## SUMMARY OF FINDINGS

The United States Department of Justice ("DOJ") conducted an investigation of Walnut Grove Youth Correctional Facility ("WGYCF" or "Facility") in Walnut Grove, Mississippi, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 ("CRIPA"), and the Violent Crime Control and Law Enforcement Act of 1994, 42 U.S.C. § 14141 ("Section 14141"). Both CRIPA and Section 14141 give DOJ the authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of youth. Consistent with the statutory requirements of CRIPA, we now report the findings of our investigation, the facts

- inadequate mental health care, including a deficient special needs unit and suicide prevention program;
- unnecessarily housing youth age 17 and younger in the facility when they would be better served with educational and rehabilitative services in the State's juvenile system; and,
- inadequate control of contraband.

During our site visit in January 2011, we conveyed our significant concerns with the Facility's practices that deviated from constitutional norms, and our expert consultants provided technical assistance in the areas of protection from harm, suicide prevention, mental health care and medical care during an extensive exit conference.

## II. BACKGROUND

WGYCF is a 1,500-bed prison that houses young men aged 13-22 years who are in the custody of the Mississippi Department of Corrections ("MDOC"). The Facility, opened in March 2001, is authorized by Miss. Code Ann. § 47-5-943 (West 2007) specifically for the incarceration of male adolescents who are convicted as adults in criminal court.

The Facility has an authorized correctional officer complement of 245 staff (162 officers and 82 security supervisors). Between May 2001 and March 2010, the population of WGYCF has more than tripled, from 350 to approximately 1,200 adolescents.[3] Twenty percent of the youth are White, 79% of the youth are Black, and 1% of the youth are categorized as other.

The Facility is owned by the Walnut Grove Development Authority ("WGDA"). The WGDA contracts with a private, for-profit company, the GEO Group, Inc. ("GEO"), to operate the Facility. GEO assumed operations of the Facility in August 2010, after acquiring and merging with Cornell Companies, Inc. ("Cornell"), which had operated the Facility since September 2003. Following GEO and Cornell's merger, key personnel, policies and training at WGYCF did not change substantially, despite GEO's claim that it made corrective reforms to reflect the GEO philosophy. The mental health and medical staffs at WGYCF are employed by Health Assurances as contract staff; they are not employees of GEO or the State.

All cells in WGYCF are configured for double-cell occupancy, but some special management units only house one youth per cell. The Facility has six main housing units bst1( bso(ous )]TJ EM

## III. FINDINGS

In violation of their constitutional rights, youth at WGYCF are not adequately protected from harm by staff or other youth, suffer sexual abuse, are denied adequate medical and mental health care, are not protected from suicide risk, and are inadequately supervised. These unsafe conditions of confinement create an environment that is dangerous and detrimental to youth development and well-being.

The constitutional deprivations uncovered by our investigation are not the result of isolated incidents or the misconduct of a few WGYCF staff members. Instead, WGYCF's deliberate indifference to protecting youth from harm is a systemic failure. We did our best to verify all of the allegations that we received during our investigation. In some cases, however, we relied on witness statements, due to the Facility's poor recordkeeping.

Indeed, many of the youth 17 and younger at WGYCF suffer disproportionately from the Facility's deficiencies and weaknessesupaj[(upo)-40ta

chemical agents; 4) poor use of force polices, reporting, training and investigations; 5) youth-on-youth violence and sexual assault; 6) inadequate staffing; and 7) inadequate life systems.

**1. The State's deliberate indifference to the high incidences of sexual misconduct between youth and staff is in violation of the Eighth Amendment.**

During our investigation, we found that staff sexual misconduct with youth in their custody occurred on a monthly basis, at a minimum. The allegations exposed wide-spread and

she heard “moaning and groaning sounds coming from the [employee] bathroom” and an unidentified voice from the restroom asking “where do you want me to put it?” The officer left the area to get another officer. Upon returning, the officer observed the accused nurse and the unaccounted for youth exit the restroom together. The youth claimed that while waiting in an exam room, he used the employee restroom. A nurse entered, and initiated and performed oral sex on the youth. The nurse denied the act occurred; however, the Facility Investigator referred

