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IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF WYOMING

BRAD SKINNER, et al.,)	Civ. No. 02-CV-033B
)	
Plaintiffs,)	PLAINTIFFS' BRIEF
)	
vs.)	IN SUPPORT OF MOTION
)	
JUDITH UPHOFF, et al.,)	FOR SUMMARY JUDGMENT
)	
Defendants)	
_____)	

INTRODUCTION

The Supreme Court and Tenth Circuit have made it clear that "[s]uffering physical assaults while in prison is not 'part of the penalty that criminal offenders pay for their offenses against society.' Rhodes v. Chapman, 452 U.S. 337, 347 (1981)." Benefield v. McDowall, 241 F.3d 1267, 1271 (10th Cir. 2001). Prisoners lose many rights, but not their

right to safety, "for in America we respect the sanctity of human life, including those confined in penal institutions." Walsh v. Mellas, 837 F.2d 789, 798 (7th Cir. 1988).

To be sure, prison officers cannot protect inmates from all violent attacks, given the nature of the prison environment. "They are, however, responsible for taking reasonable measures to insure the safety of inmates." Lopez v. LeMaster, 172 F.3d 756, 759 (10th Cir. 1999). See Farmer v. Brennan, 511 U.S. 825, 832 (1994) (holding that prison officials must "take reasonable measures to guarantee the safety of inmates.")

This lawsuit contains two separate claims for relief, one narrow, one broad. The narrow claim seeks damages on behalf of inmate Brad Skinner, who was assaulted by other inmates on November 4, 1999. The broad claim seeks declaratory and injunctive relief on behalf of a class of all present and future inmates of the Wyoming State Penitentiary (WSP), seeking an order that would require the administrators of WSP, at long last, to take reasonable measures to ensure the safety of inmates.

It is the *class claim* that is addressed in this motion for summary judgment, and not Mr. Skinner's individual claim for damages (which awaits trial). The Court has conditionally certified this case as a class action

pursuant to Rule 23(a), (b)(2). See Skinner v. Uphoff, 2002 WL 1906763 (D. Wyo. 2002). As in all other (b)(2) actions, no damages are sought for the class, but only declaratory and injunctive relief. For the reasons set forth below, Plaintiffs are entitled to summary judgment on their class claim pursuant to Rule 56 F.R.Civ.P. See Celotex Corp. v. Catrett, 477 U.S. 317 (1986); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255-56 (1986); Craig v. Eberly, 164 F.3d 490, 493 (10th Cir. 1998).

I. THE EIGHTH AMENDMENT PROTECTION

The Eighth Amendment, which applies to the states through the Fourteenth Amendment, see Robinson v. California, 370 U.S. 660, 666 (1962), prohibits the infliction of "cruel and unusual punishments." U.S. Const. Amend. VIII. The Eighth Amendment is a prisoner's safety net. "[I]t is now settled that 'the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment.'" Farmer v. Brennan, 511 U.S. 825, 832 (1994), quoting Helling v. McKinney, 509 U.S. 25, 31 (1993). When prison officials disregard the Eighth Amendment, "judicial intervention is *indispensable*." Rhodes v. Chapman, 452 U.S. 337, 354 (1981) (emphasis in original).

The Eighth Amendment imposes on prison officials a duty to "provide humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care and must 'take reasonable measures to guarantee the safety of the inmates.'" Farmer, 511 U.S. at 832, quoting Hudson v. Palmer, 468 U.S. 517, 526-27 (1984). Having incarcerated these persons and "having stripped them of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course." Farmer, at 833 (citations omitted). See Benefield v. McDowall, 241 F.3d 1267, 1270 (10th Cir. 2001); Lopez v. LeMaster, 172 F.3d 756, 759 (10th Cir. 1999).

However, "[i]t is not . . . every injury suffered by one prisoner at the hands of another that translates into constitutional liability for prison officials responsible for the victim's safety." Farmer, at 834. The test for an Eighth Amendment violation, Farmer explains, has two components, one objective and the other subjective. First, the plaintiff must show that he or she is "incarcerated under conditions posing a substantial risk of serious harm." Id. at 834. Second, the plaintiff must show that

the defendant prison official had a sufficiently culpable state of mind. Id. These components are discussed below.

1. The objective component

A prisoner alleging a violation of the Eighth Amendment must show from objective facts that a condition of confinement creates "a substantial risk of serious harm." Farmer, at 834. The Eighth Amendment "reach[es] official conduct that 'is sure or very likely to cause' serious injury at the hands of other inmates." Benefield v. McDowall, 241 F.3d 1267, 1272 (10th Cir. 2001) (quoting Helling, 509 U.S. at 33).

Thus, a substantial risk of future injury based on a dangerous present condition satisfies the first component. As the Tenth Circuit recognized two decades ago, "an inmate does have a right to be reasonably protected from constant threats of violence and sexual assaults from other inmates. Moreover, he does not need to wait until he is actually assaulted before obtaining relief." Ramos v. Lamm, 639 F.2d 559, 572 (10th Cir. 1980).

2. The subjective component

In addition to proving an objective risk of serious harm, Farmer requires an Eighth Amendment plaintiff to prove that the defendant official had a culpable state of

mind--known as "deliberate indifference." The deliberate indifference standard is a middle ground that lies "somewhere between the poles of negligence at one end and purpose or knowledge at the other." Farmer, at 836. The Farmer Court likened this standard to criminal recklessness, which makes persons liable when they "consciously disregard[] a substantial risk of serious harm." Id. at 837-38. See Smith v. Lejeune, 203 F. Supp. 1260, 1268 (D. Wyo. 2002) (per Brimmer, J.) (noting that under Farmer, the deliberate indifference test is "a *mens rea* on par with criminal recklessness.")

Proving deliberate indifference is an issue of fact that can be demonstrated "in the usual ways," including through circumstantial evidence:

Whether a prison official had the requisite knowledge of a substantial risk is a question of fact subject to demonstration in the usual ways, including inference from circumstantial evidence, *and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.*

Farmer, at 842 (emphasis added).

