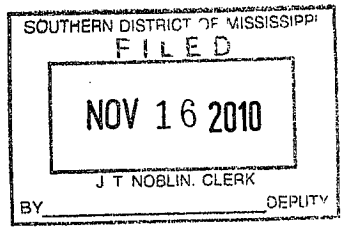
IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF MISSISSIPPI
JACKSON DIVISION



C.B., by and through his next friend, Charleston DePriest; ERIC BALL; ERIK BARNES; JAMARIO BRADY; JOSHUA CLAY; CHRISTOPHER COLEMAN; LAMARCUS CURRY; CRAIG KINCAID; LAMARSHA READUS; COZY SCOTT; LATRAVIS SMITH; BRIAN WEBSTER; and FREDRICK WHITE, on behalf of themselves and all similarly situated individuals,

Plaintiffs

v.

WALNUT GROVE CORRECTIONAL AUTHORITY; THE GEO GROUP, INC.; HEALTH ASSURANCE, L.L.C.; WALTER TRIPP, in his official capacity as Warden of the Walnut Grove Youth Correctional Facility; WESLEY VINSON, in his official capacity as Deputy Warden of the Walnut Grove Youth Correctional Facility; DAN KERN, in his official capacity as Deputy Warden of the Walnut Grove Youth Correctional Facility; K. HOGUE, in her official capacity as Health Services Administrator for Walnut Grove Youth Correctional Facility; CHRISTOPHER EPPS, in his official capacity as Commissioner of the Mississippi Department of Corrections; and DR. TOM BURNHAM, in his official capacity as Superintendent of the Mississippi State Department of Education,

Defendants

CLASS ACTION
Civil Action No. 3:10CV663 DPJ-FKB

COMPLAINT

INTRODUCTION

1. This is a class action filed on behalf of the teenagers and young men who are imprisoned in the Walnut Grove Youth Correctional Facility ("WGYCF"), located in Leake County, Mississippi. WGYCF is a prison for youth ages 13–22 who are tried and convicted in the adult criminal justice system. Sixty-seven percent of the young men at WGYCF are incarcerated for committing non-violent offenses. Constructed with over $41 million in taxpayer-funded subsidies, the facility has generated approximately $100 million for the various for-profit entities that have operated the prison since it opened its doors in 2001. Under the current contract, Mississippi taxpayers pay the Walnut Grove Correctional Authority ("WGCA") $14 million annually to operate the prison. In turn, the WGCA contracts with the GEO Group, Inc., the second largest private correctional company in the United States, to oversee the prison's daily operations.

2. The Mississippi Legislature established the WGYCF with good intentions: to ensure that young men in the custody of the Mississippi Department of Corrections ("MDOC") would have a second chance and receive rehabilitative services. Unfortunately, these good intentions were never realized. The youth imprisoned there live in barbaric, unconstitutional conditions. The for-profit entities that manage WGYCF perpetuate violence and corruption. Some prison staff exploit youth by selling drugs inside the facility. Other staff members abuse their power by engaging in sexual relationships with the youth in their care. Many youth have suffered physical injuries, some serious and some permanent, as a result of dangerously deficient security policies and prison staff who physically abuse the young men housed in WGYCF. Youth who are handcuffed and defenseless have been kicked, punched, and beaten all over their bodies. For the sole purpose of inflicting excruciating pain, some WGYCF staff have sprayed dangerous

chemical restraints on young men who are secure in their cells. Some youth are stripped naked and held in isolation for weeks at a time. Young men with serious health needs languish without required medical care—sometimes risking death or permanent injury. Courts frequently order youth sentenced to WGYCF to finish their education, and state law specifically requires WGYCF to provide educational services to all young men confined there throughout their incarceration. Despite these facts, the facility prevents most youth from accessing even the most basic education services—fewer than half of the 1,200 youth imprisoned in WGYCF attend school.

3. Many violations suffered by the young men confined at WGYCF are well documented. Over the past five years, the Joint Committee on Performance Evaluation and Expenditure Review (PEER) and the MDOC Corrections Auditor have consistently reported serious concerns related to safety, security, violence prevention, medical/mental health care and educational services at WGYCF. In 2005, 2006 and again in 2010, PEER noted that the population at WGYCF increased, while security staff decreased—creating dangerously understaffed conditions. The PEER report revealed serious understaffing of mental health care at the prison. As a result, youth suffer serious harm. PEER also documented the lack of educational services provided to young people at WGYCF—findings that were confirmed by the Mississippi Department of Education.

4. The youth who have suffered harm as a result of the unlawful conditions at WGYCF include a young man who was held hostage in his cell for almost 24 hours, brutally raped and physically assaulted after prison staff failed to heed his pleas for protection. Other youth suffered multiple stabbings and beatings—including one youth who lives with permanent brain damage as a result of an attack in which prison staff were entirely complicit.

5. On behalf of themselves and all similarly situated youth imprisoned at WGYCF, the Plaintiffs seek declaratory relief and preliminary and permanent injunctive relief ordering the Defendants to cease all unconstitutional and unlawful policies and practices at the prison and to provide class members with required care, education, and living conditions.

JURISDICTION

6. This cause of action arises under the United States Constitution, 42 U.S.C. § 1983, the Individuals with Disabilities Education Improvement Act of 2004 ("IDEA"), 20 U.S.C. § 1400 *et seq.*, Section 504 of the Rehabilitation Act of 1973 ("Section 504"), 29 U.S.C. § 794, and Title II of the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq*. Jurisdiction in this Court is proper pursuant to 28 U.S.C. §§ 1331 and 1343(a)(3). In addition, one of the claims arises under Mississippi law. This Court has jurisdiction under 28 U.S.C. § 1367 over any state law claims.

VENUE

7. Venue is proper under 28 U.S.C. § 1391(b)(2) because a "substantial part of the events or omissions giving rise to the claim[s] occurred" in this district. This Court is authorized to grant declaratory relief under 28 U.S.C. §§ 2201 and 2202, and injunctive relief pursuant to Rule 65 of the Federal Rules of Civil Procedure.

PARTIES

8. The Plaintiffs are all youth who are currently incarcerated at the WGYCF and who are subject to conditions of confinement that violate their rights under the U.S. Constitution. Plaintiffs are also denied the educational services to which they are entitled under federal and state law.

9. Plaintiff C.B. is sixteen years old. Since arriving at WGYCF, C.B. has been repeatedly beaten, robbed, and threatened. C.B. fears for his safety. He brings this action through his next friend and father, Plaintiff Charleston DePriest.

10. Plaintiff Eric Ball has a learning disability and is eligible for special education, but he receives no special education or related services at WGYCF. He also has repeatedly been punished with arbitrary placements in isolation without penological justification and for the sole purpose of inflicting wanton and unnecessary discomfort, pain, and humiliation.

11. Plaintiff Erik Barnes has received grossly inadequate mental health care for his serious mental illnesses.

12. Plaintiff Jamario Brady has a learning disability and is eligible for special education services, but he receives no special education or related services at WGYCF.

13. Plaintiff Joshua Clay has suffered serious injuries as a result of dangerously deficient security practices and the brutal use of chemical restraints. WGYCF staff have compounded his serious injuries by denying him necessary medical care.

14. Plaintiff Christopher Coleman has been repeatedly attacked and constantly fears for his safety.

15. Plaintiff Lamarcus Curry has been denied the special education services to which he is entitled.

16. Plaintiff Craig Kincaid has been subject to WGYCF's deliberate indifference to his serious medical needs.

17. Plaintiff Lamarsha Readus has been physically attacked by WGYCF staff while handcuffed. Lamarsha fears that WGYCF staff will soon attack him again.

18. Plaintiff Cozy Scott is eligible for special education and related services, but is not receiving them.

19. Plaintiff Latravis Smith was assaulted by WGYCF staff who sprayed him with dangerous chemical restraints while he was locked in his cell.

20. Plaintiff Brian Webster has been physically attacked by several WGYCF staff members, and he lives in fear that his attackers will target him for further abuse.

21. Plaintiff Fredrick White is eligible for special education and related services, but he does not receive such services at WGYCF.

22. Defendant Walnut Grove Correctional Authority ("WGCA") was created by the enactment in 1998 of House Bill No. 1878, which "created in the city a public body corporate and politic to be known as the 'Walnut Grove Correctional Authority.'" 1998 Miss. H.B. 1878. Under that special legislation, WGCA "shall have all the powers necessary or convenient to effectuate and carry out the provisions of this act," including the powers to construct a facility, and to "contract with the United States or the State of Mississippi, or any political subdivision of the State of Mississippi, to provide for housing, care and control in a facility of offenders who are in the custody of the jurisdiction. . . The facility shall at all times be operated and managed by a private contractor pursuant to a management contract unless the board of commissioners determines that the operation and management by a private contractor is not feasible or desirable. The terms and conditions of a management contract shall be approved by the board of commissioners." 1998 Miss. H.B. 1878. Under Mississippi law, and pursuant to its contract with the Mississippi Department of Corrections, the WGCA has a duty to operate and maintain the facility in accordance with all constitutional standards of the United States and the State of Mississippi and the standards of the American Correctional Association ("ACA"). 1998 Miss.

H.B. 1878; Miss. Code Ann. § 47-5-943; Residential Services Agreement between Mississippi Department of Corrections (by and on behalf of the State of Mississippi) and Walnut Grove Correctional Authority (November 10, 2006) (hereafter "WGCA/MDOC Contract"), § 4.1. The WGCA/MDOC Contract allows WGCA to assign or subcontract its contractual obligations, but states that WGCA "shall remain responsible for seeing that any subcontractor or assignee fulfills the provisions of this Agreement." WGCA/MDOC Contract, § 9.12. In 2004, the WGCA subcontracted with Cornell Companies, Inc. ("Cornell"), a for-profit corporation, for the management and operation of WGYCF.

23. Defendant GEO Group, Inc. ("GEO"), acquired Cornell in a merger that was completed on August 12, 2010. GEO has assumed all of Cornell's duties, contractual responsibilities, and liabilities. Since the merger, Defendant GEO has managed the WGYCF under a contract with the WGCA. Under its contract, GEO has responsibility for providing humane care and treatment consistent with all constitutional and ACA standards. Defendant GEO is a for-profit private corporation incorporated and existing in the state of Florida and maintaining a principal place of business at 621 NW 53rd Street, Suite 700 in Boca Raton, Florida.