- In May 2010, C.C. threw a liquid substance out of his cell and used profane language as an officer walked by. The officer then shouted "Open the cell door!" When questioned by another officer why he wanted the door open, the officer stated C.C. is trying to "hang himself." The officer entered and was in the cell for two minutes when C.C. ran out of his cell, and slipped on the puddle of liquid immediately outside of his cell. The officer then grabbed C.C. from behind by his neck and dragged the youth on the ground by his neck. Another officer, observing the incident, called for assistance. More officers arrived and observed the officer, using both hands, dragging C.C. by the neck on the floor of the unit. One of the officers attempted to pull the assaulting officer off of the youth but was unsuccessful. Another incarcerated youth assisted the officer and both were finally able to pull the assaulting officer off of the youth. The investigation supported C.C.'s and witness' accounts, and the assaulting officer admitted to grabbing and dragging the youth by the neck. He also admitted that C.C. was not acting aggressively towards him, but that he was "angry and agitated" with the youth. The Facility investigation concluded that the use of force was not justified. The officer was placed on Administrative Leave.

- In March 2010, D.D. was reportedly physically assaulted by two MTIs during two separate incidents. In the first instance, D.D. claimed the two MTIs grabbed, pushed and struck him/LI_Title <</MCID rar

and inability to breathe or speak.[10] When WGYCF officers deploy chemical agents in

### 4. WGYCF's use of force policies, reporting, training and investigations contribute to constitutional violations.

The State acknowledged, and we also find, that WGYCF fails to provide adequate use of force policies, reporting and investigations.

#### a. Inadequate Use of Force Policies

The Facility's deficient use of force system, inadequate policies and procedures, reporting and investigations led to the rampant and excessive uses of force against youth.

The use of force policy for the WGYCF is addressed primarily in the Facility policy starting at chapter 9-25 and is entitled, Use of Force and Four-Point Restraint Policy.[11] We noted that some portions of the policy are lacking important requirements and guidance. The following are examples of the policy's deficiencies:

- requirement that photographs be taken of staff injuries following a use of force incident, but no requirement to photograph injured youth;

- no guidance provided regarding the review process for determining whether or not force was justified and reasonable;

- does not provide guidance on describing the type or amount of force used. Staff uses inadequate boiler type descriptions such as, "physical takedown" or "took the inmate to the floor" to describe use of force actions; and

- does not require that reviewing supervisors have prompt access to medical evidence such as nursing notes and anatomical drawings of the body that depict the specific areas where injur T* [-6( d)4(r)-1( toc)-6Eer to9rUo9(da)ocT3Lliu towinggsch

committing crimes as adults. Accordingly, WGYCF must set up a reporting procedure that complies with Mississippi law.

**5. The State is deliberately indifferent to youth-on-youth violence in the Facility.**

The State reported, and we also find, that WGYCF fails to appropriately supervise youth and protect them from youth-on-youth violence. WGYCF has a duty, under the Eighth Amendment, to protect its prisoners from violence at the hands of other prisoners. Farmer, 511 U.S. at 832-33; Longoria, 473 F.3d at 592. WGYCF officials can be held liable for their failure to protect a youth if they are deliberately indifferent to a risk of serious harm posed by another youth's violent acts. Cantu v. Jones, 293 F.3d 839, 843-44 (5th Cir. 2002) (affirming verdict against prison guards found to have manifested the requisite deliberate indifference when they left the door to prisoner's cell open, allowing him to escape and assault another prisoner). At a minimum, a prison official may be held liable under the Eighth Amendment for a known risk that he or she disregards by "failing to take reasonable measures to abate" that risk. See Hare v. City of Corinth, Miss., 74 F. 3d 633, 648 (5th Cir. 1996) (citing Farmer, 511 U.S. at 847); Cottone v. Jenne, 326 F.3d 1352, 1359-60 (11th Cir. 2003). Accordingly, WGYCF officials must take reasonable steps to protect youth from physical and sexual violence and to provide humane conditions of confinement. Providing humane conditions requires that a corrections system satisfy youth's basic needs, such as their need for safety. , 51Jenne

units. At a minimum, there should be at least one housing unit officer assigned to each housing unit, on all shifts, at all times. This is in addition to the housing unit control center officer. For the special observation unit, there should at least be one officer assigned, on all shifts, at all times.