A prison official who "knows of and disregards an excessive risk to inmate health or safety" is deliberately indifferent. Id. at 837. The plaintiff need not wrest an admission of culpability from the defendant, but need only show that the risk was so obvious the defendant "must have

known" about it. Id. at 842. Such constructive knowledge can be demonstrated by "showing that a substantial risk of inmate attacks was 'longstanding, pervasive, well-documented, or expressly noted by prison officials in the past, and the circumstances suggest that the defendant-official being sued *had been exposed to information concerning the risk.*'" Id. (Citation omitted, emphasis added.)

Moreover, once an officer is "exposed to information concerning the risk," the officer may not turn a blind eye to it. On the contrary, either the risk must be abated or, if the officer is uncertain as to its depth or degree, an investigation must ensue. An official "would not escape liability if the evidence showed that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences that he strongly suspected to exist." Id., at 842 n.8.

The Tenth Circuit case of Lopez v. LeMaster, 172 F.3d 756 (10th Cir. 1999), illustrates these principles. The plaintiff in Lopez, an inmate in a county jail, sought damages against the sheriff, alleging that the sheriff's failure to abate a staffing deficiency in the jail led to an assault on the plaintiff. Evidence indicated that "at least one prior attack" (but perhaps only one) had occurred in the

jail due to the staffing deficiency. Id., 172 F.3d at 761. The plaintiff alleged that the prior assault had placed the sheriff on notice of the dangerous deficiency, and that the sheriff's failure to abate it demonstrated his deliberate indifference. The Tenth Circuit agreed that these allegations satisfied both components of the Farmer test. The issue, the court recognized, was not how many prior assaults had occurred. "Sheriff LeMaster was on notice of the danger" and his alleged failure "to take reasonable measures to prevent" a second assault exposed him to liability under the Eighth Amendment. Id. at 762.

Farmer also holds, and Lopez further illustrates, that an Eighth Amendment plaintiff need only show that the *risk* of injury was obvious, and need not show that the defendant wanted the plaintiff or some other particular person to be injured by the dangerous condition. "[A] prison official [may not] escape liability for deliberate indifference by showing that, while he was aware of an obvious, substantial risk to inmate safety, he did not know that the complainant was especially likely to be assaulted by the specific prisoner who eventually committed the assault." Farmer, at 843. See Lopez, 172 F.3d at 762 (citing Farmer on this point).

II. SUPERVISORY LIABILITY

The two named defendants in the class claim are Judith Uphoff, the Director of the Wyoming Department of Corrections, and Vance Everett, the Warden of WSP.¹ They are, in their official capacities, the persons ultimately responsible under state law for the general management and proper administration of the Wyoming State Penitentiary (WSP). See W.S. 25-1-104.

The Tenth Circuit has long recognized that supervisors of penal facilities must take reasonable steps to protect inmate safety. See Ramos v. Lamm, 639 F.2d 559, 572 (10th Cir. 1980) (holding that prison officials must "reasonably protect[]" inmates from assault at the hands of other inmates); Meade v. Grubbs, 841 F.2d 1512, 1528 (10th Cir. 1988) (holding that a sheriff who fails to properly train and discipline employees can be held liable when an inmate is assaulted due to employee error); Berry v. City of Muskogee, 900 F.2d 1489, 1496 (10th Cir. 1990) (same). See also Green v. Branson, 108 F.3d 1296, 1302-03 (10th Cir. 1997); Lopez v.

¹Vance Everett resigned as warden on July 26, 2002. By operation of Rule 25(d)(1) F.R.Civ.P., Everett has been automatically replaced for purposes of the class claim--which seeks only equitable relief against the warden in an official capacity--by his successor, Acting Warden Scott Abbott. See Kentucky v. Graham, 473 U.S. 159, 166 (1985).

LeMaster, 172 F.3d 756, 762 (10th Cir. 1999); Benefield v. McDowall, 241 F.3d 1267, 1271 (10th Cir. 2001).

This Court recently explained the principle of supervisory liability, quoting from the seminal case of Meade v. Grubbs, 841 F.2d 1512 (10th Cir. 1988):

"A supervisor is not liable under section 1983 unless an 'affirmative link' exists between the [constitutional] deprivation and either the supervisor's personal participation, his exercise of control or direction, or his failure to supervise."

Smith v. Lejeune, 203 F. Supp.2d 1260, 1268 (D. Wyo. 2002), quoting Meade, 841 F.2d at 1527. (Emphasis added.)

A supervisor's failure to "control," "direct[]," or "supervise" is actionable under section 1983 if it is the product of "an unconstitutional policy or custom." Meade, at 1527. In that circumstance, the supervisor is deemed to have "'acquiesced in the constitutional deprivations of which complaint is made,'" even if the supervisor was not present when the deprivations actually occurred. Meade, at 1528, quoting Kite v. Kelley, 546 F.2d 334, 337 (10th Cir. 1976). See also Worrell v. Henry, 219 F.3d 1197, 1214 (10th Cir. 2000) (citing the Meade test).

For purposes of § 1983 liability, a "policy or custom" includes written policies as well as any established practice. In Berry v. City of Muskogee, 900 F.2d 1489,

1499 (10th Cir. 1990), the court held that once the administrators of a jail had been placed on notice that their practice of not locking down violent inmates was leading to assaults, they could be held liable for subsequent assaults stemming from that practice. In Lopez v. LeMaster, as noted earlier, the court held that a sheriff's failure to correct a deficiency after one assault had called his attention to it, subjected him to liability for injuries sustained in a subsequent assault. In Green v. Branson, 108 F.3d 1296 (10th Cir. 1997), the court held that a prison warden's alleged "lackadaisical attitude" to plaintiff's medical needs and his failure to abate a dangerous condition that led to plaintiff's assault stated an Eighth Amendment claim. Id., 108 F.3d at 1303.