24. Defendant Health Assurance, L.L.C. ("HALLC"), is a limited liability corporation that has contracted with the Mississippi Department of Corrections to provide health care for the youth at WGYCF. Under the May 22, 2006 Contract for Medical Services, HALLC agrees to provide "medical, optometry, pharmaceutical services, mental health services and a dental program" for the incarcerated youth at WGYCF. The contract specifies that HALLC will provide all health services "in accordance with ACA standards, federal and state laws, constitutional standards, court orders, local laws and regulations and MDOC Policies and Procedures. If there is a difference between the above standards and/or laws then the higher

standard will be followed." HALLC is incorporated in the state of Mississippi and maintains its principal place of business at 5903 Ridgewood Road, Suite 320 in Jackson, Mississippi.

25. Defendant Walter Tripp is the Warden of the WGYCF. Warden Tripp is responsible for the administration of WGYCF. He has the duty to hire, supervise, train and discipline the staff at the prison and to ensure the prison's compliance with state policies and procedures and the laws and Constitutions of Mississippi and the United States. His duties also include reviewing, investigating and responding to prisoner grievances and complaints. He is sued in his official capacity.

26. Defendant Wesley Vinson is a Deputy Warden of WGYCF. He is responsible for the supervision and training of staff and for reviewing, investigating and responding to prisoner grievances and complaints. He is sued in his official capacity.

27. Defendant Dan Kern is a Deputy Warden of WGYCF. He is responsible for overseeing the provision of medical and education services in the prison, for supervision and training of staff, and for reviewing, investigating and responding to prisoner grievances and complaints. He is sued in his official capacity.

28. Defendant K. Hogue is the Health Services Administrator at WGYCF. She oversees and administers the provision of medical care at the facility for HALLC. Her duties include, but are not limited to, ensuring prisoners' prompt access to medical care and ensuring that physician orders are timely and consistently carried out. She is sued in her official capacity.

29. Defendant Christopher Epps is the Commissioner of the Mississippi Department of Corrections ("MDOC"). The Department of Corrections is "responsible for the management of affairs of the correctional system and for the proper care, treatment, feeding, clothing and management of the offenders confined therein." Miss. Code Ann. §47-5-23. The Commissioner,

as the head of the department, oversees all of these functions. The Commissioner has the duty and authority to do the following: establish the general policy of the department, § 47-5-20; "implement and administer laws and policy relating to corrections..." § 47-5-28; and "establish standards, ... and exercise the requisite supervision as it relates to correctional programs over all state-supported adult correctional facilities," § 47-5-28(b). The Commissioner also has "final authority to employ and discharge all employees of the correctional system." Miss. Code Ann. § 47-5-23. As Commissioner, Defendant Epps has the ultimate responsibility for ensuring that all prisons under the jurisdiction of MDOC operate in compliance with state and federal law. Defendant Epps' obligations extend with full force to privately operated facilities like WGYCF. He receives reports regarding operations at WGYCF, and has knowledge of all the conditions described in this complaint. He is sued in his official capacity.

30. Defendant Dr. Tom Burnham is the State Superintendent of the Mississippi Department of Education ("MDE"). He is sued in his official capacity. Defendant Burnham is the chief administrative officer of the state Department of Education. Miss. Code Ann. § 37-3-11. Pursuant to Mississippi Code Section 37-3-5, MDE is responsible for administering all public education services in the state of Mississippi. MDE is also responsible for administering special education services to all educable youth who reside in the state of Mississippi. Miss. Code. Ann. § 37-23-5. Pursuant to federal law, MDE has the ultimate responsibility to ensure the provision of special education services to all eligible individuals. 20 U.S.C. § 1412(a)(11)(A). MDE is obligated to ensure that the State of Mississippi implements and complies with all provisions of the Individuals with Disabilities Education Improvement Act of 2004 ("IDEA"), 20 U.S.C. § 1400 *et seq.*.

CLASS ACTION ALLEGATIONS

31. The named Plaintiffs bring this suit on their own behalf and on behalf of all youth who are, or will in the future be, incarcerated at the WGYCF.

32. The class is so numerous that joinder of all members is impractical. WGYCF currently houses approximately 1,200 prisoners and has the capacity to house 1,500 at one time. The class also includes many future members whose names are not known, as the facility regularly admits new youth.

33. There are questions of law and fact common to all class members, including but not limited to the following: whether conditions of confinement for youth confined at WGYCF violate their rights under the Eighth and Fourteenth Amendments to the U.S. Constitution; whether the Defendants' excessive use of force and use of punitive isolation violate their rights under the Eighth and Fourteenth Amendments to the U.S. Constitution; whether the systemically inadequate medical and mental health care violates their rights under the Eighth and Fourteenth Amendments to the U.S. Constitution; and whether the systemic denials of educational services violate their rights under the Individuals with Disabilities Education Act, §§ 1400 *et seq.*, Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, Title II of the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, and state law regarding the provision of educational service to youth confined at WGYCF.

34. Because the policies, practices and customs challenged in this Complaint apply with equal force to the named Plaintiffs and the other members of the class, the claims of the named Plaintiffs are typical of the class in general.

35. The named Plaintiffs will fairly and adequately represent the interests of the class. They possess a strong personal interest in the subject matter of the lawsuit and are represented by

experienced counsel with expertise in class action prison conditions litigation in federal court. Counsel have the legal knowledge and resources to fairly and adequately represent the interests of all class members in this action.

36. The Defendants have acted or refused to act on grounds generally applicable to the class: their policies, practices, acts, and omissions have affected all class members. Accordingly, final injunctive and declaratory relief is appropriate to the class as a whole.

STATEMENT OF FACTS

35. While the private prison operators increase profits, the young men imprisoned at WGYCF live in unconstitutional and inhumane conditions and endure great risks to their safety and security. Because WGYCF is dangerously understaffed and because existing staff lack the training and supervision necessary required to care for the youth in their custody, corruption and violence is rampant. Youth and staff face threats to their lives and safety on an almost daily basis. Youth struggle to secure even the most basic services at WGYCF—medical and mental health care are dangerously deficient, and youth are regularly denied educational services.

36. Mississippi taxpayers pay Defendant WGCA $31.40 per youth per day to operate the WGYCF. WGYCF opened in 2001 with 500 beds and was authorized to house "juvenile offenders" between the ages of 13–19. Since then, approximately every two years, the Mississippi legislature has amended WGYCF's authorizing legislation to increase its bed capacity and to raise the maximum age of those who are eligible to be housed in the facility. In 2002, the legislature amended the law to allow 20-year-olds at WGYCF. The legislature then doubled WGYCF's size in 2004—allowing the facility to house 500 more youths—for a total capacity of 1,000 beds. In 2005, lawmakers raised the maximum age again, and the facility began housing people until shortly after their twenty-second birthdays. WGYCF's capacity was

expanded again in 2007, when the legislature added another 500 beds. WGYCF is currently authorized to house 1,500 individuals between the ages of 13 and 22. These amendments have significantly increased WGCA's income and tripled the size the prison.

37. In 2004, WGCA subcontracted with Cornell, a for-profit corporation, for the management and operation of WGYCF. Under its contract with WGCA, Cornell had responsibility for providing humane care and treatment consistent with all constitutional and ACA standards. In violation of these duties, Cornell incarcerated youth in extremely dangerous conditions, resulting in the serious injury of numerous young prisoners, and the death of two youths. Until its recent acquisition by the GEO Group, Inc., Cornell was a for-profit corporation incorporated and existing in the State of Texas and maintaining a principal place of business in Houston. Upon assuming control of WGYCF, GEO management retained almost all of the employees who were formerly employed by Cornell. The management structure and staffing assignments have changed little since the acquisition.

38. This Complaint describes conditions that currently exist and give examples involving specific individuals who are or were incarcerated at WGYCF. Some of the individuals are named plaintiffs and some are not.

Eighth Amendment Violations: Protection from Harm and Dangerous and Violent Conditions of Confinement

38. WGYCF is an extremely dangerous prison. For years, violent fights have occurred at WGYCF at least every week, and often every day. WGYCF reported 342 fights from 2004 to 2006—an average of nearly one fight every other day. Between January and June 2010, WGYCF reported 207 fights, or on average more than one fight per day. Many other fights go unreported.

39. Defendant GEO has a policy, which began years ago under Cornell, of understaffing the prison. In much of the prison, only one officer is assigned to guard each zone, and many of the

zones hold approximately 60 youth. The prison is constantly short-staffed, so officers sometimes are left responsible for two zones at a time. Additionally, youth are often left unsupervised when the assigned officer leaves the zone for other reasons. This understaffing creates violent conditions that subject youth to serious and sometimes permanent injury.

40. Defendants WGCA, GEO, Tripp, Vinson, and Epps have long been aware that the routine understaffing of WGYCF creates a risk of serious harm to the youth incarcerated there. In a 2005 report to the Mississippi legislature, a corrections auditor specifically noted that Cornell had decreased security staff while the prison population was increasing, and warned that the decrease could present "some significant problems with the safety and security of the facility." The report also highlighted corrections officers' concerns that decreases in staffing were increasing the potential for youth-on-youth assaults. In a 2010 update to that report, the auditor noted, "Although the inmate population at WGYCF has increased, the corrections officer staffing decreased."

42. The understaffing of the facility and the minimal supervision that Defendants Tripp and Vinson provide to correctional officers in the facility contributes to staff abuse and exploitation of the youth incarcerated there. Because staffing is so thin and supervision so minimal, correctional officers who want to exploit prisoners have ample opportunity to do so.

43. Officers who enter the prison at night are not searched. This allows correctional officers to prey on vulnerable youth by smuggling in drugs. Defendants Tripp and Vinson are aware that the drug-smuggling takes place, but they have not taken reasonably adequate measures to halt the practice, including adequate measures to ensure that correctional officers are properly searched before entering the facility. The presence of illegal drugs in the facility increases violence.

44. Some correctional officers and nurses have sex with youth at WGYCF. Many of these sexual acts occur in isolated, camera-free areas in the facility, including the individual cells, medical unit examination rooms, pod control, towers, and restrooms. Pursuant to Miss. Code Ann. § 97-3-104, any correctional officer who engages in sexual activity with individuals in MDOC custody commits a felony that is punishable by up to five years in prison. Correctional officers who have sex with the youth often use their relationships to manipulate the youth into acting as pseudo-correctional officers. At the direction of these WGYCF staff, these youth enforce order on their living units by physically assaulting and intimidating others. This increases tensions between youth on the cellblocks and results in more violence. Former WGYCF employees cite sexual relationships between staff and youth as one of the major causes of violence inside the facility. The understaffing of the facility and poor supervision allow these dangerous relationships to occur.

