed to allow mental health staff to attempt to de-escalate the incident so that force might be avoided. The judge adopted this recommendation and required the jail to implement it. Several months ago, I was asked to review the jail's progress in following this new policy requirement. I was very pleased to find that when jail staff had the opportunity to attempt de-escalation, nearly 60% of the time force was in fact avoided. It is consistent with my own experience as a prison Superintendent and as Secretary of the Washington Department of Corrections, as well as what I have witnessed in several other jurisdictions. Any day an officer does not have to put their hands on an inmate to use force is a good day in corrections.

136. In my first report in this case, I criticized EMCF for failing to follow the good correctional practice of allowing mental health staff to engage in attempts to de-

[105] MDOC-CON-00005687 The last item on the list was found to be in compliance in February 2016 but not in any of the other months from September 2015 – March 2016
[106] MDOC-CON-00005687

escalate potential PUOF situations so that violence could be avoided. Oftentimes I found these opportunities were presented when the inmate took control of the food tray slot in the cell door. In my report I said:

> Some inmates start fires in their cells, flood their cells, or cut on themselves, but their primary means of registering their frustration and complaints about living conditions is to place their arms through the food tray slots in their cells doors and refuse to remove them until someone addresses their issue(s)—putting themselves and other prisoners in the unit at risk of significant injury.[107]

From my review of EORs and use of force videos, I remain critical of EMCF. I do not see that they have made progress in this area—slowing situations down so they can be turned into PUOF instead of SUOF, or in providing meaningful mental health interventions when incidents are being managed as PUOFs. There are multiple examples from my review of the records, which I describe below.

137. On June 5, 2015, an inmate was being returned to his segregation cell after time spent in a recreation cage. He began to threaten the staff, unhappy with his status on long-term segregation. He was placed back into this cell but when officers were removing his handcuffs he broke free from their control and went to the back of his cell with one hand in cuffs but the cuff key still in the lock on the handcuffs. The cell door was secure at this point and he wasn't going anywhere. According to the EOR he was immediately sprayed with a chemical agent, and then he returned the cuffs and the key. Only after the fact was a mental health staff called to the scene. But this would have been a perfect opportunity for the officers to call for a PUOF and to bring in the mental health staff before they used the spray and not after. It was clear that the inmate had an issue with his status on long-term segregation, which would have provided a place to begin a conversation. It is quite possible force could have been avoided altogether if this approach had been pursued.[108]

138. On July 13, 2015, an inmate was in a recreation cage, unrestrained. When it came time for him to be restrained and returned to his cell, he refused to allow staff to apply the restraints. Rather than slow the situation down, the officers unlocked and entered the cage where the inmate's behavior was described as being "very combative." The officers then went hands on, taking the inmate to the ground and placing him in restraints, risking injury to the inmate and to the officers. This is a textbook situation to avoid the SUOF and convert the situation to a PUOF. Again, the inmate saw mental health after the situation was all over, rather than before. Medical staff reported the inmate had abrasions to his face.[109]

[107] Expert Report of Eldon Vail (June 16, 2014), at ¶80
[108] DEF-029240–29254
[109] DEF-029487–29506

139. On May 16, 2015, during feeding time, an inmate had his arm through the food tray slot and refused to remove it and verbally threatened staff. Even though there was no immediate danger to the officer given the inmate was secure behind a locked cell door, the inmate was still immediately sprayed with a chemical agent. In this case there is no mention of involving mental health staff to de-escalate the situation either before or after the spray was used. This too should have been executed as a PUOF.[110]

140. On May 6, 2015, an inmate refused to return his cuffs after he was returned to his cell following a shower. The Captain says he attempted a verbal intervention. The EOR then says that when the inmate "reached down to pick up something at the base of his door on the inside," although still in cuffs (proper procedure would mean he was cuffed behind his back) he was immediately sprayed. The first spray had no effect so he was sprayed a second time. Mental health staff was called between the two sprays but there is no indication in the report that they were given the opportunity to attempt to de-escalate or speak with the inmate until after both sprays had been administered. Once again, the better course of action would have been to back away, slow the situation down and prepare for a PUOF.[111]

141. On April 2, 2015, a Captain responded to the segregation unit because an inmate had been able to start a fire outside of his cell. While waiting for the fire extinguisher to put the fire out, the inmate threatened to throw urine on the Captain through his food tray slot. Again, there was no immediate danger and no imminent risk of harm. And again, the inmate was immediately sprayed with a chemical agent and a mental health staff was only called in after the fact to speak with the inmate. It is a better practice for the Captain to back away from the cell so the inmate cannot successfully throw urine or other substances onto him/her and begin to develop a plan that might avoid the use of force altogether.[112]

142. On December 1, 2014, an inmate was in his cell and was given verbal commands to exit his cell but he refused. After being warned, he was subjected to pepper spray twice. He then submitted to restraints and was removed from the cell.[113] This event was listed as a SUOF when it clearly called for PUOF. The inmate was described as aggressive and combative but he was in his cell, not going anywhere. It is possible that the time and the fact of the inmate's limited ability to cause problems while in the cell might have worked to the officers' advantage if they had taken the time to try and de-escalate the situation while they assembled the staff to perform a PUOF, if it turned out to be necessary.

143. On January 22, 2015 a Captain was walking by a cell door in segregation when an inmate threw an unknown liquid substance on him through the food tray slot. There is no indication that the Captain was in any immediate danger and, in my opinion,

[110] DEF-028654–28667
[111] DEF-028585–28601
[112] DEF-028307–28316
[113] DEF-027413–27424

no immediate response was required. Rather than back away from the cell and create an organized response, the Captain immediately sprayed the inmate with a chemical agent. Once again, mental health staff was called to the scene but not until after the inmate was already sprayed.[114] In situations such as this, if the officers are well trained and well equipped, a PUOF is a better response than immediate spraying when there is no immediate danger. In other jurisdictions a cell shield or hand held shields are typically used when there is a need to protect the potential targets of an inmate who is throwing. These shields provide the immediate safety that stops the throwing from causing any harm and allows time for the inmate to calm down, allows time for a planned response to be assembled, and allows time for mental health staff to enter the situation and do what is possible to de-escalate the situation.

144. As illustrated by the above few examples (there are many others), the fact that EMCF routinely takes situations that could, and should, be managed as PUOF, and instead implements force immediately, places inmates and the officers at risk of unnecessary injury. And, as the Monitors' reports confirm, both MTC and MDOC know this is a longstanding problem that needs to be remedied. In fact, as mentioned above, on checklists between December 2014 – March 2016, with respect to whether EMCF "subscribes to prescribed confrontation avoidance procedures," the Monitor found the facility non-compliant and stated simply: "Need training on how to conduct."

145. What officers at EMCF seem to not understand is that SUOF is appropriate when there is imminent risk of harm, for example when an inmate is outside a cell and is armed or fighting and refuses to respond to the verbal orders of officers to cease the behavior. Responding immediately with force is similarly appropriate and proper when the inmate is in a cell and is assaulting his cell partner or is engaging in an act of self-harm. But when that is not the case, and especially when the inmate is securely confined to a cell and there is no imminent threat, the better course of action is to take advantage of the situation by slowing it down, making an effort to talk the inmate out of what he is doing and in the meantime, assemble a team and develop a plan to use force if it turns out to be necessary. This lack of understanding and inability to adhere to the basics of good correctional practice results in frequent unnecessary use of force events and puts inmates at risk of harm that is in many cases completely avoidable.

2. Mental Health Staff and Officers are Poorly Trained to Actually De-escalate Potential Use of Force Situations

146. Even when officers do get it right and convert situations identical to the ones above to PUOFs, because they don't allow mental health staff to engage in actual attempts to de-escalate the conflict, their practices still do not work to actually take advantage of time and circumstances so that force might not be used.

[114] DEF-027668 –27667

147. Although I am not a psychologist and have no advanced mental health degree, I have both administered and designed correctional programs for mentally ill inmates. I have worked closely with mental health staff over the years, particularly around ways to reduce the use of force. In my opinion there is a fundamental misunderstanding of what mental health de-escalation looks like at EMCF. Mental health staff efforts are not employed in an effective way but instead are engaged in rote exercises where, from the incident reports and the videos I have been able to view, no meaningful conversations between mental health and the inmate are allowed to occur. The mental health staff shows up and almost immediately says the inmate's disturbance is "behavioral" rather than a mental health issue, and then force commences. There is rarely, if ever, an attempt to actually de-escalate these situations.

148. On July 15, 2015, an inmate had thrown a liquid on staff and refused to allow his food tray slot to be secured. In contrast to the examples above, this time the officers treated the situation as a PUOF.[115] Mental health staff responded to the scene and they reported that "there were no signs of mental distress and that [the inmate's] action towards staff was due to behavioral issues."[116] This comment, typical in other PUOF situations at EMCF, misses the point. The purpose of mental health staff involvement is not to categorize the inmate's state in the present moment; it is to attempt to communicate with the inmate in an effort to de-escalate the situation. In this situation, mental health staff failed to communicate with the inmate and instead simply categorized his state in the present moment, and a chemical agent was used.

149. On October 14, 2015, a nearly identical situation was reported.[117] The inmate was locked in his cell. He threw a liquid outside of his cell and refused to submit to restraints and be removed from his cell. This was treated as a PUOF and mental health responded to the situation. The report says that the mental health staff stated the inmate's action "was behavior not mental distress." Spray was then used. Again, the process at EMCF missed the point. The opportunity to create a dialogue with the inmate so that force might be avoided was missed.

150. In another report from October 20, 2015, an inmate was refusing to be restrained to come out of the recreation cage and be returned to his cell.[118] It was treated as a PUOF situation. Again mental health was called for and the report says: "[Mental Health Counselor] Anderson spoke briefly with [the inmate] and stated on camera that the offender was not under no type of mental distress and his refusal towards staff was only behavioral." The use of the word "briefly" emphasizes that the involvement of mental health staff is only cursory and not meaningfully purposed to attempt to de-escalate the situation so that force might be avoided.