Uphoff and Everett have a duty to "take reasonable measures to guarantee the safety of inmates." Farmer, at 832. Yet they have persistently--and unconstitutionally--failed to undertake the three reasonable measures to guarantee inmate safety listed below. Namely, Uphoff and Everett have: (1) *failed to adequately supervise and train subordinates* in how to investigate (and then abate) dangerous conditions; (2) *failed to develop an effective internal review process* for the reporting of policy violations; and (3) *failed to discipline malfeasant*

employees, thereby substantially jeopardizing inmate safety.

III. STATEMENT OF UNDISPUTED FACTS

Local Rule 7.1(b)(2)(A) requires that parties seeking summary judgment "include in their respective briefs a list of all claimed undisputed and disputed facts." Plaintiffs are aware of *no* disputed facts, however, regarding the issues raised in Plaintiffs' motion for summary judgment because ALL OF THE FACTS cited in this brief come from Defendants' own deposition testimony and their prison documents.

Plaintiffs' motion for summary judgment, as just noted, raises three separate constitutional claims. Each claim relies upon its own set of facts, although some facts are common to multiple claims. The facts related to each claim are listed in the portion of the brief discussing that claim.

I.

Defendants Have Failed to Adequately Supervise and Train Their Subordinates in How to Investigate (And Then Abate) Dangerous Conditions

1. Undisputed Facts Regarding This Claim

1. Director Uphoff *knows* that "one duty of a supervisor--one very important duty--is to find out whether staff error, staff misconduct, or some institutional deficiency caused or contributed to an inmate assault so

that you could prevent the same mistake from repeating itself." [Deposition of Judith Uphoff (hereinafter "Uphoff Dep.") at 278. A copy of Uphoff's entire deposition transcript is attached as "Appendix A."] Warden Everett is also aware of this duty. [Deposition of Vance Everett (hereinafter "Everett Dep.") at 236. A copy of Everett's entire deposition is attached as "Appendix B."]

2. Obtaining information regarding staff error, staff misconduct, and institutional deficiencies (such as inadequate staffing and inadequate policies), Uphoff acknowledged, requires an investigation; Uphoff "can't know whether any staff wrongdoing occurred" in connection with an assault without an investigation. [Uphoff Dep. at 318.] Everett agreed that "you can never have a reliable determination unless you conduct an investigation." [Everett Dep. at 125.]

3. Uphoff also knows that unless she conducts an investigation, she is hindered--and sometimes precluded--from abating a dangerous condition; she can't fix what she doesn't know is broken. [Uphoff Dep. at 225, 487.] As Everett stated, "there's no chance of preventing anything unless you investigate." [Everett Dep. at 243.] There is, in short, a "domino effect": unless you investigate, then

dangerous conditions will remain undetected, and undetected dangers cannot then be abated. [Everett Dep. at 252.]

4. It is important to conduct an investigation following each inmate assault that results in serious injury, the Defendants *know*, because various types of staff errors, staff misconduct, and institutional deficiencies may have contributed to or caused them, and if left undetected and uncorrected, could cause additional assaults. "An investigation could reveal, for example, that officers were told by an informant that an assault was going to occur and they ignored the warning," Everett admitted, or that "the housing unit had been understaffed," leaving vulnerable inmates unprotected. [Everett Dep. at 124.] To illustrate, as explained in detail below, a prison investigation into the death of inmate Ellis Kennedy disclosed the presence of numerous dangerous conditions that played a role in the assault, such as inadequate staffing, inadequate surveillance of inmate conduct, and inadequate communication between staff.

5. Indeed, Uphoff is so aware of the need to conduct thorough internal investigations following every inmate assault that results in a serious injury that on April 1, 1996 she enacted Administration Regulation (AR) 7.017. (A copy of this regulation is attached as "Appendix C.")

Entitled "Reporting and Investigation of Major Incidents," AR 7.017 is the Department of Correction's (DOC's) policy for investigating inmate assaults resulting in serious injury. [Uphoff Dep. at 171.] The DOC has no other policy governing "internal investigations" of assaults, that is, investigations designed to discover whether an inmate assault was caused by staff error, staff misconduct, or some institutional deficiency. [Uphoff Dep. at 221.]

6. AR 7.017 mandates that each and every inmate assault resulting in serious injury must be investigated by a "Serious Incident Review" (SIR) committee within 14 days of the assault. [AR 7.017 at 3 ¶(3)(a), 4 ¶(5)(a).] The SIR committee is comprised of at least three members, a majority of whom must be employed at a facility other than the one at which the incident occurred. [Id. at 4 ¶(4).] At the conclusion of its investigation, the SIR committee must issue a written report, a copy of which is sent to the warden of the facility and the Director of the Department of Corrections. [Id. at 3 ¶(2).] As part of its investigation, the SIR committee shall report on whether prison employees violated any prison policies in connection with the assault, whether disciplinary action should be taken against any employee, and whether prison policy needs to be changed to prevent future assaults. [Id. at 5 ¶(b).]

Uphoff testified that the provisions of AR 7.017 are mandatory, and the policy provides for no exceptions. [Uphoff Dep. at 172, 181.]

7. By applying and implementing AR 7.017, prison officials will learn whether staff error, staff misconduct, or some institutional deficiency played a role in an inmate assault and whether anything should be changed or fixed in order to prevent another assault. As Uphoff explained, AR 7.017 was enacted "to make sure we had all of the information to look at how staff performed; are there changes to operational things that needed to be considered; or were there any other areas [regarding] management of a facility that may be brought out" from the investigation. [Uphoff Dep. at 219-220.]