45. Cell doors on many units can easily be rigged to remain unlocked when shut, allowing prisoners to leave their cells and enter the cells of others at any time, resulting in many assaults. Wardens Tripp and Vinson have received multiple reports of assaults stating that prisoners escaped or entered other cells through rigged doors, yet they have failed to adequately supervise correctional officers to ensure that they routinely and effectively examine doors to check for rigging, or to take adequate measures to ensure that the defective doors are replaced.

46. By the terms of its contract with the Department of Corrections, WGCA is responsible for operating the prison to keep the prisoners safe. GEO has also assumed this responsibility through its subcontract with WGCA, which it took over from Cornell after the merger. These Defendants have failed to replace the defective doors with non-defective ones such as those that exist in other parts of the prison.

47. Many correctional officers do not routinely conduct security checks to confirm that youth are safe inside their cells, and the security checks they do conduct are so cursory that they are ineffective in determining whether youth are actually safe. Because emergency call buttons in the cells do not work, youth often cannot get help while locked down. As a result of these failures, one youth was raped, beaten and held hostage for nearly a full 24 hours earlier this year. Yet despite their knowledge of this and other assaults that frequently occur inside cells, Wardens Tripp, Vinson and Kern have failed to train and supervise officers to ensure that they perform frequent, effective security checks on prisoners locked in cells.

48. Many officers knowingly instigate fights and attacks by purposefully opening cell doors to allow youth who are in conflict to leave their cells at the same time. Some officers order or persuade youths to attack other youths. Many officers also facilitate attacks by intentionally leaving cell blocks unsupervised and cell doors unsecured. Wardens Tripp and Vinson have received many complaints about these problems from youth, but rarely conduct thorough investigations or take corrective action.

49. Many officers ignore prisoner requests to be moved to another zone due to fear of attack. Wardens Tripp and Vinson are aware of this problem but rarely discipline officers who ignore the warnings. Tripp, Vinson and other prison officials often fail to conduct thorough investigations of young peoples' warnings of impending violence.

50. Weapons are readily available throughout the prison. Wardens Tripp and Vinson are aware of this grave problem. It is documented in the Incident Reports, Extraordinary Incident Reports, and prisoner grievances they review. Despite their knowledge, they have failed to take reasonable measures to protect youth from suffering weapon-induced injuries.

51. Youth in protective custody are not safe. While in protective custody, youth have been raped, attacked, robbed of their belongings, and stabbed. WGYCF staff fail to take reasonable measures to ensure the safety of these youth, who are particularly vulnerable to prison violence due to a variety of factors including size, disposition, nature of their offense, and mental illnesses. Unit Manager Latunja Leflore oversees Unit 4, where protective custody is housed. She and other officers routinely incite violence among prisoners, intentionally cause cell doors to open to facilitate attacks, ignore basic security precautions, and disregard youths' concerns about their safety. A number of youth have complained to prison authorities about these practices, but Defendants have failed to conduct an appropriate investigation into the allegations concerning Unit Manager Leflore or to take any other precautions to protect the youth in her custody.

52. According to MDOC policy, WGYCF staff are supposed to conduct an "in-depth investigation" before placing youth in cells together in protective custody. Defendants Tripp and Vinson frequently fail to complete proper investigations before allowing youth to be placed in cells together in protective custody. Officials have repeatedly placed youth in cells with other youth from whom they had requested separation and protection—resulting in numerous attacks. Defendants Tripp and Vinson are aware of these dangers, having received numerous complaints from youth about these issues, but have not responded. Even in a zone supposedly reserved for vulnerable youth, Defendants expose youth to the risk of serious harm.

53. Wardens Tripp and Vinson demonstrate wanton disregard for life by removing youth from protective custody against their wishes and sending them to general population, despite their knowledge of the threats of attack against them.

54. The injuries suffered by the WGYCF youth described below illustrate how the Defendants' security practices put the Plaintiffs and other WGYCF youth in danger.

John Doe (referred to as J.D. throughout the complaint).

55. In late January 2010, J.D. was held hostage, violently sexually assaulted and beaten by his cellmate.

56. About three days before the attack, Captain Michael Jones moved a youth into J.D.'s cell. J.D. was fearful of sharing a room with this youth and immediately expressed his concerns to Captain Jones. Captain Jones ignored J.D.'s concerns.

57. Over the next two days, J.D.'s cellmate became more aggressive towards him, and J.D. became increasingly fearful that his cellmate might attack him. On or about January 22, 2010, J.D. sent a note to Unit Manager Benton describing his fears and serious concerns for his safety. Benton did not respond.

58. On January 23rd, J.D.'s cellmate covered the cell door window with a towel and used a weapon to force J.D. to his knees. J.D.'s cellmate tied J.D.'s hands behind his back and forced him to perform oral sex. He then raped J.D. J.D.'s cellmate told him he would stab him if he yelled for help. After the assault, J.D.'s cellmate went to sleep. J.D., afraid to yell, wrote a note to the guard and stood at the window waiting for help. J.D. stood at the window for hours waiting for an officer to walk by or see him. No officer came. The panic buttons in his cell did not work, so he had no other way of obtaining help.

59. While J.D. was standing at the door, his cellmate woke up and saw J.D. trying to contact an officer. Angry that J.D. was trying to get help, the cellmate forced him to lie on his bed and tied him down using bed sheets.

59. J.D.'s cellmate physically assaulted him throughout the night, inflicting multiple bruises and contusions, including two black eyes. At one point, J.D.'s cellmate made him drink blue

cleaning liquid in an attempt to remove physical evidence of the sexual assault. Although J.D.'s injuries were visible and obvious, no correctional officer took any measures to protect him.

60. After J.D. suffered almost 24 hours of abuse, a correctional officer opened the cell door to deliver dinner trays. When the cell door opened, J.D. tackled his cellmate and screamed for help. It was not until then that J.D. was freed from his cellmate.

61. This incident was not the first time J.D.'s cellmate exhibited violent tendencies. Incident reports sent to Warden Tripp reveal that in the year before the attack, J.D.'s cellmate had been found with multiple weapons and had received numerous write-ups for rule violations of a sexual nature.

62. Before placing J.D.'s cellmate in the cell with him, Wardens Tripp and Vinson and WGYCF staff failed to conduct an in-depth investigation to ensure that J.D.'s roommate would not endanger him.

63. Even when J.D. warned Jones and Benton that he did not feel safe with his roommate, they ignored his warnings, subjecting him to extreme risk of harm. Wardens Tripp and Vinson fail to supervise officers in the prison to ensure that they respond to youth's concerns about safety.

64. J.D. was extremely traumatized by the attack and continues to suffer mentally, emotionally and physically. He lives with chronic back pain since the attack. J.D. also has severe insomnia, depression, anxiety, feelings of paranoia and nightmares.

C.B.

65. Plaintiff C.B. is 16 years old. He entered WGYCF when he was only 15 years old. As a result of his youth, he is a target of physical abuse and violence.

66. Only a few days after C.B. arrived at WGYCF in October 2009, four youths beat him and kicked him while he was outside of his cell during recreation. There was only one correctional officer on duty and he left the cell block unsupervised immediately before C.B.'s attack. C.B. suffered multiple injuries during this attack including bruised ribs and the temporary loss of hearing in his right ear.

67. Later, C.B. was moved to a different zone. However, he was unable to escape danger. He was housed with a 21-year-old cellmate who constantly beat him up, stole his canteen purchases, and threatened to stab him. C.B. did not dare report the abuse, fearing that staff would not protect him from retaliation.

68. In mid-August of 2010, C.B. sustained deep gashes on his chest after another inmate entered his cell and instigated a fight with C.B.. No correctional officer was on the zone at the time. Again, fearing that the staff would fail to protect him from retaliation, C.B. did not report this attack.

69. C.B. continues to fear for his safety at WGYCF. In the last few months, C.B. has witnessed multiple attacks in his zone.

CHRISTOPHER COLEMAN

70. Plaintiff Christopher Coleman is housed in protective custody, where he has been attacked repeatedly.

71. In October 2009, while he was housed in zone 5C, Christopher was attacked by several other prisoners who told him that Unit Manager Leflore had incited the attack. In July 2010, Leflore threatened to arrange another attack against Christopher. In making this threat, Leflore admitted her responsibility for the first October 2009 attack.

72. In April of 2010, Unit Manager Leflore falsely told other youth on the zone that Christopher was convicted of rape—intentionally subjecting him to the serious risk of being physically attacked as a suspected sex offender.

73. In August of 2010, Christopher was attacked by his cellmate—a person he should never have been housed with in the first place. Christopher has a slight build and weighs only 135 pounds. Leflore assigned as Christopher's cellmate a 250-pound youth whom the MDOC website describes as "extremely large." Contrary to MDOC policy, Tripp and Vinson did not ensure that an in-depth investigation took place before this assignment. Leflore should never have placed, and Wardens Tripp and Vinson should not have approved, Christopher's placement with this cellmate: the extreme danger to him was obvious.. The danger manifested when Christopher's cellmate beat him, causing excruciating pain.

74. Before the attack, the cellmate began to threaten Christopher. Because he feared for his safety, Christopher filed a request for a separation order, called "a red-tag," from his cellmate and begged to be taken out of the cell. Leflore, Tripp and Vinson ignored these requests.

75. On or about August 17, 2010, Christopher's cellmate told Unit Manager Leflore, who was standing at their cell door talking to him, that he wanted to beat up Christopher. Leflore told him to go ahead and watched as the cellmate knocked Christopher's head into the wall, bit him, and beat him for several minutes. Finally, when the attack was winding down, Leflore called other officers to the zone to respond to the attack.

76. About two days later, Christopher was attacked again. At that time, the youth were locked in their cells, and the correctional officer on duty was supposed to be letting the prisoners out one at a time to use the telephone. While this was happening, two prisoners were loudly arguing with Christopher across the cellblock where the officer was standing. Shortly thereafter,

the officer opened Christopher's door, ostensibly so he could use the phone. When he came out, Christopher was surprised to find he was not the only prisoner outside his cell: the two prisoners he had been arguing with were out too, as well as another prisoner. The two from the argument attacked Christopher and the fourth prisoner, and beat Christopher and the other prisoner up. Christopher ended up with a severe headache.