[115] MDOC policy requires video in a PUOF situation. In this and the next 5 incidents in my report, even though the EOR says a video exists, it was not in the materials disclosed.
[116] DEF-029472–29482
[117] DEF-030481–30498
[118] DEF-030552–30535

151. In an incident from August 7, 2015, an inmate refused to allow officers to check the security of his cell door in segregation.[119] This was managed as a PUOF and mental health was summoned to the scene. The EOR says: "It was noted that his actions towards staff was behavioral and that he was not under any mental distresses at the time." The inmate was sprayed twice before he complied with the officers' orders. Again, another missed opportunity to perhaps avoid force altogether.

152. On August 6, 2014, an inmate had his arm through the food tray slot and refused to remove it.[120] The situation was managed as a PUOF and mental health responded. The EOR says that mental health advised that "this was not a mental health issue but a behavior issue." The inmate was sprayed and then complied with staff orders. While the end result was the inmate's compliance with staff, it came at the cost of a use of force against the inmate and a missed opportunity to de-escalate the situation to avoid the need for spraying altogether.

153. On January 17, 2015 an inmate in a general population unit tied a string around his neck. It resulted in a SUOF as the inmate assaulted staff and was taken to the ground when he was being placed in restraints. The inmate was escorted to medical where the string was cut. The mental health staff "stated she would not talk to offender because his issues were not mental but behavioral."[121] In my experience I have never heard of a mental health staff refusing to even speak with an inmate who has just engaged in suicidal behavior. This particular example reinforces my opinion that MTC does not comprehend the proper role of mental health staff in use of force situations or, for that matter, the proper way to respond to inmates in distress.

154. As a result of failing to understand and properly utilize the communication skills of mental health staff to de-escalate PUOF situations, EMCF only goes through the rote exercise of bringing mental health staff to the scene to declare the issue is behavioral and not related to mental health. In my experience and training this is not how mental health involvement in planned use of force situations works in my own and other jurisdictions. The mental health staff—employing the advantage of time and circumstance—needs to have the leeway to establish a dialogue with the resisting inmate to see if they can use their communication skills to help the inmate find a way out of the situation short of being subjected to use of force. EMCF's failure to do so results in some situations that could be de-escalated prior to and instead of resulting in use of force. As I said previously, true mental health interventions oftentimes work and it appears that EMCF does not understand this fact, or is not choosing to allow mental health interventions to be an integral part of planned use of force situations in their facility.

[119] DEF-029830–29840
[120] DEF-026203–26214
[121] DEF-027764–27777

E. Segregation Practices at EMCF

155. In my first report in 2014, writing about my interviews with inmates in segregation I said: "The most common complaint from the prisoners is that they do not get access to out of cell exercise or to showers according to policy."[122] In 2016, I find that little has changed at EMCF.

156. The corrections industry has basic standards for conditions of confinement for inmates in segregation. The American Correctional Association (ACA) relevant standards for out of cell exercise and showers for inmates in segregation are:

- Written policy, procedure and practice provide that inmates in segregation receive a minimum of one hour of exercise per day outside their cells, five days a week, unless security or safety considerations dictate otherwise.[123]
- Written policy, procedure and practice provide that inmates in segregation have the opportunity to shave and shower at least three times a week.[124]

157. MDOC policy mirrors these standards, word for word, and specifically references the ACA standards.[125]

158. I asked for and received a sample of records for individual inmates held in segregation at EMCF. The records I received date from October 25, 2015 – February 6, 2016. I reviewed 1,078 individual records. From my review it is clear that the ACA standards and MDOC policy are not routinely followed at EMCF.

159. From my review I found that only 172 times, about 16%, did the inmates in segregation receive their required five hours of recreation per week. Another 276 times, or 26%, inmates received four hours. And 630 times, or 58%, inmates received 3 hours or less out of cell recreation while confined to segregation.

160. I also found that only 438 times, about 41%, did inmates receive their required opportunity to shave or shower three times a week while in segregation.

161. The Monitor has also addressed this issue in her monthly reports. On her checklist in the section for Special Management Unit inmates, there is an item entitled "Offenders in disciplinary SMU retain privileges as per MDOC SOP." In twenty-one months out of twenty-five months, including the available data from 2016, the Monitor found EMCF to be non-compliant with this item.[126]

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[122] Expert Report of Eldon Vail (June 16, 2014), ¶ 39
[123] ACA Standard 4-4270
[124] ACA Standard 4-4262
[125] MDOC 19-01, Offender Segregation, at 3
[126] Only from June 2015 – August 2015, and in December 2015, did the Monitor find this item to be in compliance. Otherwise, from March 2014 – May 2015, in September 2015 – November 2015, and in January 2016 – March 2016, the Monitor found EMCF to be non-compliant. Put differently, in twenty-one

162. Curiously, from September 2015 until March 2016, the Monitor entered the comment "has improved" next to this item on the checklist. The records I reviewed overlapped much of this same time period (October 2015 – February 2016) and indicate that the assertion that compliance "has improved" resulted from inmates receiving their required five hours of week out of cell recreation only about 16% of the time, and only about 40% of the time did they receive their required showers. It makes me wonder how bad the situation was before the purported "improvement."

163. When in segregation a person is completely dependent on the staff to provide for their basic human needs. Being able to regularly and routinely clean one's body by having access to a shower is fundamental to humane treatment in every correctional facility and is a basic human need. The fact that EMCF meets their own policy requirement and the relevant correctional standards for a shower only about 40% of the time illustrates their utter disregard for the dignity and welfare of the prisoners in their charge.

164. Having the opportunity to be out of the cell for one hour a day five days a week provides some relief from the extreme social isolation caused by placement in a segregation cell. There is no serious debate about the harmful effects of segregation, especially for inmates who are mentally ill. Regular out of cell recreation is one of the ways to relieve the stress of prolonged placement in segregation.

165. I have been retained to opine or consult on the harmful impacts of segregation on prisoners in a number of cases including in the states of California, Delaware, New Jersey, Georgia, Alabama, Oregon, Montana, Illinois and Virginia. I am very familiar with the research on the issue. It is widely recognized that placing mentally ill inmates in segregation creates a significant risk of harm for that vulnerable population. This has been firmly stated by the American Psychiatric Association:

> Prolonged segregation of adult inmates with serious mental illness, with rare exceptions, should be avoided due to the potential for harm to such inmates. If an inmate with serious mental illness is placed in segregation, out-of-cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out-of-cell time should be permitted. Correctional mental health authorities should work closely with administrative custody staff to maximize access to clinically indicated programming and recreation for these individuals.[127]

166. Dr. Terry Kupers, one of the country's foremost psychiatric experts on the impacts of segregation on the mentally ill prisoner and an expert in this case has said:

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of twenty-five months between March 2014 and March 2016, the Monitor found EMCF to be non-compliant.

[127] American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness*, 2012

> It is stunningly clear that for prisoners prone to serious mental illness, time served in isolation and idleness exacerbates their mental illness and too often results in suicide. This is the main reason that federal courts have ruled that prisoners with serious mental illness must not be subjected to long-term isolation.[128]

167. Based on my training and experience, segregation also presents risk to inmates who have not been previously diagnosed as mentally ill. The American Bar Association acknowledges this reality and the related research in their public statements:

> Some prisoners are sufficiently mentally resilient (or their stays in segregation sufficiently short) that isolating confinement does them no lasting harm; for others, the human cost can be devastating. Abundant research demonstrates that prisoners in segregation often experience physical and mental deterioration.[129]

168. Yet MDOC and MTC make no provision in their policies to exclude or to avoid segregation for inmates who are mentally ill. The MDOC policy on segregation makes no mention of mental illness.[130] Neither does the policy on Administrative Segregation Long Term Status (defined as more than sixty days).[131]

169. The result is that inmates at EMCF, a facility designated for the mentally ill, wind up in segregation. There is a distinct lack of practices at EMCF to recognize the risk this population presents when they are in segregation.

170. The ACA recognizes the risk for all prisoners in segregation and for that reason has developed the following language in their standards:

> Written policy, procedure, and practice require that all special management inmates are personally observed by a correctional officer twice per hour, but no more than 40 minutes apart, on an irregular schedule.[132]

171. And again, MDOC has the exact same language in their policy,[133] which MTC is required to follow. However, a review of logbooks for EMCF segregation units shows this policy is not consistently followed.

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[128] Kupers, T., *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?* The Routledge Handbook of International Crime and Justice Studies (2013), at 4 Justice Studies, at 4
[129] ABA Standards for Criminal Justice, 3rd edition, Treatment of Prisoners, 2011
[130] MDOC 19-01, Offender Segregation
[131] MDOC 19-01-03, Administrative Segregation Long Term Status
[132] ACA Standard 4-4257
[133] MDOC 19-01, at 2

172. For example, the log for December 2015 for Unit 5B contains multiple deviations from the policy requirement. I offer a sample of those deviations from pages of that logbook, showing the significant amounts of time that often pass between recorded observations of inmates:[134]

- On December 2–3, 2015, the following amounts of time passed between recorded observations of inmates:

  2 hours 35 minutes | 1 hour 10 minutes | 10 hours | 1 hour 4 minutes | 1 hour 14 minutes | 1 hour 15 minutes | 1 hour 50 minutes | 1 hour | 1 hour 30 minutes | 1 hour 10 minutes[135]

- On December 16–17, 2015, the following amounts of time passed between recorded observations of inmates:

  2 hours | 8 hours 41 minutes | 1 hour (6 times) | 1 hour 30 minutes | 10 hours 40 minutes[136]

- On December 23 and 25, 2015, the following amounts of time passed between recorded observations of inmates:

  1 hour (twice) | 11 hours 10 minutes | 1 hour 10 minutes | 1 hour 15 minutes | 1 hour 31 minutes | 11 hours 8 minutes[137]

173. The log for December 2015 for Unit 5D shows similar patterns:

- On December 2–3, 2015, the following amounts of time passed between recorded observations of inmates:

  8 hours 4 minutes | 1 hour 30 minutes | 1 hour 33 minutes | 1 hour 51 minutes[138]

- On December 12–14, 2015, the following amounts of time passed between recorded observations of inmates:

  2 hours 9 minutes | 1 hour 14 minutes | 8 hours 11 minutes | 1 hour (4 times) | 11 hours[139]