8. Deputy Warden William Hettgar, the person responsible from 1996 through 2000 for training officers in applying departmental policies, described AR 7.017 as "the single most important policy [the prison has] regarding inmate-on-inmate assaults." Deposition of William Hettgar (hereinafter "Hettgar Dep.") at 149. (The cited pages from his deposition are attached as "Appendix D.") The reason for this policy's singular importance, he explained, is due to the fact that, by implementing this one policy, the prison can detect dangerous conditions in, or failures

regarding, all other prison policies and conditions of confinement posing risks to inmate safety. [Id.]

9. Prison policy requires prison staff to send Uphoff a two-page Incident Report immediately following each inmate assault, a report that Uphoff reads and signs. [Uphoff Dep. at 51-52, 240.] These reports contain a "Narrative" that briefly describes what occurred and identifies the injuries suffered by the victim. Consequently, Uphoff can tell from reading an Incident Report whether she should expect to receive an SIR report within 14 days thereafter. [See Uphoff Dep. at 196 (agreeing that "at the moment [the Narrative describes a serious injury], you know that your SIR policy kicks in.")]

10. Prison records indicate that between 100 and 300 inmates have been assaulted at WSP during the past six years, since the enactment of AR 7.017. [Uphoff Dep. at 166-68, 421.] Uphoff kept no on-going compilation of the number, and could not supply an exact figure,² but based on two sets of unofficial records that her employees maintained, Uphoff agreed that as many as 300 assaults have occurred since AR 7.017 was enacted. [Id.]

²Uphoff acknowledged she should keep track of this information, but she does not do it. [Uphoff Dep. at 126.]

11. Uphoff *admits* that during the past six years, **there has been only one SIR investigation into an inmate-on-inmate assault**: the assault of Ellis Kennedy in March 2000. [Uphoff Dep. at 182, 430.] Two other inmate assaults--thus, a total of three--out of some 300 assaults were the subject of an internal investigation. [Id. at 168: Uphoff agrees that "in no more than three of those scores of assaults did your department conduct an internal investigation."]

12. Uphoff *admits* that she and her staff have *persistently violated* AR 7.017 by failing to conduct SIR investigations in the vast majority of instances requiring them. [Id. at 178-199, 431-32.] During her deposition, Uphoff was shown a sample of eleven Incident Reports that clearly informed her, she admitted, that those eleven assaulted inmates had suffered serious injuries. Thomas Peitsmeyer's jaw was broken; John Jessel's leg was broken; Melvin Slayton was stabbed seven times (and survived); Brian Alvis was knocked unconscious from blows to his head; Mr. Whitedress had scalding water thrown in his face causing his skin to peel away; Matthew Escobedo was punched repeatedly in the face; Brad Skinner was kicked repeatedly in the face; Mr. Sorenson's nose was broken; Shane Pitzer and James Lemma needed stitches to close lacerations on

their face; etc. Uphoff *conceded* that all of these assault should have received a thorough internal investigation under AR 7.017, but that none of them did. [Uphoff Dep. at 178-199, 431.]

13. Uphoff knows that AR 7.017 "hasn't been followed" by her staff and *admits* that although she could order her employees to comply with her policy, she has "done nothing to stop these persistent violations." [Uphoff Dep. at 485, 433.] Uphoff acknowledged that "month after month, assault after assault, serious injury after serious injury" she permitted her staff to violate AR 7.017, and that "the practice [of ignoring AR 7.017] overruled the policy." [Uphoff Dep. at 199-200. See also *id.* at 207.]

14. Warden Everett *admitted* that "the bulk of the responsibility did fall on me" as warden for not requiring staff to comply with AR 7.017. [Deposition of Vance Everett (hereinafter "Everett Dep.") at 166-67.]

15. However, as Everett points out, Uphoff obviously was aware that he was not submitting the mandatory SIR reports to her, and that if she wanted him to comply with DOC policy, "there would have been additional training for me, it would have been brought to my attention." [*Id.* at 167.]

16. Uphoff and Everett concede that inmates sustained serious injuries in later assaults due to the failure of Uphoff and Everett to implement AR 7.017 and investigate prior assaults. One example of this domino effect is the Pitzer and Slayton assaults. Both assaults occurred in C-Unit in the North prison.³ C-Unit was a housing complex in which no two inmates were permitted outside of their cells in a common area at the same time. [Everett Dep. at 121-23.] As a result of this 24-hour enforced isolation, inmate assaults could not possibly occur unless some breakdown of prison policy allowed it to occur. [Id.] Such an error occurred in June 1999, resulting in an assault on Shane Pitzer, who sustained a serious head injury in the attack. [Uphoff Dep. at 223; see also id. at 160-61.] No investigation was conducted--not even the *mandatory* SIR investigation--to determine what caused the policy violation and what needed to be done to abate it. [Everett Dep. at 172-73; Uphoff Dep. at 223-29.] Uphoff *admits* that

³The "North" prison was closed to inmate housing in July 2001, and WSP inmates now reside in the new "South" prison. A number of the assaults discussed in this brief occurred in the North prison, while others occurred in the South prison. It is unnecessary to identify in which prison any particular assault occurred for purposes of Plaintiffs' motion for summary judgment, as the policy and practice regarding AR 7.017 has remained constant during the past six years, as discussed in these recitations of fact.

the Pitzer assault "should have been investigated" [Uphoff Dep. at 406], and that the assault gave her "plenty of notice" that a dangerous condition existed. [Id. at 405.] When asked why she "turn[ed] a blind eye to the dangerousness of that situation," Uphoff said she had no explanation but clearly "the ball was dropped." [Id. at 406-07, 410.] As a result of the failure to investigate (and then abate) the cause of the Pitzer assault, Melvin Slayton was subsequently stabbed on the same Unit. Uphoff *admitted* during her deposition that, had she investigated the Pitzer assault, "it's likely" she would have prevented the Slayton stabbing because it now appears that both assaults were caused by the same error. [Id. at 405; 401-05.] Everett testified similarly, agreeing that an investigation into the Pitzer assault "would have reduced the risk of the Slayton stabbing." [Everett Dep. at 191.]