77. As a result of these attacks and the repeated threats from Leflore, Christopher fears for his life and has become increasingly anxious. He believes he is likely to be attacked again.

78. Wardens Tripp and Vinson and other prison officials have ignored the danger and abuses Christopher and other youth face from Unit Manager Leflore and other abusive officers. Christopher has written multiple grievances detailing the threats he has received, the attacks he has suffered, and his fear of future attacks. He has also directly expressed his concerns to Major Swann and other staff and sent written complaints directly to Warden Tripp. Defendants have not taken any reasonable measures to protect Christopher and other youth from Leflore, who remains the unit manager and continues to endanger the youth in her custody. Wardens Tripp and Vinson have failed to properly investigate and have not disciplined Leflore and the other officers for their misconduct.

ORLANDO THOMAS

79. In June of this year, Orlando Thomas was attacked and beaten by a group of others incarcerated at WGYCF. For many months before the attack, Orlando had repeatedly notified WGYCF staff about his safety concerns. Around February 2010, Orlando wrote a note to Case Manager McGhee saying he felt his life was in danger and needed to talk to her as soon as possible. She never spoke to him about his concerns. Around the same time, he also told Case Manager Brown that he wanted to be moved to protective custody. She denied his request. On

May 14, 2010, Thomas submitted an Administrative Remedy Program (ARP) request claiming his life was in danger for the following reasons: officers leave the zone unattended while prisoners are out of their cells; officers conduct inadequate weapons searches; doors are easily rigged; and, prisoners have sharp weapons so stabbings are common. Defendant Vinson reviewed this grievance but failed to take measures to protect Orlando from a violent attack.

80. Around June 23, 2010, Orlando learned that others were planning to attack him. Orlando felt he needed to leave his zone immediately to avoid harm, so he told Unit Manager Leflore that his life was in danger and that he needed to move out of his zone. Leflore failed to investigate Orlando's claim. Instead, she dismissed his concerns, saying no one was going to hurt him. She then returned him to the zone with the youth who had targeted him.

81. Unit Manager Leflore did more than just ignore his concerns; she instigated the attack. When she returned him to his zone, she conveyed to other youth that Orlando was a fearful "snitch"—knowing that Orlando would likely be targeted with violence as a direct result of her words.

82. Later that day, Orlando was beaten with a broom and food trays, kicked several times, and stabbed with an ice pick. He suffered severe bruising and painful bumps on his head. Orlando filed a grievance about this, but neither Warden Tripp nor Vinson responded in any way.

February 27, 2010: Dangerously Deficient Security Leads to Massive Injuries

84. On February 27, 2010, several large and extremely violent fights broke out in Unit 6.

85. Many WGYCF officers and officials were on notice that fights were coming. A day or two before February 27, a correctional officer heard prisoners on Unit 6 talking about a planned

attack and told her superiors, two lieutenants. The day before the attack, Plaintiff Joshua Clay warned Major Swann and Captain Goff that there was a great risk of attack in Unit 6.

86. At a morning staff meeting on February 27, Captain Goff warned that an out-of-the-ordinary disturbance was expected on Unit 6.

87. Defendants Tripp and Vinson had known of the dangerous conditions at the facility and failed to reasonably respond to the violence at the facility. They were aware of numerous similar incidents that had occurred previously, but did not increase supervision or training for correctional officers or increase security to prevent future incidents. Just two weeks before the incident, three youths were rushed to the hospital with stab wounds after a large fight involving several weapons.

88. Days before the attack, several weapons were found in cells in Unit 6. Despite this, Defendant Tripp failed to conduct a thorough search for weapons throughout the unit.

89. On February 27, 2010, there were approximately 60 prisoners in each of the four zones on Unit 6, but because several officers were absent from work that day, there were only three officers assigned to patrol those zones. With only three officers for approximately 240 prisoners, there was little hope they could adequately protect and supervise those in their custody.

90. Officers released one group of youth from their cells for recreation. When that group's recreation time was over, the officers failed to secure all of the cell doors before releasing another group, in spite of the warnings of imminent violence and the understaffing. Several prisoners from the first group exited their cells and joined those from the second group. At some point, the correctional officers left the zone unattended.

91. Shortly thereafter, a large fight started. Young people were stabbed, punched, kicked, stomped, and thrown from the upper tier to the lower tier. Prisoners broke televisions and used

the glass as weapons. Staff took considerable time to respond. By the time they did so, fourteen young people had suffered serious injuries that required emergency off-site medical care. Two almost died as a result of this incident.

MICHAEL MCINTOSH and MONICO LOPEZ

92. On February 27, 2010, Michael McIntosh and Monico Lopez were roommates on Unit 6 when the fight erupted in the unit. They were nearly killed in this fight.

93. Michael suffered brain trauma that required emergency surgery and a prolonged hospitalization. He had to re-learn basic functions like walking, eating, and combing his hair. He is still suffering from brain injuries he received in the fight and will likely suffer from these injuries for the rest of his life.

94. Monico was stabbed in the head and badly beaten. He was transferred to a hospital in Jackson in February and released from custody in May 2010. Since the fight, Monico continues to suffer from serious back pain and has spit up blood repeatedly.

95. Prison officials received multiple warnings of the risk of attack on Unit 6, but ignored them. Had prison officials responded to these warnings, the injuries Monico and Michael suffered could have been prevented.

JOSHUA CLAY

96. During the February 27, 2010 fight, Joshua Clay was stabbed in Unit 6. Several of the other prisoners proceeded to kick, hit, and stab Joshua. He was stabbed repeatedly around the head and on his right forearm and hand.

97. Joshua was taken by ambulance to a hospital. He was in terrible pain and the doctors put staples in his hand and put him in a neck brace.

98. To this day, Joshua still suffers from pain and limited mobility in his right hand as a result of this attack. Joshua also has anxiety and severe insomnia, and is in constant fear of another attack.

Eighth Amendment Violations: Use of Excessive Force

99. Youth in WGYCF live in constant fear and risk of staff abuse. Many correctional officers maliciously use excessive force and go far beyond what is reasonably necessary to maintain or restore discipline in the facility. Frequently, force is used as a form of punishment with no legitimate penological purpose.

100. Many officers are quick to throw the young men to the ground and punch, beat or kick them, even when they are in handcuffs and pose no threat to the officers.

101. These officers commonly assault young men in areas lacking cameras, such as inside cells or in the medical unit. After these assaults, the injured youth often do not receive immediate medical attention.

102. Many officers spray youth with excruciatingly painful chemical restraints for the sole purpose of inflicting pain and severe discomfort. Youth are most frequently subject to chemical restraints as a consequence for placing their hands outside of their cells. WGYCF staff spray youth with chemical restraints, even though they are locked in their cells and pose no threat to the officers or others.

103. Officers frequently refuse to provide youth with appropriate medical treatment immediately after the use of chemical restraint. Officers leave the young men in their cells instead of taking them to the medical unit, giving them an opportunity to rinse the stinging chemicals from their eyes and bodies, or allowing them to go outside to get fresh air.

104. Some youth, especially those with asthma, suffer adverse reactions from airborne exposure to the chemicals even if they are not directly sprayed. Many officers ignore the young men's pleas for help.

105. Warden Tripp has known for years that the young men in WGYCF face significant and unnecessary risk of injury from staff abuse. He receives many grievances complaining about staff assaults, as well as medical reports describing injuries youth have suffered from staff assaults. Warden Tripp does not take reasonable measures to ensure that incidents of staff abuse are adequately documented and investigated and that all officers guilty of misconduct are appropriately disciplined.

106. Warden Tripp routinely gives explicit approval for correctional officers to use chemical restraints to punish youth for minor rule violations. He approves of this practice and has implemented it himself. In addition, Tripp has directly ordered this unnecessary and malicious use of force on several occasions.

107. The injuries suffered by the WGYCF youth described below illustrate how the Defendants' policy and practice of inflicting unnecessary and excessive force put the Plaintiffs and and other Walnut Grove Youth in danger.

LAMARSHA READUS

108. Plaintiff Lamarsha Readus lives in constant fear of physical abuse by officers at WGYCF, particularly Captain Michael Jones. In February 2010, Captain Jones assaulted Lamarsha while he was handcuffed, and he has threatened to assault Lamarsha again. Lamarsha has notified Warden Tripp and Commissioner Epps about the incident and his fear of future harm, but nothing has been done to investigate his claims or protect him from further harm.

109. The February 2010 incident began when Captain Jones and Officer Browskin escorted Lamarsha in handcuffs from the shower to his cell. Lamarsha entered his cell while handcuffed without incident.

110. While Lamarsha was handcuffed and defenseless inside his cell, Captain Jones maliciously and sadistically slammed his body to the ground, face down, splitting Lamarsha's chin on the ground, and then pressed one foot on top of Lamarsha's neck.

111. Lieutenant White and Officers Browskin and Johnson witnessed the abuse, but failed to intervene. Faint and bleeding from his chin, Lamarsha asked Lieutenant White and Officer Johnson for medical attention. They denied his requests.

112. Eventually, when the shift changed, Lamarsha was permitted to seek medical attention. Head Nurse and Health Services Adminstrator K. Hogue examined him and observed a laceration on Lamarsha's chin, which he had suffered when he was thrown face-down to the ground.

113. Captain Jones bragged about the assault to other inmates. Since then, Jones has repeatedly threatened to assault Lamarsha again.

114. On March 10, 2010, Lamarsha submitted an Administrative Remedy Program (ARP) request to notify authorities of the incident and his fear of future assault. Lamarsha received a response to his grievance three months later. His request for relief was denied on the ground that there were no witnesses to the event.

115. Lamarsha appealed to Warden Tripp. Warden Tripp failed to investigate Lamarsha's complaint, despite his documented injuries. On August 19, 2010, Lamarsha submitted an Emergency ARP request due to his continued fear of assault.

BRIAN WEBSTER

116. In April 2010, Plaintiff Brian Webster was maliciously beaten by several WGYCF staff members, including Major John Swann. Despite compelling evidence that excessive force was used against Webster, Warden Tripp failed to thoroughly investigate the incident.