- On December 24–26, 2015, the following amounts of time passed between recorded observations of inmates:

[134] I do not illustrate deviations from the policy of less than an hour, of which there are many.
[135] MTC-CON-00092157
[136] MTC-CON-00092168
[137] MTC-CON-00092175
[138] MTC-CON-00090350
[139] MTC-CON-00090357

8 hours 18 minutes | 1 hour 5 minutes | 2 hours 16 minutes | 2 hours 11 minutes | 1 hour 11 minutes | 1 hour 26 minutes | 17 hours 55 minutes | 1 hour 5 minutes | 1 hour 24 minutes[140]

174. The log for December 2015 for Unit 6D similarly shows:

- On December 8–9, 2015, the following amounts of time passed between recorded observations of inmates:

  8 hours 30 minutes; 1 hour 30 minutes; 1 hour (twice); 3 hours 16 minutes[141]

- On December 18–20, 2015, the following amounts of time passed between recorded observations of inmates:

  2 hours 19 minutes | 1 hour 4 minutes | 1 hours 6 minutes | 1 hour 6 minutes | 2 hours 6 minutes | 2 hours | 8 hours 34 minutes | 6 hours 20 minutes | 1 hour 6 minutes | 3 hours 7 minutes | 1 hour 43 minutes | 1 hour 2 minutes | 1 hour[142]

- On December 24–26, 2015, the following amounts of time passed between recorded observations of inmates:

  8 hours 35 minutes | 1 hour 3 minutes | 1 hour 7 minutes | 1 hour 3 minutes | 1 hour 10 minutes | 9 hours 11 minutes | 1 hour 23 minutes | 1 hour 32 minutes | 3 hours 48 minutes[143]

175. Obviously these samples from the logs clearly illustrate that EMCF is not checking on inmates in their segregation cells as required by policy. Though there are times that half hour checks are logged, there are also many examples of wide deviations from the policy as I demonstrate above.

176. The MDOC Monitor on a regular basis has identified the lack of proper logging in the EMCF segregation units. From March 2014 – March 2016, this item was found to be in non-compliance by the Monitor.

177. The fact that these logs are so bad, literally the worst I have ever seen in my career as a prison administrator and expert, reveals a disturbing lack of accountability on the part of those who supervise EMCF. Keeping a running log that accurately and consistently reports what has happened in the living unit is one of the easiest, yet most fundamental ways for supervisors to know what has gone on in their living

[140] MTC-CON-00090367
[141] MTC-CON-00092087
[142] MTC-CON-00092091
[143] MTC-CON-00092094

units during their absence. If supervisors are not regularly and routinely in the living units they supervise, they are not detecting that rules for inmates and expectations for officers are not being followed. This sends the message to both staff and inmates that there is no accountability for failing to follow the rules. I cannot tell whether supervisors are checking these logs regularly and just not doing anything about the deviations from policy, or whether they don't check them at all. Either way, this failure is quite profound and has consequences for the safe operation of their segregations units.

178. In previous sections of this report I have written about the problems of use of force in the EMCF segregation units. Inmates repeatedly act out by refusing to comply with rules regarding the food tray slot in their cell door. In my experience and from my conversations with inmates, it is my opinion this can be related to lack of supervision and interaction with inmates while they are in their segregation cells. When hours go by without anyone doing required security checks it is not surprising that inmates will misbehave out of frustration and take control of what little they can, like the food port, or starting a fire, or flooding their cell. The reason regular check of segregation cells is required by the ACA and MDOC is to make sure that inmates are safe but it also allows the inmate to tell the officer if they have any immediate concerns. This practice is not followed at EMCF and it creates a substantial risk of harm for the prisoners. Sometimes that risk results in tragic outcomes.

179. A three-year study in the New York City jail clearly illustrates the risk of suicide and self-harm attempts for inmates in segregation:

> In 1303 (0.05%) of these incarcerations, 2182 acts of self-harm were committed, (103 potentially fatal and 7 fatal). Although only 7.3% of admissions included any solitary confinement, 53.3% of acts of self-harm and 45.0% of acts of potentially fatal self-harm occurred within this group. After we controlled for gender, age, race/ethnicity, serious mental illness, and length of stay, we found self-harm to be associated significantly with being in solitary confinement at least once, serious mental illness, being aged 18 years or younger, and being Latino or White, regardless of gender.[144]

180. Documented events of self-harm also predictably happen in the EMCF segregation units.

181. In February 2016, an inmate housed in Unit 5A committed an act of self-harm by putting a piece of glass in his arm. He required offsite medical treatment.[145]

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[144] Fatos Kaba, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates,* Am J Public Health, 2014 March;104(3):442–447, *available at* https://www.ncbi nlm nih.gov/pmc/articles/PMC3953781/

[145] DEF-031817–31822

182. In late February 2016, an inmate in Unit 5B committed an act of self-harm by sticking glass shard under his skin. He required offsite medical treatment.[146]

183. In January 2016, an inmate in Unit 5A had to be transported offsite because he had a self-inflicted wound to his abdomen. The EOR says: "The offender cut himself after he was placed on property restriction for a 72 hour period after the offender set fire to his state issue." Upon his return to EMCF he was placed on suicide watch.[147]

184. In January 2016, an inmate housed in Unit 6D was found with a self-inflicted wound to his leg. He was taken to an offsite hospital for treatment. He was returned to EMCF and placed back into segregation in Unit 6D.[148]

185. In October 2015, an inmate from Unit 6D was transported to the hospital "for a self-inflicted wound to his right lower abdomen area which he reopened and placed a foreign object inside." Upon his return from the hospital he was returned to a segregation cell.[149]

186. Also in October 2015, another inmate from Unit 6D was taken offsite for medical treatment due to a self-inflicted wound to his leg.[150]

187. In September 2015, an inmate in Unit 5A tied a string around his neck. He was given orders to come to the cell door and submit to restraints. He refused. Officers opened the cell door and used force to remove the string. The inmate was placed in hand and leg restraints and taken to medical following the SUOF. After a medical assessment he was returned to a segregation cell. He received an RVR for this incident.[151]

188. In July 2015, an inmate housed in Unit 5A was sent out via ambulance for a self-inflicted wound to his neck.[152]

189. Also in July 2015, an inmate housed in Unit 5B set fire and flooded his cell, resulting in use of force. He was subjected to chemical spray and ceased the behavior. He was taken medical for an assessment and then returned to the same cell. He received two RVRs.[153]

190. In May 2015, an inmate housed in Unit 6D required emergency care for a possible overdose. The EOR says: "Offender stated he had taken a handful of pills including

[146] DEF-031877–31882
[147] DEF-032140–32144
[148] DEF-031554–31559
[149] DEF-030574–30585
[150] DEF-030586–30594
[151] DEF-030206–30277
[152] DEF-029483–29486
[153] DEF-029436–29455

Xanax and was visibly and mentally impaired." He was taken to the hospital via ambulance.[154]

191. In December 2014 an inmate housed in 6D had to be taken to the hospital for a self-inflicted wound to his leg.[155]

192. In October 2014, another inmate housed in Unit 6D was taken offsite to the regional medical emergency center for treatment due to an act of self-harm. He "had reopened old wounds and placed foreign objects in the wound."[156]

193. In September 2014, an inmate from Unit 6D was taken to medical as he had "an ink pen inside of his stomach" as a result of a self-inflicted cut. The note from the EMCF provider said, "Inmate presented to medical after cutting his throat and sticking a pen in his stomach into an old cut." He was taken off-site to the emergency room.[157]

194. In August 2014, an inmate from Unit 5B was taken to the hospital for treatment for two self-inflicted wounds to his left arm.[158]

195. These are desperate and disturbing acts by individuals in distress. It may be because they are mentally ill or it may be because they are experiencing the stress from the extreme social isolation that comes with living in a segregation cell. Whatever the reason, it is simply unconscionable that EMCF fails to perform the basic and fundamental function of regularly and routinely checking on the welfare of the inmates in their segregation units.

VII. CONCLUSION

196. I recently received a declaration from an inmate who has been at EMCF since 2011. In that declaration, which is attached hereto as **Exhibit 5**, the inmate reports that on the evening of October 25, 2016, he was assaulted by approximately seven other prisoners in a cell on the upper floor in Housing Unit 5D. The cell he was assaulted in was not the cell to which he was assigned. The inmate then goes on to say:

- He was hit, kicked, and stabbed.
- Following the assault, he was kept in the (wrong) cell overnight, with "security" posted in front of the cell so he could not leave the cell or get help. He did not see officers do any of their required security checks the entire night.
- Around 7:30 the next morning a Lieutenant and a Unit Manager entered the cell and could see blood on the bed,

[154] DEF-028497
[155] DEF-027262–27266
[156] DEF-026976–26981
[157] DEF-026649–26653
[158] DEF-026215–26221

> floor, and wall from the assault. He reports his right eye was completely swollen shut and that his clothes were covered in blood.
> - At the same time other prisoners came to the door of the cell. The Unit Manager asked those inmates if this was a "violation," meaning, I believe, a beating received as internal discipline from the other inmates. One of the inmates said: "Yes, that is all it was." The Unit Manager's response was: "That's normal. This is prison." The Unit Manager and the Lieutenant then exited the cell.
> - The following day, October 27, another group of prisoners who were sympathetic to the victim's condition, escorted him back to his assigned cell on the lower floor.
> - Once back in his assigned cell he got the attention of an officer and said he needed to see medical. That officer contacted medical but they said he needed to turn in a sick call slip.
> - Four days later, on October 31, he saw a Sergeant he trusted and told him of the assault and that he needed medical attention.
> - He was taken to medical on that day and was sent to an outside hospital when he was told he had a broken nose, a bone broken under his right eye, and several bruised ribs. He had been stabbed in his back and on his forearm and he had been bitten on the chest during the assault.[159]

197. This example illustrates the complete dysfunction that characterizes the operation of EMCF. The inmate suffered a serious assault that was condoned by EMCF supervisors who simply said: "This is prison." Despite obvious evidence of the assault, including visible injury to the inmate's face, supervision of the unit was so lax that no one noticed, and for nearly a week, until the inmate encountered an EMCF staff that he thought he could trust, he received no medical attention. This example is very recent. There is clearly a substantial risk of serious harm at EMCF on a current and on-going basis.