17. Additionally, Uphoff and Everett *admit* that the assaults on Brian Alvis and Brad Skinner could have been prevented had they investigated the earlier assault on John Jessel. All three assaults occurred on the very same tier, with the Jessel assault occurring in May, Alvis in June, and Skinner in November of 1999. Uphoff *admits* that no investigation was conducted to determine whether staff error caused those incidents and that, for all she knows,

"the same error or deficiency caused all three of those assaults." [Uphoff Dep. at 280.] It is certainly possible, Everett agreed, that "the same error caused all three." [Everett Dep. at 237.]

18. At the end of his deposition, after reviewing a number of prison assault files, Everett *conceded* that persistent staff errors "may have led to more than one assault," and that the only safe conclusion one can make, given that no investigation was ever conducted into the vast majority of inmate assaults, is that "had [his] staff obeyed AR 7.017, they might have prevented some of the later assaults by correcting errors that caused the earlier ones." [Everett Dep. at 320.]

19. As Uphoff and Everett acknowledged during their depositions, the assault of Matthew Escobedo illustrates the wisdom of AR 7.017, which requires that all serious injuries be investigated--regardless of what the situation might appear on the surface. During their depositions, Uphoff and Everett were shown the Incident Report in the Escobedo assault, which occurred in August 1999 in the prison's recreation yard. Uphoff testified that when she first read the report, she assumed it was "two inmates involved in spontaneous fighting" for which staff could not be held responsible. [Uphoff Dep. at 196.] During her

deposition, however, Uphoff was shown additional documents obtained from prison files, which disclosed the presence of staff error. Uphoff then agreed that her initial presumption had "no basis whatsoever" in the actual facts. [Id. at 209.] Upon reading the Escobedo Incident Report during his deposition, Everett reached the same initial conclusion as had Uphoff, only to agree after examining the other documents that staff error was strongly indicated. [Everett Dep. at 314-15, 319.]

21. During their depositions, Uphoff and Everett were confronted with prison files in the Alvis, Escobedo, Orosco, Pitzer, Slayton, and Skinner assaults and, after reviewing those files, Uphoff and Everett confessed that evidence of staff error was readily apparent or indicated in each of those assaults and yet none of them had been investigated under AR 7.017, as each one should have been. [See Uphoff Dep. at 252 (Alvis); 211-15, 520 (Orosco); 403-07 (Peitsmeyer); 555-573 (Skinner); Everett Dep. at 219 (Slayton); 315-20 (Escobedo).]

20. As mentioned earlier, in addition to the one SIR investigation that has been conducted during the past six years, Uphoff and Everett conducted two non-SIR investigations into inmate assaults. [Uphoff Dep. at 169.] Significantly, all three of these investigations *concluded*

that systemic violations of policy had occurred in connection with those assaults. Defendants' first investigation--their only SIR investigation--involved the March 2000 murder of inmate Ellis Kennedy. The SIR Report disclosed such dangerous conditions as insufficient staffing of Kennedy's housing unit, inadequate surveillance checks ("rounds" or "walk-throughs"), and inadequate communication between staff regarding the risk of assault that Kennedy faced. [Uphoff Dep. at 341-58.] The second investigation, which examined the October 2000 stabbing of Melvin Slayton, discovered that overworked officers were being assigned to operate the cell-door control panel, and their frequent errors resulted in allowing violent inmates, who were supposed to be kept isolated, to attack one another when multiple cells door were simultaneously opened by mistake. [Everett Dep. at 219-21.] The third investigation, examining an assault in April 2001, found "a failing of the overall management" of the Maximum Security Compound and "serious breaches in security procedures" had contributed to the incident. [Uphoff Dep. at 479, 481.]

21. Uphoff and Everett admit *knowing* that investigating inmate assaults is one way "to decrease inmate violence." [Uphoff Dep. at 529; Everett Dep. at 329.] Likewise they *know* that, by having not conducted

more investigations, they increased the risk that a dangerous condition would then cause another inmate assault because, as Uphoff stated, she "couldn't know what was broken." [Uphoff Dep. at 530; Everett Dep. at 329.]

2. Conclusions of Law Regarding This Claim

Farmer, Lopez, Berry, and Meade (and the principles upon which they rest) control this claim. Prison officials are "responsible for taking reasonable measures to insure the safety of inmates." Lopez, 172 F.3d at 759 (citing Farmer). Prison officials who know that an employee's misconduct creates "a substantial risk of serious harm" must take "reasonable measures" to abate that risk. Farmer, at 834, 842.

The undisputed facts show that Uphoff and Everett *know* that investigating inmate assaults resulting in serious injury is not only a reasonable measure to protect against further assaults--*it is absolutely essential*. They *know* the domino effect: they must conduct investigations in order to detect and then abate dangerous conditions. (Indeed, Uphoff enacted AR 7.017 in response to this critical need.) They *know* that inmates are at substantial risk of serious harm whenever assaults are not investigated. They also *know* from the three investigations

they did conduct that staff error *does cause* inmate injury. Yet they have persistently allowed their staff (and themselves) to disregard these known risks to inmate safety (and to violate their own policy, AR 7.017, in the process).

The facts show that Uphoff and Everett, in derogation of their duty to take reasonable steps to protect inmates from assault, "customarily failed to properly supervise" their employees regarding an indispensable matter of inmate safety: the investigation of assaults resulting in serious injury. See Meade, 841 F.2d, at 1528. They turned a blind eye to what their own (three) investigations told them.

Lopez makes it clear that one unnecessary and preventable assault is one too many, and that an administrator who overlooks the dangerous conditions that caused that assault is deliberately indifferent to inmate safety. Lopez, 172 F.3d at 762. See also Berry, 900 F.2d at 1499. Significantly, Uphoff and Everett *admit* that a number of assaults--including Slayton, Alvis, and Skinner--could have been prevented had they not overlooked the dangerous conditions that caused earlier assaults.