Another example of inadequate youth supervision was noted during our tour in the academic and vocational areas. Staff reported that there are usually two officers assigned to this area; however, the area contains numerous classrooms and vocational areas that are difficult to monitor by only two officers. Despite this claim, during our tour, we did not observe a single officer in the education or vocational area.[14] Further complicating the supervision issue in the education area is the fact that many of the in-house security cameras located in the classrooms to monitor the youth and observe the instructor do not work.

In reviewing staffing levels, we reviewed the after-action report concerning the February 2010 melee, conducted by Cornell Companies, Inc. Following this major disturbance and the serious injury many youth sustained, it appears that the Facility made attempts to improve the operations. For example, a Security Threat Group management program was developed following the incident to better deter gang activity; however, gangs are still prevalent in the Facility, even among WGYCF staff. The auditors found that there was not enough staff on duty on the date of the disturbance to respond to the incident. However, in the wake of this report, staffing patterns have not significantly changed. Lack of staffing is exposing youth to risks of significant harm and the Facility's failure to address the risk bespeaks of deliberate indifference.

The State reported and we find that the lack of adequate staffing is severely limiting the time that youth are allowed out of their cells. The inadequate out of cell time increases stress and creates a tense atmosphere that is ripe for violence. We also found that the vocational programs have a waiting list of approximately 50 youth. This is a significant number of youth who should be learning a skill to enhance future employment opportunities. Numerous youth reported that they are eager to attend school or a vocational program, but there is not enough security available to supervise them. Consequently, youth who do not attend school due to lack of staffing are denied the opportunity for early release from the Facility that may be available when a youth obtains his GED certificate or regularly attends a vocational program.

### 7. WGYCF's inadequate life safety systems pose an unreasonable risk of harm to youth.

WGYCF fails to ensure adequate life safety systems throughout the Facility. We observed numerous deficiencies during our tour that endanger the life and safety of youth and staff. Numerous panic buttons were not working, and staff seemed to be unaware of the problem. Further, youth complained that the staff is not responsive when they activate panic buttons in the cells either because the buttons are inoperative or because staff ignores the call. Therefore, we conducted a test of the classroom and library emergency panic button system that the staff is supposed to use in an emergency situation. A staff member is supposed to be available to respond to uses of the panic button. However, when we pressed the panic button, no

staff responded. Instead, unbeknownst to security and program staff, the entire emergency panic alarm system was not functioning in the education areas. Therefore, staff in the classrooms and library, as well as youth, had a false sense of safety and security. The Facility lacks any system to regularly check cell panic buttons for functionality. We note that the staff apparently took steps to address this problem. By the end of our tour, the Facility generated approximately 300 maintenance work orders regarding faulty cell panic buttons and associated equipment.

We also noted that youth are able to sabotage their cell locking mechanisms and get out of their cells, resulting in a serious breach of security and safety to staff and other youth. This deficiency results in a high incidence of youth-on-youth violence and severe injury to unsuspecting youth. Either the cell door locking devices are inferior or security staff is not inspecting the cell door locking mechanisms on a frequent enough basis.

During the tour, we also noted a serious problem with the emergency key control system. It appears the Facility does not have a system in place to regularly check emergency keys and locks. We conducted a mock emergency drill in one of the housing units. Staff failed to access emergency keys and were not able to promptly open a cell door manually. Such a lapse in life safety management can have harmful and even deadly consequences to staff and youth when faced with real emergencies. Conditions violate the Constitution when they pose an unreasonable risk of serious damage to a prisoner's current or future health, and the risk is so grave that it offe thq2ofavehq2of4(le)4( t)8(h)-1(e)4(que)4(n)-10(cf[(unr)10(e al)-6(s[-6(s[-6t4-2(s)-(a)4(l)-2(t)-2

The Facility does not perform its own mental health screening. This is problematic for two reasons. First, cases of mental illness are often missed by the State's screening process. Second, severe mental illness typically presents itself in youth ages 16 to 22. After the State transfers youth to WGYCF, youth routinely experience extreme delays before seeing mental health staff. As a result, new cases of depression, psychosis, and bipolar disorder may develop in the interim between screening by the State and when the youth are eventually seen by mental health staff at WGYCF.

In spite of the fact that WGYCF is not supposed to house youth with serious mental health needs, WGYCF placed approximately 285 youth – nearly one quarter of its population – on suicide watch during the period of July 2010 to December 2010. A psychiatrist only performed follow-up evaluations on 7-8% of these youth.