198. In another disturbing example, the frustration of the Monitor at the dangerous conditions in the prison due to the lack of control by MTC staff is clear in an email she sent on October 14, 2015 regarding the need to move specific inmates from EMCF. She says:

> These are ten offenders[160] who have been calling the shots/running the offenders/staff here with the ability to move almost anywhere the want to go.

[159] Declaration of Cordarious Nelson (December 2, 2016), *Dockery v. Fisher*, No. 3:13-cv-326-TSL-JMR
[160] The Monitors' email references 10 inmates but her list has only 9 names. She offers reasons for the transfers for only 7 of them.

- [Inmate] controls/runs unit 4
- [Inmate] was just placed on long term by Mrs. M. Jackson but I believe he will still have control while locked down here.
- [Inmate] is on the seg unit but still runs things and staff. He even question me about knowing who he is when I removed a broom from his pod stating, "You must not know who I am" and I stated an inmate.
- [Inmate] controls/runs unit 2
- [Inmate] lots of control
- [Inmate] has lots of control
- [Inmate] control even though he supposed to be locked down constantly out his cell.[161]

While I again applaud the Monitor for trying to make the prison safer, I conclude from her email that she was so frustrated with MTC's ability to control these inmates that she felt it necessary to demand they be transferred out of EMCF. But over a year after the Monitor made this demand, four of these inmates are still housed at EMCF, and the inmate who the Monitor noted "controls/runs unit 2" remains housed on Unit 2.

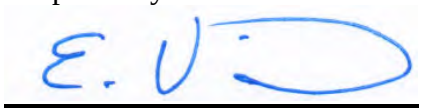
199. Two years after my first visit to EMCF, MTC continues to demonstrate that they do not have the ability, the capacity, the knowledge of basic prison operations—or perhaps the resources—to successfully manage a prison with close custody and mentally ill inmates, many of whom resort to gang allegiances to keep themselves safe because the staff continue to demonstrate that they are unable to do so. Equally culpable, MDOC has received a steady stream of information about the problems at EMCF, yet they have failed to act to correct those problems.

200. When there are too few staff to supervise the inmates to the point where inmates are doing the counts; when inmates are not expected to follow a rule as basic as not blocking the view into their cells; when inmates do not regularly and routinely get answers to legitimate questions they raise; when staff are not proficient in use of force procedures, especially conflict avoidance procedures, the result is a dangerous prison where the inmates, not the staff, exercise considerable control. Moreover, mentally ill inmates—which describe many of the inmates housed at EMCF—need coherent, structured programs that keep them active while clinicians work to help them learn how to control their own behavior. The overall operation at EMCF is so far away from resembling an environment where inmates are safe enough for real treatment to occur that it is challenging to recommend how they would start to go about it.

[161] DEF_ESI_0005926

201. At this point in the evolution of the facility MTC and MDOC have demonstrated an utter incapacity to manage, control, and treat the inmates confined at the facility. MTC continues to subject all inmates, many of them mentally ill, to an significant risk of serious harm, and MDOC continues to fail to hold MTC accountable. While a number of urgent reforms are needed, including substantial expansion, upgrading, and retraining of staff, as well as substantially improved staff supervision and, at long last, effective repair or complete replacement of the defective cell door locking mechanism, there is absolutely no reason to think that MTC and MDOC have the will or the ability to make these and other necessary reforms, as discussed in my report, absent the intervention of the Court.

Respectfully Submitted:



Eldon Vail

Exhibit 1

ELDON VAIL
1516 8th Ave SE
Olympia, WA. 98501
360-349-3033
Nodleliav@comcast.net

WORK HISTORY

Nearly 35 years working in and administering adult and juvenile institutions, and probation and parole programs, starting at the entry level and rising to Department Secretary. Served as Superintendent of 3 adult institutions, maximum to minimum security, male and female. Served as Secretary for the Washington State Department of Corrections (WADOC) from 2007 until 201l.

▪ Secretary	WADOC	2007-2011
▪ Deputy Secretary	WADOC	1999-2006
▪ Assistant Deputy Secretary	WADOC	1997-1999
▪ Assistant Director for Prisons	WADOC	1994-1997
▪ Superintendent	McNeil Island Corrections Center	1992-1994
▪ Superintendent	WA. Corrections Center for Women	1989-1992
▪ Correctional Program Manager	WA. Corrections Center	1988
▪ Superintendent	Cedar Creek Corrections Center	1987
▪ Correctional Program Manager	Cedar Creek Corrections Center	1984-1987
▪ Juvenile Parole Officer	Division of Juvenile Rehabilitation	1984
▪ Correctional Unit Supervisor	Cedar Creek Corrections Center	1979-1983
▪ Juvenile Institution Counselor	Division of Juvenile Rehabilitation	1974-1979

SKILLS AND ABILITIES

- Ability to analyze complex situations, synthesize the information and find practical solutions that are acceptable to all parties.

- A history of work experience that demonstrates how a balance of strong security and robust inmate programs best improves institution and community safety.

- Leadership of a prison system with very little class action litigation based on practical knowledge that constitutional conditions are best achieved through negotiation with all parties and not through litigation.

- Extensive experience as a witness, both in deposition and at trial.

- Experience working with multiple Governors, legislators of both parties, criminal justice partners and constituent groups in the legislative and policymaking process.

- Skilled labor negotiator for over a decade. Served as chief negotiator with the Teamsters and the Washington Public Employees Association for Collective Bargaining Agreements. Chaired Labor Management meetings with Washington Federation of State Employees.

HIGHLIGHTS OF CAREER ACCOMPLISHMENTS

- Reduced violence in adult prisons in Washington by over 30% during my tenure as Secretary and Deputy Secretary even though the prison population became much more violent and high risk during this same time period.

- Long term collaboration with the University of Washington focusing on improving treatment for the mentally ill in prison and the management of prisoners in and through solitary confinement.

- Implemented and administered an extensive array of evidence based and promising programs:

    - Education, drug and alcohol, sex offender and cognitive treatment programs.
    - Implemented sentencing alternatives via legislation and policy, reducing the prison populations of non-violent, low risk offenders, including the Drug Offender Sentencing Alternative and, as the Secretary, the Family and Offender Sentencing Alternative. http://www.doc.wa.gov/community/fosa/default.asp
    - Pioneered extensive family based programs resulting in reductions in use of force incidents and infractions, as well as improved reentry outcomes for program participants.
    - Established Intensive Treatment Program for mentally ill inmates with behavioral problems.
    - Established step down programs for long-term segregation inmates resulting in significant reduction in program graduate returns to segregation. http://www.thenewstribune.com/2012/07/10/2210762/isolating-prisoners-less-common.html

- Initiated the Sustainable Prisons Project
  http://blogs.evergreen.edu/sustainableprisons/

- Improved efficiency in the agency by administrative consolidation, closing 3 high cost institutions and eliminating over 1,200 positions. Housed inmates safely at lowest possible custody levels, also resulting in reduced operating costs.

- Increased partnerships with non-profits, law enforcement and community members in support of agency goals and improved community safety.

- Resolved potential class action lawsuit regarding religious rights of Native Americans.
  http://seattletimes.nwsource.com/html/opinion/2015464624_guest30galanda.html

- Successful settlement of the Jane Doe class action law suit, a PREA case regarding female offenders in the state's prisons for women.

- Led the nation's corrections directors to support fundamental change in the Interstate Compact as a result of the shooting of 4 police officers in Lakewood, WA.

- Dramatically improved media relations for the department by being aggressively open with journalists, challenging them to learn the difficult work performed by corrections professionals on a daily basis.

EDUCATION AND OTHER BACKGROUND INFORMATION

- Bachelor of Arts - The Evergreen State College, Washington – 1973

- Post graduate work in Public Administration - The Evergreen State College, Washington - 1980 and 1981

- National Institute of Corrections and Washington State Criminal Justice Training Commission - various corrections and leadership training courses

- Member of the American Correctional Association

- Associate member, Association of State Correctional Administrators (ASCA)

- Guest Speaker, Trainer and Author for the National Institute of Corrections (NIC)

- Commissioner, Washington State Criminal Justice Training Commission 2002-2006, 2008-2011

- Member, Washington State Sentencing Guidelines Commission 2007-2011

- Instructor for Correctional Leadership Development for the National Institute of Corrections

- Author of *Going Beyond Administrative Efficiency—The Budget Crisis in the State of Washington*, published in Topics of Community Corrections by NIC, 2003

- Advisory Panel Member, *Correctional Technology—A User's Guide*

- Consultant for *Correctional Leadership Competencies for the 21st Century*, an NIC publication

- Co-chair with King County Prosecutor Dan Satterberg, *Examining the Tool Box: A Review of Supervision of Dangerous Mentally Ill Offenders* http://your.kingcounty.gov/prosecutor/DMIO%20-WorkgroupFinalReport.pdf

- Consultant for Correctional Health Care Executive Curriculum Development, an NIC training program, 2012

- Guest lecturer on solitary confinement, University of Montana Law School in 2012

- On retainer for Pioneer Human Services from July 2012 - July 2013

- On retainer for BRK Management Services from September 2012 – April 2013

- Guest Editorial, Seattle Times, February 22, 2014 http://www.seattletimes.com/opinion/guest-opinions-should-washington-state-abolish-the-death-penalty/

CURRENT ACTIVITIES

- Serve on the Board of Advisors for Huy, a non-profit supporting Native American Prisoners

- Serve on the Board of Directors for HEAL for Reentry, a non-profit supporting Native Americans' transition to the community

- Registered Agent for the Association of State Correctional Administrators (ASCA) in Washington

- Retained as an expert witness or correctional consultant in the following cases:

    - ***Mitchell v. Cate,***
      No. 08-CV-1196 JAM EFB
      United States District Court, Eastern District of California,
      Declarations, March 4, 2013, May 15, 2013 and June 7, 2013
      Deposed, July 9, 2013
      Case settled, October 2014

    - ***Parsons, et al v. Ryan,***
      No. CV 12-06010 PHX-NVW
      United States District Court of Arizona
      Declarations and reports, November 8, 2013, January 31, 2014, February 24, 2014, September 4, 2014
      Deposed, February 28, 2014 and September 17, 2014
      Case settled, October 2014