117. The beating occurred on or about April 22, 2010. Brian had covered the window of his cell with a piece of paper. In response, Captain Michael Jones, Major John Swann and several other staff members (called an "Extraction Team") entered Brian's cell, slammed him to the ground, and began kicking him. When Brian resisted in an effort to protect himself, the Extraction Team repeatedly kicked his body and beat his head on the ground, maliciously using excessive force that was entirely unnecessary to subdue the 135-pound youth or to maintain or restore control in the unit.

118. In addition to Major Swann and Captain Jones, another high-ranking official, Deputy Warden Vinson, was present during the incident.

119. On April 22, 2010, WGYCF staff submitted two Extraordinary Occurrence reports to Warden Tripp which mentioned that staff had "struggled" with Brian and mentioned the presence of Captain Jones, Major Swann, and Deputy Warden Vinson. On May 26, 2010, Brian submitted an ARP request describing the abuse and the involvement of Swann, Jones, and the extraction team. More than a month later, Brian received notice that his request had been rejected because he had failed to write an exact date for the incident. (He wrote "End of April 2010.") Brian submitted a corrected ARP request on July 29, 2010. Defendants did not investigate the matter.

JOSHUA CLAY

120. In early April 2010, Plaintiff Joshua Clay told several officers that he needed medical attention for a painful rash and requested a sick call slip. The officers refused. Joshua later put

his arm through the food flap in his cell door to try to get the attention of another officer to ask for medical attention. Although Joshua was not aggressive or violent, the officer responded by maliciously spraying Joshua in the face with chemical restraints. For several minutes, Joshua was coughing uncontrollably and could barely breathe. Eventually, he was removed from his cell and left in the recreation yard, where he remained from breakfast until dinner time. Defendants never provided Joshua with any medical care.

121. Joshua submitted an ARP request on May 6, 2010, to notify Defendants of this incident. In his ARP request, Joshua asked for "a better system for people to get to medical with out doing something to harm themselves." He did not receive a response. On August 20, 2010, Joshua wrote a letter to Commissioner Epps stating, "I don't think it's fair that people have to get mace to get medical help."

JARED EPPERSON

122. Plaintiff Jared Epperson was diagnosed at an early age with a seizure disorder that requires him to take daily medication. On average, WGYCF medical staff have failed to deliver Jared his seizure medication once per week, and multiple times have failed to deliver it for four to five days in a row.

123. In late October 2010, WGYCF medical staff failed to give him his medication for around five days. He suffered recurring headaches during this period. Every day he told the nurses on pill call that he needed his medication, but they failed to provide him with his medication.

124. Around the fifth day, Jared still had not received any medication, so he stuck his arm through the tray flap of his closed door to summon the officer on duty. In response to Jared's request for medical attention, the officer called Lieutenant Cox. When Lieutenant Cox arrived on the unit, Jared reiterated his request for his medication. Cox responded by spraying him through

the tray flap with chemical restraints in the face causing him excruciating pain and compromising his ability to breathe..

ANTONIO DUNNIGAN

125. On the morning of March 9, 2010, Antonio Dunnigan's cellmate had begun to experience pain and breathing problems. He was afraid his cellmate might die, so Antonio told Lieutenant McAfee that the cellmate needed immediate medical attention.

126. By lunchtime, the cellmate's condition persisted, and he still had not received any medical attention. Antonio placed his arm outside of the flap to try and speak to a captain. Lieutenant McAfee and several other officers came to the cell in response. Antonio told the officers that the cellmate needed emergency medical treatment for his asthma. Rather than provide treatment, the officers sprayed Antonio and his cellmate with chemical restraints. Antonio and his cellmate could barely breathe.

127. Officers moved Antonio and his cellmate to the recreation yard where a nurse came and took their blood pressure but did not provide any medical treatment for the cellmate's asthma or shortness of breath.

128. On March 12, 2010, Antonio submitted an ARP request informing Defendant Vinson about this incident.

LATRAVIS SMITH

129. In mid-October, 2010, Captain Michael Jones assaulted Plaintiff Latravis Smith with chemical restraints while he was completely naked and locked in a cell in the special needs unit.

130. Latravis had no bed, blanket, clothes, or even a paper gown in this special needs cell. Latravis had asked Captain Jones for some clothes or a blanket. After arguing with Latravis over

his requests, Jones left the cell block without providing him anything he could use to cover himself.

131. About two hours later, Captain Jones returned to the special needs cellblock, went directly to Latravis' cell door, and sprayed him with chemical restraints through the food flap. Latravis was not threatening Captain Jones or anyone else and posed no threat to prison security.

132. Latravis was standing close to the door at the time, so the spray landed directly on his skin. The chemicals went on his genitalia and caused a painful burning sensation.

Eighth Amendment Violations: Punitive Isolation

133. Some staff members routinely subject youth to punitive isolation and sensory deprivation by arranging to place to place non-suicidal youth in a suicide watch cell without any penological justification and for the purpose of inflicting wanton and unnecessary discomfort, pain and humiliation. Non-suicidal youth who are forced into punitive isolation in a suicide watch cell are stripped naked with the exception of a thin paper gown. Youth are forced to sleep on a steel bed frame without mattresses. Though the cells in suicide watch are cold, youth are only given one blanket. Youth are confined to their cells for 24 hours a day, denied physical exercise or recreation, and provided with limited opportunities to care for their personal hygiene needs. Youth receive little to no human interaction and are not allowed to receive mail, make phone calls, have visitation, or receive any of their property, including radios, canteen food, pictures, paper, or pens.

134. Once a youth is designated by a staff member as suicidal, he must remain in isolation until he is evaluated by a mental health professional who can determine whether the youth remains a suicide risk. The psychiatrist usually performs these evaluations, but he only conducts assessments of youth on suicide watch two days out of the week. As a result, these non-suicidal

youth are forced to wait for days or even a week before they are evaluated and removed from isolation.

135. One youth has been subject to punitive isolation in a suicide cell on three separate occasions. Unit Manager Leflore arranged this punitive isolation as a punishment when the youth refused to agree to leave the protective custody unit. When officials transported him to isolation, the youth told Warden Vinson, Major Swann and Lieutenant McAfee that he was not suicidal and that Leflore was lying. These officials ignored the youth's statements, stripped him naked and isolated him.

136. Another youth had to spend over a week in isolation on suicide watch after a verbal disagreement with a WGYCF staff member. The youth witnessed the staff member lie to the medical personnel and state that the youth had threatened to kill himself. Medical personnel transported him to isolation where he remained for around one week.

137. Defendants Tripp and Vinson have known about this abusive practice and have failed to respond. Several youth, including the one mentioned above, have informed them of their placement on suicide watch as punishment. Despite their knowledge, they continue to allow certain staff to inflict this unlawful punishment. They have failed to investigate the young men's claims and failed to discipline the officers or take other action to protect the youth from this punishment that is calculated solely to assault their human dignity and inflict serious discomfort.

138. The injuries suffered by the WGYCF youth described below illustrate how the Defendants' policy and practice of imposing arbitrary isolation without penological justification for the purpose of inflicting wanton and unnecessary harm place WGYCF prisoners in danger.

ERIC BALL

139. Unit Manager Leflore has sent Eric Ball to punitive isolation in a suicide watch cell three times in the past few months even though he was not suicidal.

140. The last time this happened, Leflore had become upset at Eric for stopping at another cell to get some notebook paper. To punish him, she radioed officials and told them he was suicidal. Eric was taken to the medical unit and placed in an isolated suicide cell. Even though he told medical staff that he was not suicidal, they placed him on suicide watch anyway.

141. While placed in an isolated suicide cell, Eric was forced to strip naked and wear only a thin paper gown. He was denied access to recreation, phone calls, visitation, and reading materials. He was denied human contact and locked in a cell for 24 hours a day. Recently, after Eric was returned to the zone, Leflore threatened to isolate him in a suicide watch cell again if he did not tuck in his shirt. Eric feels it is only a matter of time before he is again subject to punitive isolation in a suicide watch cell again, as Defendants Tripp and Vinson have not put a stop to this abusive practice.

Eighth Amendment Violations: Inadequate Medical and Mental Health Treatment

142. MDOC contracts with Defendant Health Assurance, L.L.C. (HALLC) to provide almost all medical and mental health care at WGYCF. Under the May 22, 2006 Contract for Medical Services, HALLC agrees to provide "medical, optometry, pharmaceutical services, mental health services and a dental program" for the incarcerated youth at WGYCF. Under this contract, HALLC is responsible for all costs of care, except that MDOC is responsible for the costs of hospitalizations over 72 hours and for the costs of treating prisoners with HIV, AIDS, and Hepatitis-C.

143. Defendant GEO also has responsibilities related to medical and mental health care at WGYCF. Walnut Grove Correctional Authority subcontracted with GEO to fulfill its operational

responsibilities at WGYCF under the Authority's contract with MDOC. As the subcontractor responsible for general operation of the prison, GEO has the duty to provide "access to counseling and mental health programs," and to operate a Regimented Inmate Discipline program at the prison that provides "psychological counseling." Pursuant to Miss. Code Ann. § 47-5-951, WGYCF ". . . shall provide each juvenile offender housed in the facility alcohol and drug counseling and treatment throughout his incarceration."

144. Defendants HALLC, Tripp, Kern, Hogue, and Epps are deliberately indifferent to the serious medical and mental health needs of youth in WGYCF. Defendants fail to provide youth adequate access to health care. In WGYCF, non-medical professionals—most often correctional officers—often decide whether a youth will receive medical attention. The forms the youth must use to request medical attention are not readily available to them. To obtain the forms, youth often must request them from an officer on duty, because nurses are sent to the cellblocks infrequently and often do not have the forms. Some officers refuse to give out the forms; sometimes officers tell the young people that forms are unavailable. When young people make urgent medical requests, correctional officers—rather than medical staff—often decide whether the youth's illness constitutes a medical emergency. Nurses do not work on site during the night and on weekends and therefore are unavailable to react promptly to emergencies at those times.

145. Even when young people manage to obtain medical service request forms, they often must submit multiple requests over the course of several weeks before they are able to see a nurse or doctor.

146. HALLC has a policy and practice of delaying the timely provision of needed medical care. Youth experience lengthy delays before they receive medically required care and suffer substantial physical pain and serious risks to their health and well being as a result.