Youth who are under suicide watch are not monitored appropriately, which is also indicative of deliberate indifference to serious mental health needs. Matis v. Johnson, 2008 WL 248556 (5th Cir. 2008) (dismissing an appeal from a denial of qualified immunity on a claim of

- In May 2010, the State conducted a mental health evaluation of A.H. and noted that he had a prior diagnosis of schizophrenia and had been on and off medication for several years. At the screening, the youth complained of auditory and visual hallucinations, including hearing voices calling his name. In spite of this history and complaint, he was sent to WGYCF. In June 2010, upon arrival to WGYCF, A.H. was held "in the infirmary"[15] until the psychiatrist could perform an evaluation. Three days later, A.H. was finally evaluated and prescribed medication; the psychiatrist noted that A.H. reported hearing voices in his head and feeling the devil was after him. A.H. did not see a psychiatrist again until two months later. At the time of our investigative tour in January 2011, he had not seen a psychiatrist since August 2010.

- In December 2008, A.I. submitted a psychiatric request slip, which stated: "Something in my ear is making my head hurt very bad." An LPN documented his complaint and noted that he was hearing screaming noises, but did not refer him to the psychiatrist. Several months later, in June 2009, the youth submitted another slip, this time complaining that he was hearing voices in his head telling him he was going to die. There is no record a mental health professional met with him at that time. In February 2010, the youth complained that he could not sleep and that his depression was getting worse. It was nearly two months later before the psychiatrist met with him. In May 2010, A.I. was sent to the hospital to extract a razor blade that he used to cut his arm. In August 2010, A.I. noted he again needed his medication and that he was not receiving it consistently. He was referred to the psychiatrist one month later.

Additional cases reviewed showed a clear pattern: youth were admitted with a history of substance abuse issues and/or psychiatric treatment, developed bizarre behaviors such as flight of ideas, depression, agitation, or confusion, and were evaluated months later, usually only by a nurse. Subsequently, youth were returned back to general population due to alleged "malingering" with no mental health follow-up and sometimes became suicidal. This pattern of care evidences a deliberate indifference to serious mental health needs and is a violation of youth's constitutional rights. Gates, 376 F.3d at 335 (noting the inadequacy of a prison's mental health services where some inmates are medicated "but there is essentially no other mental health services" provided).

### c. Staffing Deficiencies Responsible for a Lack of Essential Services

As the State acknowledges, and we agree, mental health staffing levels at WGYCF are inadequate. One psychiatrist, who was on call an average of 14 hours per month in 2010, is responsible for providing psychiatric coverage at WGYCF. This equates to a .08 full time equivalent ("FTE") psychiatrist for a population of 1200 prisoners. That level of psychiatric staffing is shockingly low. The psychiatrist, who has no formal on-call duties, estimates that he was called at home approximately one or two times every two weeks. There are two psychologists who each work part-time on alternating weeks, once per week for five hours per day. This is the equivalent of 1.25 FTE psychologists, an equally shocking lack of mental health staff for a prison of that size. The State reported that the lack of available mental health staff

[15] It is not clear what the reference to an "infirmary" means. The medical unit at WGYCF has no beds.

WGYCF fails to identify and treat youth who present obvious symptoms of serious illness and injury. When WGYCF does identify youth in need of medical treatment, the

serve as documentation of medication administration. At the time of our investigation, there were many sites on the medication administration record the(r)- em8.25pdy16(, h)-10w-hd

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e. Develop a process to track all serious incidents that captures all relevant information, including: location, any injuries, medical care provided, primary and secondary staff involved, reviewing supervisor, external reviews and results, remedy taken, and administrative sign-off.

f. Increase video surveillance in critical housing areas and adjust staffing patterns to provide additional direct supervision of housing units.

## B. MEDICAL AND MENTAL HEALTH REFORMS

### 1. Access to Medical and Mental Health Care

a. Ensure that sick call slips are directly and readily available to youth.

b. Implement a corrective action plan for remediation of service delays.

c. Track all requests for medical and mental health care.

d. Establish a system for review of all grievances regarding medical and mental health services.