- ***Ananachescu v. County of Clark***
  No. 3:13-cv-05222-BHS
  United States District Court, Western District of Tacoma
  Case settled, February 2014

- ***Gifford v. State of Oregon,***
  No. 6:11-CV-06417-TC
  United States District Court, For the District of Oregon,
  Eugene Division,
  Expert report, March 29, 2013
  Case settled, May 2013

- ***Coleman et al v. Brown, et al***
  No. 2:90-cv-0520 LKK JMP P
  United State District Court, Eastern District of California,
  Declarations, March 14, 2013, May 29, 2013, August 23, 2013 and February 11, 2014
  Deposed, March 19, 2013 and June 27, 2013
  Testified, October 1, 2, 17 and 18, 2013

- ***Peoples v. Fischer***
  No. 1:11-cv-02694-SAS
  United States District Court, Southern District of New York
  Interim settlement agreement reached February 19, 2014,
  Case settled, March 2016

- ***Dockery v. McCarty***
  No. 3:13-cv-326 TSL JMR
  United States District Court for the Southern District of Mississippi, Jackson Division
  Report, June 16, 2014

- ***C.B., et al v. Walnut Grove Correctional Authority et al***
  No. 3:10-cv-663 DPS-FKB,
  United States District Court for the Southern District of Mississippi, Jackson Division
  Memo to ACLU and Southern Poverty Law Center,
  March 14, 2014, filed with the court
  Reports to the court August 4, 2014 and February 10, 2015
  Testified, April 1, 2 and 27, 2015

- ***Graves v. Arpaio***
  No. CV-77-00479-PHX-NVW,
  United States District Court of Arizona
  Declaration, November 15, 2013
  Testified, March 5, 2014
  Declaration, April 1, 2016

- ***Wright v. Annucci, et al***
  No. 13-CV-0564 (MAD)(ATB)
  United States District Court, Northern District of New York
  Reports, April 19, 2014 and December 12, 2014

- ***Corbett v. Branker***
  No. 5:13 CT-3201-BO
  United States District Court, Eastern District of North Carolina, Western District
  Special Master appointment November 18, 2013
  Expert Report, January 14, 2014
  Testified, March 21, 2014

- ***Fontano v. Godinez***
  No. 3:12-cv-3042
  United States District Court, Central District of Illinois, Springfield Division
  Report, August 16, 2014
  Testified June 29, 2016
  Case settled June 30, 2016

- ***Atencio v. Arpaio***
  No. CV12-02376-PHX-PGR
  United States District Court of Arizona
  Reports, February 14, 2014 and May 12, 2014
  Deposed, July 30, 2014

- ***State of Oregon v. James DeFrank***
  Case # 11094090C
  Malheur County, Oregon

- ***Disability Rights, Montana, Inc. v. Richard Opper***
  No. CV-14-25-BU-SHE
  United State District Court for the District of Montana, Butte Division

- ***Larry Heggem v. Snohomish County***
  No. CV-01333-RSM
  United States District Court,
  Western District of Washington at Seattle
  Report, May 29, 2014
  Deposed, June 27, 2014

- ***Padilla v. Beard, et al***
  Case 2:14-at-00575
  United States District Court, Eastern District of California, Sacramento Division
  Declaration, February 26, 2016
  Deposed June 3, 2016

- ***Dunn et al v. Dunn et al***
  No. 2:14-cv-00601-WKW-TFM
  United States District Court, Middle District of Alabama
  Declarations, September 3, 2014, April 29, 2015 and June 3, 2015, Expert Report, July 5, 2016
  Deposed August 21, 2016
  Testified, December 22, 2016

- ***Sassman v. Brown***
  No. 2:14-cv-01679-MCE-KJN,
  United States District Court, Eastern District of California, Sacramento Division
  Declaration, August 27, 2014, Report, December 5, 2014
  Deposed, December 15, 2014

- ***Doe v. Michigan Department of Corrections***
  No. 5:13-cv-14356-RHC-RSW
  United States District Court, Eastern District of Michigan, Southern Division

- ***Robertson v. Struffert, et al***
  Case 4:12-cv-04698-JSW
  United States District Court, Northern District of California
  Declaration, March 16, 2015
  Deposed May 4, 2015
  Case settled, October 2015

- ***Commonwealth of Virginia v. Reginald Cornelius***
  Case No: GC14008381—00
  General District Court of the County of Stafford
  Report, January 12, 2015
  Pardon granted

- ***Latson v. Clarke***
  No. 1:16-cv-00447-GBL-MSN
  U.S. District Court, Eastern District of Virginia
  Report, November 16, 2016
  Deposed, December 13, 2016

- ***Star v. Livingston***
  Case No: 4:14-cv-03037
  United States District Court, Southern District of Texas,
  Houston Division
  Reports, March 3, 2015 and October 12, 2016

- ***Doe v. Johnson***
  Case 4:15-cv-00250-DCB
  United States District Court for the District of Arizona
  Reports, December 4, 2015 and March 10, 2016
  Testified, November 14, 2016

- ***Redmond v. Crowther***
  Civil No. 2:13-cv-00393-PMW
  United States District Court, Central Division,
  State of Utah
  Report, April 28, 2015
  Deposed, July 28, 2015

- ***Flores v. United States of America***
  Civil Action No 14-3166
  United States District Court, Eastern District of New York
  Report, August 14, 2015

- ***Bailey v. Livingston***
  Civil Action No. 4:14-cv-1698
  United States District Court, Southern District of Texas,
  Houston Division
  Report, August 5, 2015
  Deposed, December 2, 2015

- ***Rasho v. Godinez***
  Civil Action No. 07-CV-1298
  United States District Court, Central Division of Illinois,
  Peoria Division
  Case settled, December 2015

- ***State of Arizona, Appellee, v. Pete J. Van Winkle, Appellant***
  No. CR–09–0322–AP
  Testified, March 28, 2016

- ***Morgal v. Williams***
  No. CV 12-280-TUC-CKJ
  United States District Court for the District of Arizona
  Report, February 1, 2016
  Deposed, February 25, 2016

- ***Williams v. Snohomish County***
  Case No. 15-2-22078-1 SEA
  Superior Court for the State of Washington, King County

- ***Sacramento County Sheriff***
  Retained by Sacramento County Sheriff to evaluate housing units in the Sacramento County jails, including maximum custody, segregation and protective custody
  Report, June 27, 2016

- ***Fant v. The City of Ferguson***
  Case No. 415-cv-00253 E.D. MO
  United States District Court, Eastern District of Missouri
  Report, January 8, 2016

- ***Community Legal Aid Society, Inc. v. Robert M. Coupe***
  Case No. 1:15-cv-00688
  United States District Court for the District of Delaware
  Report, March 31, 2016
  Settled, August 2016

- ***P.D. v. Middlesex County***
  Case No. MID-L-3811-14
  Superior Court of New Jersey
  Report, July 29, 2016

- ***C-Pod Inmates of Middlesex County Adult Correction Center, et al. v. Middlesex County***
  Civil Action No. 15-7920 (PGS)
  United States District Court for the District of New Jersey
  Report, July 29, 2016
  Settlement discussions ongoing

- ***Johnson v. Mason County***
  NO. 3:14-cv-05832-RBL
  United States District Court, Western District of Washington at Tacoma
  Declaration, April 5, 2016
  Deposed, October 26, 2016

- ***Gould v. State of Oregon, et al***
  Case No. 2:15-cv-01152-SU
  United States District Court for the District of Oregon
  Settled, October 2016

- ***U.S. Department of Justice***
  Retained by DOJ to join team investigating sexual harassment, sexual abuse and sexual assaults by inmates and staff in the Georgia Department of Corrections
  Report, October 2016

- ***Daniel Evans v. Management and Training Corporation, et al***
  NO. 3:15-cv-770-DPJ-FKB
  United States District Court, Southern District of Mississippi, Northern Division
  Report, October 17, 2016

- ***Webb v. Livingston***
  Civil Action NO. 6:13cv711
  United States District Court, Eastern District of Texas, Tyler Division

Exhibit 2

Documents Considered in Forming Expert Opinions

1. Expert Report of Eldon Vail and underlying documents (June 16, 2014), *Dockery v. Fisher*, No. 3:13-cv-00326-TSL-JMR
2. Declaration of Cordarious Nelson (December 2, 2016), *Dockery v. Fisher*, No. 3:13-cv-00326-TSL-JMR
3. *Depriest, et al. v. Walnut Grove Correctional Authority, et al.*, No. 3:10-cv-00663-CWR-FKB, Order at 26–27 (S.D. Miss. June 10, 2015) (Reeves, J. presiding).
4. Occupational Saftey and Health Administration, *Citation and Notification of Penalty to the GEO Group*, Inspection No. 315306357 (June 11, 2012)
5. MS Code § 47-5-1223 (2015)
6. ACA Standard 4-4257
7. ACA Standard 4-4262
8. ACA Standard 4-4270
9. American Psychiatric Association, *Position Statement on Segregation of Prisoners with Mental Illness*, 2012
10. Kupers, T., *Isolated Confinement: Effective Method for Behavior Change or Punishment for Punishment's Sake?* The Routledge Handbook of International Crime and Justice Studies (2013)
11. Fatos Kaba, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*, Am J Public Health, 2014 March;104(3):442–447, *available at* https://www.ncbi nlm nih.gov/pmc/articles/PMC3953781/
12. American Bar Association, Standards for Criminal Justice, *Treatment of Prisoners* (3d ed. 2011)
13. AG 120
14. AG 930
15. AG 2644
16. AG 2996
17. AG 3249
18. AG 3281
19. AG 3333
20. AG 4705
21. AG 4910
22. AG 5459
23. AG 5529
24. AG 5844
25. AG 5649
26. AG 5718
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2561. MTC-CON-00092400, 2C December 2015
2562. MTC-CON-00127946, HU 1 January 2016
2563. MTC-CON-00128146, HU 6 January 2016
2564. MTC-CON-00128540, HU 5 January 2016

Exhibit 3 to the Vail 2016 Report is the Vail 2014 Report. This exhibit has been removed and is Plaintiffs' Exhibit 1.