Another case directly on point is Nissen v. Silbaugh, 104 F.3d 368, 1996 U.S. App. LEXIS 37639 (10th Cir. 1996)

(unpublished opinion).⁴ In Nissen the Tenth Circuit held that former WSP Warden Duane Shillinger could be held personally liable for having failed to "properly disseminate" a policy that required the officers who supervised the prison's kitchen to safely store all knives whenever they left inmate workers unattended, a failure that led to the stabbing of plaintiff Nissen. As Nissen recognizes, promulgating a policy necessary for inmate safety but not supervising and training staff in its implementation is a constitutional error.

It may sound harsh, but it is true: in every practical sense, Uphoff and Everett have blood on their hands as a result of not investigating the vast majority of inmate assaults that resulted in serious injury, and violating their own policy in the process. Uphoff's and Everett's failure to supervise and train their employees in implementing AR 7.017 was "'so reckless or grossly negligent that future misconduct [was] almost inevitable.'" Meade, 841 F.2d at 1527." Smith v. Lejeune, 230 F. Supp.2d at 1268-69.

⁴The Local Rules of the Tenth Circuit permit reliance on an unpublished decision when, as here, "it has persuasive value with respect to a material issue that has not been addressed in a published opinion and it would assist the court in its disposition." 10th Cir. R. 36.3. See, e.g., Hunt v. Uphoff, 199 F.3d 1220, 1224 (10th Cir. 1999) (citing an unpublished opinion).

"[A] factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious." Farmer, at 842. Uphoff and Everett know that a failure to investigate inmate assaults substantially increases the risk of recurrence. The hazards of their practice and custom--to conduct investigations in a tiny fraction of assaults--is obvious. Consequently, this Court must conclude that Uphoff and Everett are deliberately indifferent to a known risk.

Uphoff essentially conceded that her practices reflect deliberate indifference, a conclusion that is inescapable given the undisputed facts:

Q. [By Mr. Pevar] You've only done three [internal investigations into inmate assaults] in more than six years?

A. [By Ms. Uphoff] That's correct. That's correct.

Q. Okay. And those three found systemic violations. Now, perhaps if those three investigations found no violations, you might have grounds to--to tell me, "Well, Mr. Pevar, I think it would be a waste of taxpayer money to try to determine whether my staff is violating policy when we've conducted three and it's squeaky clean." But you can't make that claim, can you?

A. No, I can't.

Q. If anything, the results of the three that you did conduct would prompt you to do more--more of them, wouldn't it?

A. In terms of the policy and that setup, yeah, under [the AR 7.017] format.

Q. . . . I've come to the conclusion that you're not interested in finding out the errors [that are causing inmate assaults] because you're not looking for them. Now, how--*what evidence do you have that you are concerned about discovering violations of policy by your staff and protecting my clients?*

A. *You know, in terms of the written reports, in terms of the SIRs, I can't give you anything.*

Uphoff Dep. at 488-490. (Emphasis added.) Warden Everett made a similar admission:

Q. [By Mr. Pevar] If at trial Judge Brimmer turns to you . . . and says, "Mr. Everett, it seems to me that you wanted to stay in the dark about staff error, given how rarely you conducted internal investigations," what can you say in response?

A. [By Mr. Everett] I don't know what my response would be. I--I guess I'd have to agree with him.

Everett Dep. at 251. Everett later added, in words that Plaintiffs hope this Court incorporates into an Order:

I agree with you. The investigations are necessary, and I'll be in full support of them. **I hope they institute them** or follow the SIR policy or whatever needs to be done **to protect some of those guys from getting beat up**. . . . I support that investigation policy.

Everett Dep. at 200 (emphasis added).

Uphoff and Everett have engaged in "willful blindness," Maldonado-Denis v. Castillo-Rodriguez, 23 F.3d 576, 582 (1st Cir. 1994), and "ostrich-like avoidance," Doe

v. Hillsboro Indep. Sch. Dist., 81 F.3d 1395, 1404 (5th Cir. 1996), by refusing to investigate the vast majority of inmate assaults. They have violated their duty to "'take reasonable measures to guarantee the safety of the inmates.'" Farmer, at 832 (citation omitted). Plaintiffs are entitled to summary judgment on this claim.

II.

Defendants Have Failed to Develop an Effective Internal Review Process for the Reporting of Policy Violations

Many courts have now recognized that law enforcement agencies, including prisons and jails, often establish or pursue the custom known as a "code of silence": the refusal of employees to report wrongdoing committed by fellow employees. As the Ninth Circuit recently noted, this custom "has been observed around the country," and "[t]he seriousness of such a custom and the need for a civil rights remedy" to halt it is manifest. Blair v. City of Pomona, 223 F.3d 1074, 1081 (9th Cir. 2000). See also Jeffes v. Barnes, 208 F.3d 49, 63 (2d Cir.), cert. denied, 531 U.S. 813 (2000); Sharp v. City of Huston, 164 F.3d 923, 935 (5th Cir. 1999).

The undisputed facts show that Uphoff and Everett have established a code of silence regarding staff wrongdoing committed in connection with inmate-on-inmate assaults.

Their custom is evidenced by the fact that (1) they have created *no procedural mechanism* whereby officers could or should report or document such wrongdoing, and (2) there is a paucity of such documentation despite an (over) abundance of wrongdoing.

1. Undisputed Facts Regarding This Claim

1. During their depositions, Uphoff and Everett were shown a number of incident reports written by officers who had responded to inmate assaults, including assaults that had to have been caused by staff error. Not a single report mentioned the presence of staff error. Indeed, out of the hundreds of pages of individual officer incident reports produced by Defendants in this lawsuit, not one of them mentions the existence of a staff error. Uphoff and Everett explained that the reason these reports did not disclose the presence of staff error--even when the reporting officer had to have known or suspected that staff error had actually caused the assault--is because "they weren't expected to." [Everett Dep. at 128.] Staff error is only documented if Everett or Uphoff commission an entirely separate investigation into that subject (something they did only three times in six years, as just discussed). [Id.] Officers "didn't investigate and they

weren't expected to investigate [or report on] staff misconduct," Uphoff explained. [Uphoff Dep. at 561.]