### 2. Youth Specific Care

a. Consult with adolescent health specialists, including medical and mental health professionals, familiar with correctional health care in the development and implementation of correctional policies and procedures dealing with youth.

b. Implement a policy and procedure to report child abuse of any youth less than 18 years of age that complies with Mississippi's child abuse law.

c. Admission Screening

i. Provide exam tables in the exam room.

ii. Ensure that medical staff performs a complete examination of the youth's body during intake screening.

iii. Provide screenings as required by the Health Assurance Medical Services Manual and the American Academy of Pediatrics.

d. Chronic Medical Care

i. Provide evaluation and treatment plans for all youth with abnormal blood pressure measurements.

ii. Implement an audit system to verify the provision of chronic care to youth who require treatment, with a special focus on the monitoring of hypertension.

**3. <u>Medical Administration</u>**

a. Ensure that adequate psychotherapeutic medication administration is provided.

b. Provide standardized storage of medication so that pharmaceuticals can be easily located.

c. Establish a system to track medication ordering and delivery.

d. Provide nursing with a housing move list every day.

e. Establish a system to train and monitor accurate medication administration recording.

f. Provide a more stringent system for date and time stamping of provider orders.

**4. <u>Quality Assurance and Improvement</u>**

a. Develop and implement an effective quality assurance program for the Medical Unit which ensures that policies, procedures, and practices are being followed. This will require, at a minimum:

i. creating standards that reflect current medical and mental health policies;

ii. establishing a process for auditing medical and mental health practices that includes document review, interviews with youth and staff, and observation of operational procedures and programs;

iii. drafting a written report on the level of compliance with each quality assurance standard; and

iv. creating a corrective action plan to address the deficits noted by the quality assurance audits.

**5. Physical Plant Issues**

a. Provide direct visuals of youth in the Special Needs modules and in the segregated units.

## C. MENTAL HEALTH AND SUICIDE PREVENTION REFORMS

**1. Admission Screening**

a. Revise intake procedures and forms to adequately screen incoming youth for mental health issues and for suicide risk upon a youth's arrival to WGYCF and prior to housing assignment. The intake screening questionnaire must include, among other things, inquiry regarding:

i. Past suicidal ideation and/or attempts;

ii. Current ideation, threat, plan;

iii. Prior mental health treatment/hospitalization;

iv. Recent significant loss (relationship, death of family member/close friend, etc.);

v. History of suicidal behavior by family member/close friend; suicide risk during prior confinement; and

vi. Transporting officer(s) belief as to whether the inmate is currently at risk.

b. Incorporate mental health screening results into youth's files and implement a formal communication process between intake and classification staff.

c. Ensure that all staff conducting intake screening

g. Prohibit the routine use of isolation rooms for youth on suicide precautions. Ensure that isolation rooms are only used when legitimate security concerns exist and are documented.

h. Ensure that any youth assigned to a special housing unit or disciplinary housing receives opportunities for educational and other programming.

i. Ensure that youth who have been identified with a high risk of suicide receive one-on-one supervision by a direct care staff with no other duties until the youth is transferred out of the Facility.

j. Clarify WGYCF's policy regarding levels of observation of suicidal youth (e.g., constant observation, unpredictable intervals not to exceed 15 minutes, etc.) and ensure that corrections officers implement documented appropriate levels of observation.

k. Implement treatment plans for suicidal youth that identify signs, symptoms, and preventive measures for suicide risk.

l. Require adequate emergency intervention training for all staff who regularly interacts with youth. Enforce a policy requiring corrections officers to initiate CPR if they are the first responders to suicide attempts.

m. Ensure that cut-down tools are readily available to staff who may be first responders to suicide attempts.

n. Conduct adequate multidisciplinary morbidity-mortality reviews of all suicides and serious suicide attempts (i.e., suicide attempts requiring hospitalization), and implement any appropriate remedial action. A preliminary review should occur within 30 days of the incident, and a comprehensive review should occur within 30 days of the completion of a coroner's report.

**3. <u>Mental Health Care Treatment</u>**

a. Develop and implement policies and procedures to ensure youth with serious mental health needs receive timely treatment as clinically appropriate, in a clinically appropriate setting.

b. Ensure crisis services and acute care in an appropriate therapeutic environment, including access to beds in a health care setting for short-term treatment (usually less than ten days) and regular, consistent therapy and counseling.

c.