Exhibit 4

Mississippi Department of Corrections

On-Site Contract Monitoring Worksheet

Facility/EMCF **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

	CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
	Administration & Management				
1	**Staffing Pattern**				
A.	Comprehensive staffing analysis determines staffing needs and plans.		C	more staff needed	
B.	Essential posts and positions are filled with qualified personnel.		C		
C.	Personnel hired after background check in compliance with MDOC policy and procedures		C		
D.	Personnel vacancies filled within 30 days		C		
E.	Authority notifies MDOC of any position vacant longer than 30 days		C		
F.	Authority and/or Operator has a random drug screening program of employees working at the facility		C	10 staff members were tested for March/ results are pending.	
G.	Orientation and training program of employees per ACA		C		
H.	Personnel subject to testing for contagious disease per State Board of Health		C		
2	**Staff Training**				
A.	The facility conducts appropriate orientation, initial training, and annual training for all staff, contractors, and volunteers.		C	has improved	
B.	Staff training is conducted according to a regular schedule with sufficient classes to maintain pre-service and in-service training hour compliance.		C		
3	**Quality Control**				
A.	Contract Facility QCP in place.				
B.	Contract Facility reports shared with CM.		C		
C.	Subcontractor QCPs in place.		NA		
D.	Subcontractor QCPs reports shared with MDOC personnel.		NA		
E.	Using Offendertrak randomly select a sample no less than 10 employees, volunteers, and contract workers and verify that their information has been entered in Offendertrak as required by SOP.		C		
4	**Staff-Offender Communication**				
A.	Housing unit rounds conducted frequently by housing unit security staff.		C		
B.	Housing unit rounds conducted daily by Unit Management staff.		C	I have observed unit managers making rounds	
C.	Offender requests answered within MDOC requirements.		NC	not written in offender trak, offenders state no response	asap

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Facility/EMCF **Month/Year March/2016** **Contract Monitor Vernell Thomas**

		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
D.		Members of facility management visit housing units and interact with offenders.		C	has improved	
E.		Request forms are available to offenders.		C		
5		**Offender Funds and Personal Property**				
A.		Inventory personal property/funds is maintained.		C		
B.		Funds/valuables documented on receipt.		C		
C.		Offenders property searched for contraband.		C		
E.		Offender funds are deposited into the appropriate account.		C		
F.		Offender personal property is appropriately secured.		NC	Plan in place but it does not include offender monitoring property being packed and inventoried which it should.	asap
6		**Commissary**				
A.		Only MDOC approved items are stocked in Commissary.		C		
7		**Offender Files**				
A.		Offender file present/created for each new arrival .		C		
B.		Offender files contain documents generated during custody.		C		
C.		Offender files maintained in a secure area.		C		
Physical Plant						
8		**Physical Plant**				
A.		Security officer posts located in or immediately adjacent to offender living areas to permit officers to see or hear and respond promptly to emergency situations.		NC	Camera set up need work	asap
B.		Personal contact and interaction between staff and offenders is required and facilitated.		C		

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	CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
	Institutional Operations				
9	**Emergency Plans**				
A.	Staff trained, and able to identify signs of offender unrest.		C		
B.	Written plans locate emergency shut off valves and switches.		C		
C.	Evacuation routes primary and secondary.		C		
D.	A complete set of emergency plans is up ro date and available.		C		
E.	Facility conducts mock emergency exercises throughout the year to test specific plans.		C	3/31/16 exercise conducted zone filled with smoke. Only minor issues addressed.	
F.	Staff work stoppage plan is available.		C		
G.	The facility meets annually with local, state, & federal officials to discuss MOUs and cooperative contingency plans.		C		
10	**Environmental Health and Safety**				
A.	System for storing/issuing/maintaining hazardous materials.		C		
B.	Complete inventories of hazardous materials maintained.		C		
C.	A complete list of MSDS readily accessible to staff and offenders.		C		
D.	Fire prevention/control/evacuation plan.		C		
E.	Fire alarm system is operational.		C		
F.	Conduct fire/evacuation drills according to schedule/standard.		C		
G.	Staff trained to prevent contact with blood and bodily fluids.		C		
H.	Emergency generators are tested bi-weekly.		C		
I.	Every employee and offender using flammable, toxic, or caustic materials receives advance training in their use, storage, and disposal.		C		
J.	Safety Office (or officer) maintains files of inspection reports; including corrective actions taken.		C		
K.	Facility appears clean and well maintained.		C	has improved	
L.	All flammable and combustible materials (liquid and aerosol) are stored and used according to label recommendations.		C		
11	**Transportation**				
A.	Documentation indicating safety repairs are completed immediately and vehicles are not used until they have been repaired and inspected, is available for review.		C		
B.	Policies and procedures are in place addressing the use of restraining equipment on transportation vehicles.		C		
C.	Vehicles have 2 way radios, cellular telephones, equipment boxes in accordance with the Use of Force standard.		C	Transportation officers have acess to cell phones	
D.	Vehicles have written contingency plans on board.		C		

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Facility/EMCF **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
71	**12**	**Contraband**				
72	A.	Policy in place for handling contraband.		C		
73	B.	Contraband disposed of properly and documented.		C		
74	C.	Facility staff make a concerted effort to control contraband.		C	has improved	
75	**13**	**Facility Security and Control**				
76	A.	Central control/housing units (CC/HU) logs in place.		C		
77	B.	CC/HU: Equipment logs in place.		C		
78	C.	CC/HU: Equipment inventories accurate.		NC/NA		
79	D.	CC/HU: Post Orders in place and signed.		NC/NC		
80	E.	Staff are required to conduct security checks of assigned areas.		C		
81	F.	All visitors officially recorded in a visitor log book.		C		
82	G.	Front entrance staff inspect ID of everyone entering/exiting.		C		
83	H.	Maintain a log of all incoming and departing vehicles.		C		
84	O.	Housing unit searches occur at irregular times.		C		
85	P.	Area searches documented in log book.		C		
86	Q.	Daily/Monthly fence checks completed and logged.		C		
87	R	Daily procedures include: perimeter alarm system tests; physical checks of the perimeter fence; documenting the results.		C		
88	S.	Tools taken into the secure area of the facility are inspected and inventoried before entering and prior to departure.		NC	Have not observed tools being inventoried upon exit of a unit.	15-Dec
89	T.	The facility has in place a procedure and practice to gather, analyze and utilize intelligence information to include areas such as STGs, narcotics trafficking, financial info, telephone surveillance, high profile offenders, visiting room activities, et al.		C		
90	U.	The facility shares intelligence information with MDOC.		C		
91	V.	Male and females are segregated from each other per MDOC SOP.		NA		
92	Y.	Unit shakedowns are conducted.		C		
93	Z.	Random shakedowns conducted & documented.		C		
94	AA.	The facility employs a schedule to insure that all areas of the facility are routinely searched.		NC	I have not seen a schedule.	
95	**14**	**Armory**				
96	A.	Master inventory in place.		C		
97	B.	Sign-in/out for equipment.		C		
98	C.	Inventories accurate.		C		

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Facility/EMCF **Month/Year March/2016** **Contract Monitor Vernell Thomas**

		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
99	15	**Key and Lock Control**				
100	A.	Maintain inventories of all keys/locks/locking devices.		C		
101	B.	Emergency keys are available for all areas of the facility.		C		
102	C.	Chit system used to issue security equipment/keys/radios.		C		
103	D.	Policy regarding restricted keys present and followed by staff.		C		
104	E.	Facility has a key accountability policy and procedures to ensure key accountability. The keys are physically counted daily.		C		
105	F.	Locks and locking devices are continually inspected, maintained, and inventoried.		C		
106	16	**Offender Counts**				
107	A.	Staff conduct formal count at least once per 8 hour shift/ 3x per day.		NC	counts are conducted improperly	asap
108	B.	Recount conducted when incorrect count is reported.		C		
109	C.	Face to photo count conducted as necessary.		NC		asap
110	D.	Each offender positively identified during count.		NC	staff do not take items down that are hanging therfore they cannot see in the cell to verify offenders	asap
112	17	**Post Orders**				
113	A.	Every post has a post order, current & signed by the facility administrator.		C	Not signed by the administrator.	
114	B.	Housing unit officers record offender activity in a log as directed by MDOC SOP.		NC	has improved	
115	C.	Supervisor visits each housing area once per shift.		NC	Has improved.	
116	D.	Staff sign post orders, regardless of whether the assignment is temporary, permanent, or due to an emergency.		C		
117	E.	Anyone assigned to an armed post qualifies with the post weapons before assuming post duty.		C		
118	18	**Special Management Units**				
119	A.	Written order/detention notice accompanies offender placed in SMU.		NC		
120	B.	SMU reviews are conducted in a timely manner (7/30/other).		NC	Has improved	
121		Verify that no offenders are double celled in segregation without authorization of DCI.		C		
122	C.	Admin SMU offenders enjoy same privileges as gen pop.		C		
123	D.	Offenders in SMU have access to legal materials.		C		
124	E.	Offenders in SMU retain visiting privileges.		C		
125	F.	Maintain a permanent log regarding offender related activities.		NC		
126	G.	Written order accompany offender placed in disciplinary SMU.		NC		
127	H.	Offenders in disciplinary SMU have access to legal materials.		C		

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Facility/EMCF **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
128	I.	Offenders in disciplinary SMU retain designated privileges as per MDOC SOP.		NC	Has improved	
129	J.	The facility administrator (or designee) visits each SMU daily.		NC		
130	K.	A health care provider visits offenders in a SMU as per MDOC SOP, and offenders are provided any medications prescribed for them.		C		
131	O.	When a offender has been held in Admin Segregation for more than 30 days, the facility administrator notifies MDOC.		NC	this is not provide. Most times the ADOS has not being advised there are offenders in the seg for several weeks.	asap