147. Youth often must wait for weeks or months to receive urgently needed medical care, with the result that injuries that could have been treated effectively if timely addressed become permanent and untreatable. Trips to specialists are often delayed repeatedly. Doctors' orders for specialist consultations for serious medical problems are often ignored.

148. Officers and medical staff routinely ignore repeated requests from young people with dangerous and painful medical and mental health problems. As a result, the young people must resort to extreme measures—like yelling, banging and kicking doors, and breaking sprinklers—to get needed attention. Even then, they are often left to suffer through painful and dangerous conditions without medical attention. One youth who had been requesting medical attention for weeks had to be transported by ambulance to a hospital when his condition became so urgent and life-threatening that it could no longer be ignored by prison staff.

149. There is no reliable way to get medical help in case of emergencies, even for youth with conditions like severe asthma and seizure disorders, and for those at high risk of suicide. The panic call buttons in the cells do not work and often no officers are present in areas where youth are housed.

150. Young people who need medical attention are discouraged from seeking necessary care because they are charged a six-dollar copayment for most visits with medical personnel.

151. Defendant HALLC has a policy and practice of failing to supervise its medical staff and to implement effective systems to ensure that medications are timely ordered and delivered and that prescribed care is provided. Medical staff commonly fail to provide prescribed treatment. Inconsistent prescription drug delivery and other lapses in treatment are customary. HALLC staff have repeatedly run out of medication prescribed for youths' chronic conditions, causing lengthy gaps in treatment. The medical staff routinely fail to provide prescribed care for open wounds

susceptible to infection. Staff fail to monitor youths taking prescribed medications and thus unnecessarily subject youth to risk of serious adverse reactions to medications. As Health Services Administrator, Defendant Hogue has a duty to ensure these lapses do not occur, but she does nothing to correct these recurrent problems.

152. HALLC fails to provide or ensure minimally adequate mental health services to young people in WGYCF who have serious mental health needs.

153. A significant number of the young people incarcerated in WGYCF have untreated serious mental health needs. HALLC fails to ensure adequate psychological assessments of youth in the prison, resulting in under-identification of, and inadequate treatment for, youth with serious mental illnesses. The young people do not receive adequate mental health evaluations. The mental health evaluations they do receive are perfunctory.

154. HALLC has a policy and practice of hiring insufficient numbers of qualified medical and mental health professionals. In accordance with this policy and practice, HALLC has not hired enough staff to properly care for the mental health needs of 1,200 youth. HALLC currently employs one full-time, master's level psychologist who solely conducts intake assessments, and contracts with one psychiatrist who is required to provide on-site services for only sixteen hours per month. The psychiatrist does not conduct minimally adequate assessments or review necessary information before diagnosing patients and prescribing medication. The psychiatrist also has been known to prescribe medications solely based on the evaluation of the masters-level psychologist without ever meeting the patient. His evaluations are grossly incompetent—he generally spends less than 10 minutes interviewing, observing and evaluating his patients and he rarely reviews prior medical records before prescribing medication.

155. In providing this level of staffing, HALLC has been openly violating its contract with MDOC for years. The contract, which was drafted when the prison only held 940 prisoners, requires a substantially higher minimum level of mental health staffing and care. Under the contract, HALLC is required to provide a "Psychiatrist/Psychologist" for twelve hours per week. "[I]n addition," HALLC must provide a licensed "Ph.D." psychologist to provide mental health services to prisoners a minimum of eight hours per week and a psychiatrist for a minimum of sixteen hours per month. HALLC must also make individual therapy available to prisoners. HALLC is also required to increase this staffing as needed to meet growth in prison population.

156. In violation of the contract, HALLC does not employ a Ph.D. psychologist to provide mental health services to prisoners at all, does not provide a psychiatrist/psychologist twelve hours per week, and does not provide individual therapy. Although the population of the prison has increased by about 260 youth since the contract was drafted, HALLC has not increased staffing. Although aware of HALLC's understaffing of the prison, Defendant Epps has repeatedly renewed HALLC's contract.

157. HALLC, Health Services Administrator Hogue, and Wardens Tripp, Vinson and Kern fail to ensure that WGYCF staff receive necessary training on managing mentally ill young people. Most staff members are unable to recognize and properly react to the obvious needs of youth with known, demonstrable, serious mental disorders. Consequently, youth often feel they must resort to self-harming behavior to receive the services they need. The suicide prevention practices in place at WGYCF are dangerously deficient. These deficient practices result in injury and a significant risk of injury or death to young people with serious mental health needs. In the first six months of 2010, nine attempted suicides were recorded.

158. Many facility staff receive no suicide prevention training; they do not know how to identify warning signs and symptoms of impending suicidal behavior or how to appropriately respond to youth who threaten suicide. Staff do not take appropriate care to ensure that suicide observations cells contain no objects that can be used for self-harm. Staff sometimes ignore suicide threats or respond to the threats by egging the young people on to hurt themselves. Some officers assigned to conduct fifteen-minute checks of youths in suicide watch cells simply sit at a desk filling out false information on the paperwork without actually checking on the youth.

159. The woefully deficient training, monitoring, and supervision of WGYCF staff has already led to one tragic death of a youth. In October 2009, a youth cut his arm, showed his wound to a nurse and officer and told them that he was going to kill himself, emphasizing his resolve to follow through on his threat. The nurse and officer failed to take any precautionary steps; instead, they left the youth alone in his cell. Around a half hour later, the young man informed three officers that he was going to kill himself that day. One officer observed something tied around the youth's neck, but commented that the youth was just playing around and left. Around one hour later, the youth told another officer that he was going to kill himself. That officer informed a captain, who responded by telling the youth in profane language to untie the object around his neck and ordering the officer to leave the youth alone. Less than two hours later, the youth's dead body was found hanging from the light fixture in his cell.

160. The injuries suffered by the WGYCF youth described below illustrate how the Defendants' policies and practices of deliberate indifference to youth's serious medical needs harm the Plaintiffs and the class members.

CRAIG KINCAID

161. Craig Kincaid has a metal plate in his left leg and metal screws in his right knee as a result of injuries sustained when he was hit by a car. Over the past few years, Craig has had chronic infections in his left leg that are extremely painful and make it hard for Craig to sit or exercise for long periods of time. Craig has repeatedly informed Warden Tripp, Administrator Hogue, and Commissioner Epps about the history and seriousness of his leg injuries. Defendants have consistently subjected Craig to long delays in receiving urgently needed care for this condition.

162. In April 2008, soon after Craig arrived at WGYCF, he started having serious problems with his left leg. On April 16, 2008, Craig submitted a sick call slip. A week passed before he was seen by a nurse, who referred him to a doctor. Several more days passed before Craig finally saw a doctor. By this time, an extremely painful pus-filled sore had formed on his left leg.

163. Craig received wound care on his leg for two weeks. Two weeks after wound care ended, symptoms recurred, and Craig submitted another sick call slip request form on June 16, 2008. Craig's next documented medical visit was not until seven months later, on January 13, 2009.

164. In February 2009, Craig's left leg deteriorated. The sore was very painful and leaked pus and blood. On February 11, 2009, Dr. Sutton, a HALLC employee who works at WGYCF, ordered that Craig be referred to a surgeon. The order was ignored by Administrator Hogue

165. For the rest of the year, Craig continued to experience severe pain in his leg and repeatedly notified the medical staff of his ongoing problems. On November 30, 2009, Craig informed the medical staff that he needed to see the doctor as soon as possible because "the hole in [his] leg was leaking pus." Craig was not seen by a doctor until December 11, 2009. During

this visit, Dr. Sutton again referred Craig for surgery, nearly a year after Dr. Sutton had made the initial order for surgery that Hogue had ignored.

166. On December 28, 2009, still not having received surgery and frustrated by the growing pain and stiffness in his leg, Craig again notified Administrator Hogue about his serious medical need and his surgery referral. By the time Hogue scheduled Craig for surgery evaluation, his infection had progressed to the point that emergency surgery was required.

167. Recently, the infection returned. Craig continues to experience difficulties getting access to medical care and fears he may lose his leg.

168. In November or December 2009, Craig submitted a grievance notifying Defendants of the lack of medical care he received. He received his First Step Response from Administrator Hogue in February 2010 and appealed to the Second Step. Craig received the Second Step Response from Warden Tripp in April 2010 and submitted his request to appeal to Commissioner Epps that same day. Craig received no response from Commissioner Epps. On August 20, 2010, Craig wrote another letter to the Commissioner requesting a response. In September 2010, Craig received a response from an MDOC medical official, saying there was no record of Craig's grievance.

169. As the Health Services Administrator for WGYCF, Hogue is ultimately responsible for ensuring physician's orders are followed. She knew the chronic and serious nature of Craig's condition and twice failed to follow a physician's prescribed order.

170. In August 2010, the infection in Craig's leg returned. Because the infection was so deep, surgeons had to cut out a large section of his thigh. As a result, Craig's mobility has been seriously affected, and he is no longer able to sit or lay for long periods of time without experiencing excruciating pain.

171. On August 20, 2010, Craig wrote an emergency ARP notifying Defendant Epps of the continuous problems he is experiencing accessing medical care at WGYCF. Craig still has not received a response.

JOSHUA CLAY

172. On February 27, 2010, Plaintiff Joshua Clay was stabbed multiple times in a fight and suffered a significant injury to his right arm and hand. Joshua was transported to a hospital for evaluation and treatment. On the discharge paperwork given to WGYCF staff, the emergency room doctor noted that Joshua experienced a decreased range of motion in his right wrist and fingers, and that this decreased range of motion was "significant for possible tendon injury." The doctor recommended that Joshua "be referred to hand/orthopedic surgeon for evaluation of right forearm tendon region." This form was returned to WGYCF and placed in Joshua's HALLC medical file. There was no follow-up, and he never saw a surgeon.

173. After Joshua was discharged from the emergency room, he received wound care in the infirmary for a week or so. Since then, Defendants have failed to provide Joshua with any medical treatment for his hand. Even though his wounds have visibly healed, his right hand continues to hurt. Joshua has limited mobility in his right hand and cannot use it for more than a few minutes at a time.