2. There is, in fact, no place where this information is to be documented, Uphoff *admits*:

Q. [By Mr. Pevar] Did you have a policy, and do you have a policy, requiring the people who write those incident reports to disclose potential policy violations, yes or no?

A. [By Ms. Uphoff] In the incident report, no.

Q. And there's no other place, either, in which, when [policy] violations like this occur, it's required to be documented as such? There is no other logbook, there's no other place?

A. No.

Uphoff Dep. at 393-94.

3. The failure to document policy violations, Uphoff agreed, could be viewed as a cover-up. [*Id.* at 230.] Everett agreed: "I guess if you wanted to look at it in that vein, yes, you could probably say that." [Everett Dep. at 179.]

2. Conclusions of Law Regarding This Claim

The problem with Defendants' policy of not documenting policy violations is two-fold. First, the practice creates or condones an official cover-up: a concealment of wrongdoing. But that in itself may not render it unconstitutional. What renders it unconstitutional is its second infirmity: it inhibits supervisors from discovering

(and thus abating) dangerous conditions. Line officers are not reporting--and are not *expected* to report--staff errors, staff misconduct, and institutional deficiencies that are causing inmate assaults, and this "report no evil" policy inevitably makes it more difficult--and in some instances impossible--for a dangerous condition to be abated promptly.

Therefore, Defendants' code of silence is unconstitutional for the same reasons their "do-not-investigate" policy, discussed above, is unconstitutional: it prevents supervisors from discovering, and thus abating, dangerous conditions. Prison administrators have a duty to take reasonable measures to guarantee inmate safety, Farmer, 511 U.S. at 832, and a code of silence violates that duty. See Blair v. City of Pomona, 223 F.3d at 1081; Jeffes v. Barnes, 208 F.3d at 63. Plaintiffs are entitled to summary judgment on this claim.

III.

Defendants Have Failed to Discipline Malfeasant Employees, Thereby Jeopardizing Inmate Safety

Inmate safety from attack depends ultimately on prison officers taking remedial action to abate dangerous conditions. Accordingly, once an officer is "exposed to information concerning the risk [of serious injury]," the

officer must then "take reasonable measures to abate it." Farmer, at 842, 847. See Lopez, 172 F.3d at 762 (holding that a jail supervisor could be held liable for failing to abate a dangerous deficiency after learning of its existence); see also Nissen, 1996 U.S. App. LEXIS 33264 *17-19 (holding that a prison warden must ensure proper implementation, on an on-going basis, of a policy designed to protect inmates from assault).

1. Undisputed Facts Regarding This Claim

1. At the outset of his deposition, Everett asserted in no uncertain terms: "I took a real hard line approach on employee discipline." [Everett Dep. at 52.] "[I]f I saw any wrongdoing, I would take care of it immediately." [Id. at 43.] "If anything," Everett said, ["I was] too harsh." [Id.] Everett estimated he fired 150 employees for violating prison policy, and stated that he wanted his testimony to be "really clear" that if he "received any kind of compelling information about wrongdoing at the penitentiary," he would take "immediate action." [Id. at 42.]

2. During the next two days of deposition, Everett recanted all of those expressions as they related to inmate-on-inmate assaults. He was shown numerous assault files that he had read as Warden that contained compelling

information of staff wrongdoing. In each instance, Everett *conceded*, he had ignored that information. Indeed, as Everett finally admitted, not *one* of the employees he had fired was terminated in connection with an inmate-on-inmate assault, and he had *no evidence* indicating that he had ever disciplined a single officer for wrongdoing in connection with an inmate-on-inmate assault. [*Id.* at 252-254.] After reviewing the evidence, Everett *admitted*: "I think it's probably clear that I haven't disciplined people in that area. Other areas I have." [*Id.* at 297.]

3. After reviewing the Department's disciplinary files, Uphoff confirmed that "**not a single officer has been disciplined for violations of policy in connection with an inmate assault.**" [Uphoff Dep. at 428. See also *id.* at 297-298.]

4. As explained earlier, Uphoff and Everett know from the Incident Reports they received and the three investigations they commissioned, that staff errors have caused some inmate assaults. Uphoff and Everett *admitted* that they did not even discipline the officers who they *knew* had caused these unnecessary injuries; in fact, not one such officer was even required to undergo additional training. [Uphoff Dep. at 306-07; Everett Dep. at 255-56.] Uphoff, for instance, acknowledged that Lt. Hewitt and Sgt.

Ebell violated prison policy in connection with the assault on inmate Brad Skinner, and yet neither officer was reprimanded or disciplined in any fashion. [Uphoff Dep. at 573.]

5. The Kennedy SIR report identified by name four officers who had violated prison policy in connection with the murder by other inmates of Ellis Kennedy in March 2000. None of those officers was disciplined. [Uphoff Dep. at 363-64.] After reviewing the Kennedy SIR report during his deposition, Everett *admitted* that, in addition to those four officers, their two supervisors (once more, Hewitt and Ebell) should have been disciplined, as they were equally as guilty of the wrongdoing, if not more so. [Everett Dep. at 295-96, 298-303.]

6. Everett *admitted* that the supervisor responsible for the stabbing of Melvin Slayton (here again, Ebell) should have been disciplined. Yet Ebell has not been disciplined. [Everett Dep. at 219.]

7. Everett knows there is no justification for failing to discipline known policy violators. Everett gave the following testimony in reference to all the assaults that Everett knew were the product of staff misconduct:

Q. [By Mr. Pevar] Can you justify the lack of disciplinary action in those situations in which you knew that staff misconduct had caused

unnecessary and entirely preventable injuries to an inmate?

A. No, sir.

Everett Dep. at 257.