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Facility/EMCF **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
19	**Tool Control**					
A.	Tool inventories conducted as specified.		C		
B.	Tools marked and readily identifiable.		C		
C.	Procedures for issuance of tools to staff and offenders.		C	offenders are not issued tools	
D.	Inventory made of all tools by contractors prior to enter and exit.		NC		
E.	There is an individual who is responsible for developing a tool control procedure and an inspection system to insure accountability.		C		
F.	Broken or worn out tools are surveyed and disposed of in an appropriate and secure manner.		C		
G.	Department heads are responsible for implementing proper tool control procedures as per MDOC SOP.		C		
20	**Use of Physical Force and Restraints**					
A.	Policy governing immediate/calculated use of force consistent with MDOC.		NC		
B.	All use of force incidents documented and reviewed.		NC	improving	
C.	Use of Force consistent with law and MDOC, incident report prepared and MDOC notified asap by phone/fax, contract monitor notified		NC		
D.	Incident reports, other than critical, furnished w/in 1 week		NC		
E.	Video tapes of incidents preserved/catalogued as per MDOC.		NC		
F.	Offender is seen by medical immediately after incident.		NC		12/15/2014
G.	Facility subscribes to prescribed confrontation avoidance procedures.		NC	Need training on how to conduct	12/15/2014
H.	Staff trained in use of force techniques.		C		
I.	Appropriate procedures in place for using 4 and/or 5 point restraints.		C		
J.	Medical staff consulted prior to calculated use of force situations.		NC	Not in some situations	
21	**Disciplinary System**					
A.	Rules of conduct/sanctions provided in writing.		C		
B.	Investigation of rule violations is conducted as per MDOC SOP.		C		
C.	Disciplinary hearings held within 7 days unless there is written justification.		NC	has improved	
D.	Disciplinary sanctions are in accordance with standards.		C		
E.	Staff representation available.		C		
22	**Law Libraries and Legal Material**					
A.	Adequate equipment is available for offenders.		C		
B.	Legal materials/law library current and available for offenders consistent with MDOC SOP.		C		

1 On-Site Contract Monitoring Worksheet

2 **Facility/EMCF** **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

3		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
160	C.	Offender access provided to include SMU.		C		
161	D.	Denials documented.		C		
162	23	**Transfer of Offenders**				
163	A.	Offender provided with offender transfer notification form.		NA		
164	B.	Health records/transfer summary accompany offender.		C		
165	C.	Funds and personal property accompany offender.		C		
166	D.	Offender file/information accompanies each offender.		C		

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Facility/EMCF **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

	CONTRACT MONITORING ASSESSMENT		F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
167		Institutional Services				
168	24	**Food Service**				
169	A.	Post orders in place and signed.		C		
170	B.	Appropriate food temperatures are maintained for both hot and cold food and food storage with temperatures logged.		NC		
171		Freezer: temperature 0 degrees.		C		
172		Refrigerators: 35 to 45 degrees.		C		
173		Dry storage: 45 to 85 degrees.		C		
174		Dishwasher final rinse: 180 degrees w/o sanitizer.		C		
175		Dishwasher rinse w/sanitizer 140 to 160 degrees.		C		
176	C.	Equipment and chemical logs are in place.		C		
177	D.	Equipment and chemical inventories are accurate.		C		
178	E.	Sanitation supplies are issued according to policy/procedure.		C		
179	F.	Food Service department maintained at a high level of sanitation.		C		
180	G.	Offenders receive safety and appropriate equipment training prior to beginning work in department.		C		
181	H.	Offenders are monitored daily for health and cleanliness, with documentation.		C		
182	I.	Food Service offender workers exchange garments daily.		NC	Some of the offenders need new issues.(dirty/stains)	
183	J.	Sharps and tool control inventory and procedures are in place.		NC	tools were out but not signed out	asap
184	K.	Facility has a standard MDOC approved menu cycle; 2900 calories per day.		C		
185	L.	A registered dietician conducts nutritional analysis.		C		
186	M.	Menu is served as scheduled/all menu changes documented.		C		
187	N.	Special diet/religious diet menu for authorized offenders.		C		
188	O.	Weekly inspections conducted and documented.		C		
189	25	**Hunger Strikes**				
190	A.	Procedures for referring offender to medical if verbally refused or observed refusing to eat as per MDOC SOP.		C		
191	B.	Staff receive training in identification of hunger strike.		C		
192	C.	Process for determining reason for hunger strike.		C		
193	26	**Medical Care**				
194	A.	Intake process includes medical and mental health screening.		C		
195	B.	Sick call procedures established.		C		
196	C.	Adequate medical staff available proportionate to population.		C		
197	D.	Pharmaceuticals stored in a secure area.		C		

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		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
198	E.	All offenders receive physical examination/assessment as per MDOC SOP.		C		
199	F.	Sick call slips available in all housing areas.		NC	forms are not always available	
200	G.	The facility has a written plan for 24 hour emergency health care when no medical staff are on-duty or when immediate outside medical attention is required.		C		
201	H.	Medical records are available and transferred with the offender.		C		
202	I.	Records are maintained of medication distribution.		C		
203	J.	All sharps are under strict control and accountability.		C		
204	K.	A sharps container is used to dispose of used sharps.		C		
205	L.	The medical department is maintained at a high level of sanitation.		C		

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Facility/EMCF **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
206	27	**Personal Hygiene**				
207	A.	Clothing provided upon intake and exchanged weekly.		C		
208	B.	Sheets and towels exchanged weekly.		C	has improved	
209	C.	Climate appropriate clothing issued and maintained in good repair.		NC	offenders alter the clothing	
210	D.	Facility provides and replenishes personal hygiene items as needed, at no cost to offender.		C		
211	E.	Offenders are provided with basic personal hygiene items such as water, soap, toilet paper, cups for water, feminine hygiene items, shampoo, toothbrush, toothpaste...		C		
212	F.	Offender housekeeping meets standards for neatness, cleanliness and sanitation.		C	Has improved a lot still need a little more work.	
213	G.	Showers operate between 100 degrees and 120 degrees.		C		
214	H.	Showers meet ADA standards and requirements.		C		
215	28	**Suicide Prevention and Intervention**				
216	A.	The facility has a written suicide prevention and intervention program approved and signed by the health authority and facility administrator which is reviewed annually.		C		
217	B.	Every new staff member receives suicide-prevention training. Suicide-prevention training occurs during the employee orientation program and annually thereafter.		C		
218	C.	The facility has a designated and approved isolation room for evaluation and treatment.		C		
219	D.	Staff observes and documents the status of a suicide-watch offender at least once every 15 minutes.		C		
220	29	**Terminal Illness, Advanced Directives, and Death**				
221	A.	Offenders who are chronically or terminally ill are transferred to an appropriate off-site facility.		C		
222	B.	There is a policy addressing Do Not Resuscitate Orders.		C		
223	C.	The facility has written procedures detailing the proper notifications.		C		
224	30	**Offender Handbook**				
225	A.	Staff aware of handbook contents and follow procedures.		NC	rules according to offender handbook are not followed	15-Dec
226	B.	Available to offenders in a language and/or manner that they can understand.		C		
227	C.	Handbook is updated as necessary.		C		
228	D.	Orientation material available to and explained illiterate offenders.		C		
229	31	**Grievance System**				

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		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
230	A.	Grievance procedures in place.		C	needs work.	
231	B.	Staff awareness of procedures for emergency grievances.		NC		
232	C.	Grievance log is utilized.		C		
233	D.	Staff forward any grievances that include staff misconduct to MDOC.		NA	most don't leave EMCF	12/15/2014
234	E.	Informal resolution to a offender grievance documented in detention file.		NA	some unit do not use informals	
235	32	**Admission and Release**				
236	A.	MDOC information is available for initial classification.		C		
237	B.	Medical screening taking place within timeframes.		C		
238	C.	Inventory offender personal effects.		C		
239	D.	Offender funds accountability in place for admin/release.		C		
240	E.	Appropriate clothing and bedding issued.		C		
241	F.	Request for Residential Services Form provided to Contractor		C		
242	G.	Complete copy of offender record furnished to MDOC by Contractor.		C		
243	H.	Within 90 days and at 6 month intervals, offender progress, adjustment and recommendations furnished to MDOC.		C		
244	I.	Access furnished to MDOC to Facility info system.		C		

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		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
33	**Classification System**					
A.	All offenders classified appropriately upon arrival.		C		
B.	Reassessment and reclassification processes in place.		C		
C.	Housing assignments are based upon classification.		C		
D.	Work assignments are based upon classification system.		NC	has improved	
E.	Offenders are assigned to classification and programs as required by MDOC verified via Offendertrak.				
F.	Verify monthly offender contact with the case manager.		C		
G.	Review offenders pending placement in the Behavior Modification Program and verify MDOC SOP time frame compliance.		NA		
H.	Check offenders assigned to sensitive job placements to verify appropriate classification.		C		
I.	Verify that offenders that work off-site are classified appropriately and qualified.		NA		
J.	Verify that offenders assigned to computer jobs meet MDOC SOP quidelines.		NA		
34	**Sexual Abuse and Assault Prevention and Intervention**					
A.	The facility has a Sexual Abuse and Assault Prevention and Intervention Program.		C		
B.	Offenders are advised of the program.		C		
C.	All staff are trained, initially and in annual refresher training, in the prevention and intervention areas.		C		
D.	Sexual Assault Awareness Notice is posted on all housing unit bulletin boards.		C		
Offender Programs						
35	**Correspondence and Other Mail**					
A.	Incoming mail screened and delivered daily.		C		
B.	Outgoing mail screened for contraband.		C		
C.	Legal mail opened in front of offender.		C		
D.	Incoming funds processed properly.		C		
E.	Rules for correspondence and other mail posted or annotated in offender handbook.		C		
F.	Facility has a system for offenders to purchase postage.		C		
G.	SMU has same correspondence privileges as general population.		C		
36	**Recreation**					
A.	Outdoor/indoor recreation is provided.		C	has improved	

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2 **Facility/EMCF** **Month/Year** **March/2016** **Contract Monitor** **Vernell Thomas**

3		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
272	B.	Access to outdoor recreation activities permitted am/pm daily weather permitting with documentation.		C	has improved	
273	C.	Staff conduct daily searches of recreation areas.		C		
274	D.	In unit activities are available		C		
275	37.	**Religious Practices**				
276	A.	Offenders are allowed to engage in religious services.		C		
277	B.	Authorized religious items are allowed in Offender possession.		C		