174. On March 25, 2010, Joshua submitted an ARP request stating he had been stabbed multiple times in the hand and still had "serious pain." As a remedy, Joshua requested treatment for his continuing injuries. On May 14, 2010, Joshua submitted another ARP notifying Defendants of his persistent need for medical care. On June 22, 2010, Joshua submitted a note to Ms. Tracey Morgan, ARP Administrator at WGYCF, notifying Warden Tripp that he still needed medical help for his hand.

175. Joshua did not receive a response until mid-June. In the First Step Response, Deputy Warden Vinson stated: "The medical staff reports you did receive several injuries during the 2-27-10 incident but none of your injuries were considered debilitating." In early July 2010, Joshua submitted another sick call slip. Defendants continued to ignore his requests for help.

176. Joshua appealed and received a Second Step Response from Wardens Tripp and Kern dated July 16, 2010. In the response, Wardens Tripp and Kern did not address the problems with Joshua's hand.

177. On August 20, 2010, Joshua submitted an emergency ARP, notifying Commissioner Epps and Warden Tripp about his serious medical needs and his previous unsuccessful efforts to secure medical attention. On that same day, Joshua sent another note to Commissioner Epps requesting a response to his May 14, 2010 ARP. Defendants continue to ignore Joshua's requests for medical care.

178. Defendants HALLC, Hogue, Tripp, Vinson, Kern and Epps also have subjected Joshua to continuing pain and substantial risk of permanent pain and disability by failing to ensure that he has received any follow-up medical care for his hand despite his repeated requests.

179. Despite multiple requests, Joshua still has not received any medical care for his hand. Joshua continues to experience pain and limited mobility in his hand. Because of Defendants' continuing refusal of care, Joshua has experienced needless pain and suffering, and may suffer permanent disability.

ERIK BARNES

180. Plaintiff Erik Barnes has an extensive mental health history. Erik has been diagnosed with bipolar disorder, schizophrenia, intermittent explosive disorder, mood disorder, impulse control disorder, and attention deficit hyperactivity disorder (ADHD). Since the age of five, he

has received psychiatric outpatient treatment and been hospitalized or placed in long-term treatment facilities numerous times. He has a history of self-harming behavior. Over the years, Erik has been prescribed various antipsychotic medications. Erik has frequent mood swings and is afraid that he might hurt himself or others if he does not receive appropriate medication. Since his arrival at WGYCF, Erik has been denied all medication for lengthy periods of time. He also has informed the Defendants and the WGYCF medical staff about his various disorders and has asked numerous times for appropriate mental health treatment.

181. WGYCF medical staff's knowledge of Erik's serious mental health needs is well-documented. On November 12, 2009, Marilyn Johnson, LPN, at the Central Mississippi Correctional Facility (CMCF), conducted an intake mental health screening of Erik. This was soon after his commitment to MDOC and before he was sent to WGYCF. Her report documented the following information: prior diagnoses of ADHD, bipolar disorder and schizophrenia; a recent schizophrenic episode two days earlier; prescriptions for psychiatric medications (including antipsychotics to treat schizophrenia) since the age of five; more than five hospitalizations; current signs of depression and anxiety; and hallucinations. On November 15, 2009, while still at CMCF, a psychiatrist named Dr. Gurdial Sandhu evaluated Erik and also noted hallucinations, paranoia, and Erik's history of prescriptions for antipsychotic medicines. On November 18, 2009, Erik participated in a MDOC Initial Psychological Evaluation Screening at CMCF, during which he reported auditory and visual hallucinations, depression, sleep disturbance and a family history of mental illness. He again described in detail his extensive mental health history and even took care to include the names of different mental institutions where he'd been placed. All of this information was noted by the screener, who recommended a psychiatric referral. Similar information was noted by Nurses Leach and Hogue during their

health screening of Erik at WGYCF on December 22, 2009. They additionally noted that Erik felt he could lose control of his temper.

182. While at CMCF, Erik was diagnosed with "Psychotic Disorder NOS" and "Major Depressive Disorder, Recurrent, Moderate" and prescribed an anti-depressant and anti-psychotic medication. The first anti-depressant medication, Celexa, gave him headaches, so the psychiatrist at CMCF, Dr. Sandhu, switched him to Prozac.

183. Erik was transferred from CMCF to WGYCF in late December 2009. He did not receive either of his prescribed mental health medications for over a month.

184. Once at WGYCF, he did not see a psychiatrist until January 30, 2010, when he saw Dr. Sandhu, the psychiatrist who had seen him during his intake screening at CMCF. The doctor spent only a few minutes with him on this January 30 visit at WGYCF. Dr. Sandhu noted that Erik reported "he has been treated with unknown meds while he was at CMCF." But Dr. Sandhu did not review the prior medical records and apparently did not remember that Erik was his patient at CMCF. Based on their brief meeting, he prescribed Celexa, the same medication he had discontinued for Erik at CMCF. He failed to prescribe any anti-psychotic medication.

185. Erik finally started receiving Celexa, an anti-depressant, three days later, on February 2, 2010. Later that month, HALLC staff failed to administer Erik's anti-depressant medication for four days. In July or August of 2010, HALLC staff failed to deliver his medication for about two weeks after they ran out of it.

186. Erik conveyed his prior diagnoses to the nurses and doctors who screened him at the Central Mississippi Correctional Facility and at WGYCF, and informed them of his need for medications to controls his mood disorders and limit the risk of harm to himself and others around him.

187. At WGYCF, he told Deputy Warden Vinson about his prior diagnoses and was instructed to fill out a sick call request form. On December 22, 2009, Erik submitted a sick call request form saying he had been diagnosed with schizophrenia, bipolar disorder, ADD and ADHD, had problems sleeping, and had previously taken the antipsychotic Seroquel, which is used for treating schizophrenia and bipolar disorder. On March 2, 2010, he submitted another sick call request saying he couldn't sleep and his medications weren't helping his nerves. On May 7, 2010, he submitted an Administrative Remedy Program (ARP) request seeking medications to control his mood swings. On August 19, 2010, Erik submitted an Emergency ARP request expressing his fear that he could hurt himself or others without medications to control his mood disorders. He also wrote a letter to Commissioner Epps asking for review of his unanswered ARP request. Finally on November 1, he received a response to his May 7, 2010 ARP request, written by Administrator Hogue, saying that if his medication is not working, the "appropriate step... would be to notify the medical department and a follow-up would be scheduled with the appropriate doctor." Erik had already notified the medical department multiple times.

188. WGYCF and HALLC staff have ignored all of Erik's requests for medication to control his mood disorders. He is currently prescribed two medications: Celexa and a sleeping medication, neither of which is used in the treatment of bipolar disorder or psychosis. Erik has repeatedly stated that those medications do nothing to help his mood swings—swings he fears could push him to harm to himself or others.

JARED EPPERSON

189. Plaintiff Jared Epperson was diagnosed at an early age with a seizure disorder that requires him to take daily medication (Depakote). On average, WGYCF medical staff has failed

to deliver Jared his seizure medication at least once per week, and multiple times has failed to deliver it for four to five days in a row.

190. On one these occasions, in October 2009, Jared broke the sprinkler head in his cell in a desperate attempt to get his seizure medication. Nine months later, he was indicted for damaging jail property, was convicted, and now has to serve two additional years in prison.

191. Just recently, in late October 2010, HALLC medical staff failed to give him his medication for at least four days. He suffered recurring headaches during this period. Every day he told the nurses on pill call that he needed his medication, but they responded that they had no medicine to give him.

192. Because the medical staff has not consistently delivered Jared's seizure medication, and WGYCF staff has failed to respond to his complaints, Jared has been exposed to a substantial risk of serious harm.

EDWARD WHITE

193. Edward White needs intensive mental health services. However, he is deprived of counseling and other therapy because of Defendants' failure to provide or ensure adequate psychological assessments and mental health services to youth at WGYCF.

194. The care currently being provided to Edward is grossly deficient given his suicidal tendencies and self-harming behavior. Evaluations by doctors are wholly cursory and last no more than two to three minutes. Edward receives no counseling or other therapeutic services, and HALLC staff have been inconsistent in administering his prescribed medication.

195. For more than one year, Edward has consistently communicated his need for intensive mental health services. He has expressed a desire to kill himself numerous times and informed medical staff of audio and visual hallucinations. For example, on June 8, 2009, Edward wrote on

a medical service request form, "Thinking bout killing myself. Am kinda crazy." On October 9, 2009, Edward told Nurse C. Stewart, "I feel like I'm going to kill myself. My head is messed up because of my mama. I can't be here. I need some help bad." On October 31, 2009, Edward told a doctor that he was thinking of killing himself because his mother and sister were dead. He also said he was hearing "crazy" voices and seeing "little men" that were after him. Meanwhile, in October 2009, medical staff failed to provide Edward his prescribed anti-depressant medication for two weeks. On November 14, 2009, Edward told Dr. Gurdial Sandhu that he was suicidal and wanted to be transferred to East Mississippi Correctional Facility, where he believed he could get adequate mental health services. On December 12, 2009, he told Dr. Sandhu he was suicidal because his father passed away the week earlier. He also was hearing voices and feeling paranoid. On December 17, 2009, Edward told Dr. Sutton that he wanted to die and dreamed about people killing him and mentioned that his mother, father and "homeboys" are dead. On December 27, he told Dr. Sandhu he had a nervous breakdown. In 2009, he spent a total of nearly five months in suicide prevention housing.

196. Edward's mental illness is so serious it manifests in self-harming behavior that includes scratching and cutting himself, carving into his stomach with a metal razor, and eating his own feces. His file reveals that HALLC medical staff have been well aware of these behaviors, but have failed to provide him with the care needed to alleviate his serious mental illness.

197. On April 29, 2010 and May 8, 2010, Edward submitted medical service request forms seeking help for his strong desire to injure himself. At the end of May 2010, Edward cut his left arm with a razor.

198. On February 17, 2010, Edward submitted an Administrative Remedy Program (ARP) grievance in which he expressed his need for therapy and more time with doctors. In June 2010,

Edward sent a letter to Commissioner Epps requesting review of his February 2010 grievance. On August 19, 2010, Edward submitted an Emergency ARP request as well on the same issue. None of these efforts have secured Edward the mental health services he needs.

IDEA, Section 504, ADA, and State Law Violations:
Denial of Access to Educational Services

199. When it created the WGYCF, the Mississippi Legislature passed a law mandating that WGYCF " shall provide any juvenile offender housed in the facility with continuing education throughout his incarceration which leads to the presentation of a high school diploma or General Education Development (GED) equivalent." Miss. Code Ann. §47-5-949 (2010).