8. One of the most obvious examples of Uphoff's and Everett's failure to discipline malfeasant officers concerns an aspect of the Kennedy assault. Before discussing this failure to discipline, certain facts regarding what is a "walk-through" need to be explained. In a "walk-through" (or "round"), an officer walks down the hallway of a cellblock and visually inspects the inside of each cell. A walk-through, Uphoff explained, serves two purposes. First, it allows officers to see whether an inmate is injured or in distress, and second, it acts as a deterrent by "let[ting] inmates know that you're actively monitoring them so as to deter inmate assaults and other violations of policy." [Uphoff Dep. at 140.] Walk-throughs are an essential part of every prison safety program. "Walk-throughs are tremendously important" to inmate safety, said Everett. [Everett Dep. at 115. See also Uphoff Dep. at 139-41.]

9. Uphoff and Everett instituted a policy of half-hourly walk-throughs--that is, 48 walk-throughs a day--immediately following their receipt of a report issued by

the U.S. Department of Justice in June 1999 that castigated WSP for, among other things, not conducting half-hourly walk-throughs. [Everett Dep. at 97-98.]

10. Ellis Kennedy was murdered in his cell on March 23, 2000. Prison logs show that not a single walk-through was conducted in his cellblock during the six-hour period from 6 a.m. to noon, during which time Kennedy was assaulted. [Uphoff Dep. at 149.]

11. Uphoff *admits* that enforcement of the walk-through policy might have saved Ellis Kennedy's life. [Uphoff Dep. at 357.] The failure to conduct walk-throughs, said Uphoff, "certainly created a way for that murder to happen. It certainly assisted whatever [the assailants'] plan was." [*Id.* at 359.] Yet neither the line officers who failed to conduct the walk-throughs nor their supervisors who should have been monitoring this situation were disciplined in any fashion, despite the fact that their malfeasance could have, as Uphoff knew, cost Kennedy his life. [Uphoff Dep. at 363-64.]

12. Uphoff *knows* the importance of demonstrating to her staff that malfeasant officers will suffer the consequences. When asked whether "another way to reduce inmate violence is to discipline the officers whose errors caused or led to inmate violence," Uphoff *conceded* that

there "[s]hould be consequences of some kind" imposed on them. [Uphoff Dep. at 530.] However, as stated above, she has not imposed any form of discipline on malfeasant officers in connection with an inmate-on-inmate assault.

2. Conclusions of Law Regarding This Claim

Supervisors who are aware that a subordinate has engaged in unauthorized and dangerous behavior and "fail to correct this conduct" through appropriate disciplinary action exhibit deliberate indifference to the safety of their charges. Currier v. Doran, 242 F.3d 905, 923 (10th Cir. 2001). See also Meade v. Grubbs, 841 F.2d at 1528 (holding that a county sheriff can be held personally liable "for improperly training, supervising and disciplining his deputies.")

Supervisors who rarely or sporadically--or, in this case, *never*--enforce their own rules on employee misconduct inevitably send their staff a message that they can "get away with anything." Larez v. City of Los Angeles, 946 F.2d 630, 647 (9th Cir. 1991). When supervisors indicate that an employee's misconduct "would not engender either serious investigation . . . or official sanctions," they acquiesce in that misconduct. Marchese v. Lucas, 758 F.2d 181, 188 (6th Cir. 1984). See also Grandstaff v. City of Borger, 767

F.2d 161 (5th Cir. 1985) (holding a supervisor liable for the misdeeds of his employees based on the fact that, following their misconduct, "there were no reprimands, no discharges, and no admissions of error.")

In Bordanaro v. McLeod, 871 F.2d 1151 (1st Cir. 1988), the court held that "[t]he absence of a strictly enforced disciplinary system led the [malfeasant] officers to believe they were above the law and would not be sanctioned for their misconduct," a policy and custom of the Mayor and Chief of Police, the court concluded, that "showed a reckless or callous indifference to the rights of others." Id., 871 F.2d at 1162, 1163. Uphoff and Everett have established this very same policy and custom. Until they begin insisting that officers obey the rules on inmate safety by *enforcing* those rules, inmates cannot be safe. Defendants *know* the importance to inmate safety of disciplining officers whose malfeasance has caused inmate assaults, and therefore their failure to discipline reflects deliberate indifference. Plaintiffs are entitled to summary judgment on this claim.

CONCLUSION

An appropriate summary of the unconstitutional acts of Defendants Uphoff and Everett is found in the deposition of Deputy Warden William Hettgar:

Q. [By Mr. Pevar] As I see it, [AR 7.017] is the single most important policy that you have here regarding inmate-on-inmate assaults. Do you agree?

A. [By Mr. Hettgar] I would agree, yes.

Q. So Ms. Uphoff enacts that policy, and then both she and Mr. Everett repeatedly violate it; right?

A. I would agree, yes.

Q. Warden Everett enacted walk-through policies, but then he didn't enforce them, and he didn't punish the supervisors who repeatedly violated the policy; correct?

A. I -- yes, I agree.

Q. The two of them repeatedly received evidence that staff error did cause in some instances and may have caused in other instances needless suffering by inmates through assaults, and yet they failed to pursue most of that evidence and didn't discipline anyone, even the known policy violators; correct?

A. Yes, it appears that way.

Q. And I don't know of any policy that they enacted that they then consistently enforced to protect my clients from further assaults. Do you?

A. Not that I could say consistently.

Q. *So to me all the evidence points to--what the phrase is--deliberate indifference, or a lack of caring on their part, for inmate safety. Do you have any evidence to the contrary?*

A. *You know, I don't have anything that I can think of right off the top of my head.*

Hettgar Dep. at 148-150 (emphasis added).

Respectfully submitted this 24th day of October, 2002.

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ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

The undersigned attorney of record in this case hereby certifies that a true and correct copy of the foregoing PLAINTIFFS' BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT was sent by U.S. mail postage prepaid this 24th day of October, 2002, to:

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