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		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
278	**38**	**Telephone Access**				
279	A.	Upon intake, offenders are made aware of phone policies.		C		
280	B.	Out of order phones reported and maintenance notified.		C		
281	C.	Telephones inspected regularly by staff.		NC		
282	D.	Telephone access rules posted in each housing unit.		C		
283	E.	Emergency phone call messages delivered to offenders.		C		
284	F.	Special access calls are available to offenders.		C		
285	G.	Notification of telephone monitoring posted by unit phones.		C		
286	H.	Using Offendertrak select 10 offenders to verify that they were able to update their telephone list on the annual date of entry to MDOC.		NC		
287	**39**	**Visitation**				
288	A.	Written visitation schedule posted and accessible to the public.		NC		
289	B.	General visitation log book maintained.		C		
290	C.	Visitor dress code enforced.		C		
291	D.	Facility complies with visitation schedule.		C		
292	E.	Visitors are searched and identified per standards.		C		
293	F.	Verify in Offendertrak via interviews with offenders opportunity to update visitation list.		C		
294	G.	Using Offendertrak select 10 offenders to verify that visitors were registered in the system.		NC		
295	**40**	**Work & Programs**				
296	A.	Facility has a work program.		C		
297	B.	RID first 90 days.		NA		
298	C.	Counseling and mental health: alcohol/drug, chaplaincy, pre-release, literacy, individual counseling, other programs and services necessary to comply with ACA.		C		
299	D.	Authority provides educational programs: compulsory, literacy, GED, ABE and special ed.		C		
300	E.	Authority provides 5 separate vocations				
301	F.	ABE curriculum meets MDOE.		C		
302	G.	Substance abuse treatment consistent with MDOC similar population.		C		
303	H.	Facility maintains documentation of all work assignments/classification levels.		C		
304	I.	Facility complies with work hour and pay requirements for offenders.		C		
305	J.	Offenders are medically screened to participate where required.		C		
306	K.	Offenders receive proper training and safety equipment.		C		

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		CONTRACT MONITORING ASSESSMENT	F	Rating C/NC/NA	Corrective Action Required / Comments	Due Date
307	L.	All offenders are appropriately assigned to work and/or programs.		C		
308						

Exhibit 5

1. I, Cordarious Nelson, declare the following under penalty of perjury pursuant to 28 U.S.C. § 1746.

2. I am a prisoner in MDOC custody. My MDOC number is 150153. I have been at EMCF since on or around May 2011.

3. On Tuesday, October 25, 2016 I was assaulted by approximately seven other prisoners on Housing Unit 5D. It happened in cell 205.

4. On Tuesday, October 25, 2016, sometime between 8:00 p.m. to 9:00p.m., I stepped into Cell 205 on 5D. I walked into that cell because it was empty, and I needed to use the restroom. I was followed inside by seven other prisoners: Isaiah Sanders, Craig Williams, Adrian Larry, Max Armstrong, Jessie Wilson, Anthony Day and Joseph Bennett. Once inside the cell, I was hit, kicked, and stabbed by all of these prisoners. I don't know how long it lasted, but it felt like at least five minutes. Prisoner Terrance Williams stood outside of the cell door to make sure that no other prisoner or staff member came into the cell during the assault.

5. After I was assaulted, I stayed in the vacant cell, cell 205 on 5D, overnight. I did not have any property and I did not see any officer do security checks that night, so I had no way to get assistance. The prisoners who assaulted me posted security in front of the cell so I could not get help or get out of the cell. There were two prisoners close to the cell door at all times.

6. On Wednesday morning, October 26, 2016, I did not come out of my cell early to help Sgt. Pollard pass out food trays, which is something I do every day. When I was not up and out of my cell, I believe Sgt. Pollard told the next shift that someone should check on me.

7. Lt. Cooney and Unit Manager Anderson came onto the zone on Wednesday morning around 7:30 a.m. Lt. Cooney and Unit Manager Anderson entered the cell. There was blood on the bed, floor, and wall from the assault. In addition, my right eye was completely swollen shut and my left eye was almost swollen shut. My clothes were covered with blood.

8. When Unit Manager Anderson and Lt. Cooney came to cell 205, about three or four of the prisoners who assaulted me crowded around the doorway. Unit Manager Anderson asked, "What was this—a violation?" One of the prisoners who assaulted me responded,

"Yes, that is all it was." Then, Unit Manager Anderson stated, "That's normal. This is prison." He then turned around and walked out of the cell. Lt. Cooney followed him.

9. Neither Unit Manager Anderson nor Lt. Cooney asked me anything about what happened or asked if I needed medical attention. At some point that day, an officer came on the zone to conduct a security check, but the prisoners in front of my cell prevented the officer from looking into the cell. The officer kept walking, and I had no way to seek assistance from the officer without risking further injury.

10. I stayed in Cell 205 until Thursday, October 27, 2016, when six or seven other prisoners who I know came and helped me get back to my own cell where I was assigned. This happened Thursday morning. I went to my assigned cell, 113. Once I was back in 113, I asked an officer for medical attention. The officer radioed to Ms. Moore, the picket officer, who called Medical. The response from Medical was that I needed to submit a sick call. At this time, my face was still badly swollen and it was obvious to anyone that I had been assaulted. I tried, how I could, to seek assistance from officers, but was fearful I might be attacked again if I reported the prisoners who assaulted me.

11. I was in cell 113 on 5D from Thursday, October 27, 2016 through Monday, October 31, 2016. On each of those days, I saw approximately two officers on the zone each day, but I was still fearful for my safety. During that time, I still had visible injuries to my face.

12. On Monday, October 31, 2016, I saw Sgt. McAlister while I was in the recreation yard and felt like I could trust him enough to get me off the zone safely. I told him that I had been assaulted and needed medical attention. Sgt. McAlister helped me get off the zone and brought me to medical. Before I left the zone on October 31, 2016, Unit Manager Anderson or Lt. Cooney never came back to the zone to offer assistance or to make sure I received medical attention or further investigate what had occurred.

13. On my way to Medical, Sgt. McAlister and Officer Matthews were escorting me and they stopped by Investigator Sistrunk's office and Investigator Sistrunk took pictures of my injuries and I told him who had assaulted me.

14. Once I was taken to medical, I was sent to Anderson Hospital on Monday, October 31, 2016 in a van. At Anderson Hospital, I was told that I had a broken nose, a broken bone under my right eye, and several bruised ribs. I was stabbed in my upper back and had another wound from the knife on my left forearm. I have scars from those stab wounds. I was also bitten on my chest during the assault.

15. I returned to EMCF later that day and was placed in medical. When I returned from the hospital, I met with Investigator Sistrunk and Lt. McCarra and completed a written statement about what happened.

16. I filed an ARP about this incident on or around sometime in mid-November 2016.

17. I declare under the penalty of perjury that the above statements are true and correct to the best of my knowledge.

Signature Cordarious Nelson

Dated this 2nd day of December, 2016.

Cordarious Nelson, MDOC #150153
East Mississippi Correctional Facility

Exhibit 6

Prisoner Interviews Considered in Forming Expert Opinions

Paragraph No.	Prisoner Name	MDOC No.	Housing Unit
18	Charlie Jones	36565	1D
	Marcus Smith	176377	1A
	Timothy Morgan	65975	3B
	Nakiea Sutton	R4655	3A
	Richard Dunn	174130	4D
	Michael Voyles	167958	4B
	Joshua Clay	151757	2C
	Jermaine Dockery	K2538	1D
	Antonio Chapman	158868	1A
	Steven Crosby	49954	6A
	Michael Willie	72748	1D
	Gentry Smith	106460	5B
	David Grogan	174048	5A
	Richard Lewis	136897	5C
	Merlin Hill	R4779	3A
	James Ferguson	60446	5A
	Johnathon Mosby	166998	5A
	Bobby Trotter	L4136	5B
	Xavier Crosby	137584	5B
	Timothy Ervin	109209	5B
	Moses Simpson	Unknown	5B
	Alvin Luckett	44018	5B
	Ricky Thomas	198449	5B
	William Griggs	143581	Unknown
	Terry Pierce	155018	5B
	Bernard Carter	K7922	Unknown
42	Charlie Jones	36535	1D
	Marcus Smith	176377	1A
	Timothy Morgan	65975	3B
	Nakiea Sutton	R4655	3A
	Richard Dunn	174130	4D
	Michael Voyles	167958	4B
	Joshua Clay	151757	2C
	Jermaine Dockery	K2538	1D
	Antonio Chapman	158868	1A
	Terry Pierce	155018	5B
	David Grogan	174048	5A
	Richard Lewis	136897	5C
	Merlin Hill	R4779	3A
43	Marcus Smith	176377	1A
	Joshua Clay	151757	2C
	Jermaine Dockery	K2538	1D
	Antonio Chapman	158868	1A

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	Merlin Hill	R4779	3A
45	Charlie Jones	36535	1D
	Michael Voyles	167958	4B
	Joshua Clay	151757	2C
	Jermaine Dockery	K2538	1D
	Antonio Chapman	158868	1A
	David Grogan	174048	5A
67	Charlie Jones	36535	1D
	Jermaine Dockery	K2538	1D
	Antonio Chapman	158868	1A
71	Richard Dunn	174130	4D
	Michael Voyles	167958	4B
	Joshua Clay	151757	2C
	Jermaine Dockery	K2538	1D
	Steven Crosby	49954	6A
	Merlin Hill	R4779	3A
78	Marcus Smith	176377	1A
	Joshua Clay	151757	2C
	Jermaine Dockery	K2538	1D
	Antonio Chapman	158868	1A
	Merlin Hill	R4779	3A
110	Charlie Jones	36535	1D
	Marcus Smith	176377	1A
	Timothy Morgan	65975	3B
	Nakiea Sutton	R4655	3A
	Richard Dunn	174130	4D
	Michael Voyles	167958	4B
	Jermaine Dockery	K2538	1D
	Terry Pierce	155018	5B
111	David Grogan	174048	5A
178	Steven Crosby	49954	6A
	Gentry Smith	106460	5B
	Terry Pierce	155018	5B
	David Grogan	174048	5A

Supplemented on March 17, 2017