200. Federal law requires that youth eligible youth who are imprisoned at WGYCF receive special education services pursuant to the Individuals with Disabilities Education Act, §§ 1400 et seq ("IDEA"), which requires that all students with disabilities receive a free and appropriate education. The implementing regulations of the IDEA provide that "[y]outh with disabilities through age seventeen who are incarcerated in adult prisons will be identified and provided special education and related services." 34 C.F.R. § 300.101(a), § 300.102(a)(2). In addition, "[y]outh with disabilities aged eighteen through twenty-one who are incarcerated in adult prisons are also entitled to a free and appropriate education if they were previously identified as having a disability under IDEA." 34 C.F.R. §300.102(a)(2).

201. Section 504 of the Rehabilitation Act and Title II of the Americans with Disabilities Act prohibit public entities from discriminating against individuals with disabilities. Pursuant to Section 504 and Title II, public entities are prohibited from excluding youth with disabilities from participating in or receiving educational and related services. Each student with a disability must be provided access to all programs provided to non-disabled students. 42 U.S.C. § 12132; 29 U.S.C. § 794; 34 C.F.R. §§ 104.21. Furthermore, Section 504 and Title II require that each

disabled student be provided reasonable accommodations and modifications designed to provide meaningful access to educational benefits, or as necessary to avoid discrimination on the basis of disability 34 C.F.R. § 104.33; 28 C.F.R. § 35.130(b)(7).

202. The United States Department of Education's Office for Civil Rights (OCR) has routinely determined that, as recipients of federal financial assistance, state educational agencies like the Mississippi Department of Corrections are ultimately responsible for ensuring the provision of a free appropriate public education to each qualified person in its jurisdiction under Section 504. Individuals with Disabilities Educ. L. Rep., 352:627-631, 628-29, OCR Ruling: *Complaint No. 03-88-1024 West Virginia Department of Education.* MDOC is also a recipient of federal funding and is therefore subject to Section 504's requirements.

203. An interagency agreement between MDOC and MDE specifies that MDE is responsible for ensuring compliance with the IDEA and that "all educational programs for children with disabilities in the state... will be under the general supervision of individuals in the state who are responsible for educational programs for children with disabilities and shall meet the educational standards of the MDE."

204. The interagency agreements recites the agencies' responsibility to identify youth who are eligible for special education services, to evaluate youth for such services, to develop individualized education plans for such youth, and to regularly report detailed information regarding the provision of special education services.

205. In a November 2006 monitoring report, MDE documented MDOC's systemic failure to comply with the IDEA and with the interagency agreement. As a result of these failures, MDE concluded that youth incarcerated at Walnut Grove Youth Correctional Facility were denied a free and appropriate education. The systemic failures documented by MDE include a failure to

identify and evaluate students with special education needs and a failure to provide necessary related services. Related services include interventions like counseling that are required in order for a youth to receive educational benefit.

206. Nearly four years after MDE first documented and became aware of WGYCF's systemic failures to provide educational services, youth are still denied the educational services to which they are entitled under federal and state law.

207. While Miss. Code §47-5-949 requires that all youth incarcerated at WGYCF receive educational services that will lead to a high school diploma or GED "throughout" their incarceration, a recent PEER review reveals that only one-quarter of the youth imprisoned at WGYCF receive any kind of educational services. Youth are frequently denied access to educational services and their requests to attend school are ignored or denied.

208. A large number of youth incarcerated at WGYCF live with learning disabilities, cognitive impairments and mental health conditions that interfere with their learning. Many of these youth struggle with basic reading and writing, were identified as eligible for special education services before entering WGYCF, and received such services in school before they were incarcerated. WGYCF has an affirmative obligation to identify these youth and to evaluate and identify youth who are under the age of seventeen and who may be eligible for special education services.

209. Defendants WGCA, GEO, Tripp, Kern, and Epps have not established an adequate system for identifying, locating, and evaluating all children with disabilities, as required by the ChildFind provisions of the IDEA. Many youth entitled to receive special education at WGYCF do not receive any special education services because the prison fails to identify them as children with disabilities. National studies conclude that between 30-70% of youthful offenders are

eligible for special education services. Mary Magee Quinn, Robert B. Rutherford, Peter E. Leone, David M. Osher & David M. Poirier, *Youth With Disabilities in Juvenile Corrections: A National Survey*, 71 COUNCIL FOR EXCEPTIONAL CHILDREN 339, 340 (2005). At WGYCF, only 46 youth—less than 4 % of the entire population of approximately 1200 youth—are currently identified as eligible for special education services. In 2006, MDE documented that WGYCF identified only 2-4 % of its population as eligible for special education services. Since then, MDE has failed to ensure that WGYCF modified its ChildFind procedures to ensure the identification of all eligible youth incarcerated at WGYCF.

210. Many youth at WGYCF require individualized related services such as psychological services to benefit from special education, but WGYCF provides no such services. In 2006, MDE documented that WGYCF provided inadequate related services to students with disabilities. MDE noted that the only related services available were counseling, and even these services were offered so infrequently that they were unlikely to meet the educational needs of students with disabilities. Four years later, WGYCF has not increased its related services offering. To the contrary, the population of the facility has expanded, and WGYCF still relies on the same part-time contractual service providers that MDE found inadequate when the facility housed significantly fewer youth. The quality and frequency of related services has actually decreased since 2006.

211. WGYCF does not provide individualized special education services for youth at the facility in the least restrictive environment. Most students who are determined eligible for special education are placed together in segregated classes, regardless of their individual disabilities or educational levels.

212. Youth with cognitive and learning disabilities housed in protective custody are barred from accessing any educational services. WGYCF provides these youth with packets of worksheets, regardless of their individual educational needs, and denies them access to a qualified teacher and/or education professional who could provide instruction and feedback. The packets are not delivered on a regular schedule, but usually are given to youth every two to three weeks. For those youth who either cannot read or who lack the cognitive functioning to teach themselves, the educational "packets" are meaningless. These youth gain no education benefit from merely receiving packets that they cannot read or understand. This failure to accommodate the disabilities of youth who live with disabilities and who require protective custody violates federal law.

213. Despite having clear notice of WGYCF's IDEA and 504 violations, MDE has failed to promulgate and implement policies, practices and procedures to ensure that students with disabilities who are incarcerated at WGYCF receive the services to which they are entitled under federal law.

214. GEO and WGCA fail to comply with their obligations pursuant to state law to provide educational services to "provide any juvenile offender housed in the facility with continuing education throughout his incarceration which leads to the presentation of a high school diploma or General Education Development (GED) equivalent."

215. The deprivations of educational services suffered by the WGYCF youth described below illustrate how the Defendants' policy and practice failing to comply with federal and state education laws place unnamed class members at a substantial risk of irreparable harm.

JAMARIO BRADY

216. Plaintiff Jamario Brady has been in WGYCF for three years and has never attended classes. He entered WGYCF at the age of fifteen and is now nineteen. For most of his time at WGYCF, Jamario has been housed in protective custody, where he has received occasional packets of worksheets instead of instruction by a teacher, and no help or feedback on his work.

217. Before his incarceration, Jamario was identified as a youth in need of special education and related services and received such services at the last school he attended in accordance with an Individualized Education Plan (IEP). Jamario has difficulty reading and writing. He also has behavioral issues that interfere with his ability to learn. WGYCF has failed to identify Jamario as a youth eligible for special education and has failed to provide him with special education and related services.

COZY SCOTT

218. Before his incarceration, Plaintiff Cozy Scott was identified as a youth in need of special education and related services and received special education at the last school he attended in accordance with an IEP. However, in his years at WGYCF, he has not been identified as eligible for special education. As a result, he has received no special education or related services.

219. Cozy was incarcerated at WGYCF in 2008 and then again starting in February of 2009. Around the second week of October 2010, Cozy was enrolled in school for the first time at WGYCF. About two weeks later, he was removed from school. Since then, he has not been re-enrolled in school and has not received alternative forms of education. The judge who sentenced Cozy ordered him to earn his GED during the term of his incarceration. Under his current circumstances, he cannot obtain a GED.

LAMARCUS CURRY

220. Plaintiff Lamarcus Curry is twenty-one years old and has severe difficulties reading and spelling. He recently tested at a first-grade reading level. Before his incarceration, he was identified as a youth in need of special education and related services and received such services at the last school he attended in accordance with an IEP.

221. When Lamarcus arrived at WGYCF, he requested to enroll in school. WGYCF placed Lamarcus in a regular classroom setting without first administering an appropriate test to evaluate his abilities and needs. Because he was not able to learn in that setting, he told both his teacher and the principal of the WGYCF school about his special education status and his inability to read or write. They gave him no supplemental assistance or services. When he was moved to a different zone, he waited one full month before being placed back in school. He told his new teacher that he could not read or write and had previously been placed in special education classes, but, again, received no special education or related services. Over one month ago, Lamarcus was withdrawn from school; he was told that he could not attend school because the facility lacks the appropriate teachers for him. Lamarcus has not attended school in over one month.

FREDRICK WHITE

222. Before entering WGYCF, Plaintiff Fredrick White was identified as a youth in need of special education and related services and received such services in the last school he attended in accordance with an IEP. Fredrick entered MDOC custody at the age of eighteen and is now twenty.

223. Fredrick White has lived in protective custody at WGYCF since January 2010. Since entering protective custody, he has not been allowed to attend classes and has received no instruction from a teacher; instead, he receives packets of worksheets every one to three weeks.

Fredrick receives no help in completing the worksheets and never receives any feedback on the work he submits. The worksheets are not individualized for him and are not calculated to help him receive educational benefit and earn his GED. WGYCF has not provided him with individualized special education or related services.

ERIC BALL

224. Plaintiff Eric Ball was previously identified as a youth in need of special education and related services and received such services at his last school accordance with an IEP before entering prison. Eric entered MDOC custody at the age of nineteen and is now twenty. WGYCF has failed to identify Eric as a youth eligible for special education and has denied him special education and related services.

225. Eric has severe trouble reading and writing. He currently lives in protective custody where he receives packets of worksheets every one to three weeks in lieu of attending school. No one helps Eric complete the worksheets or provides any instruction or feedback on his work. He has received no educational benefit during his time at WGYCF.

EXHAUSTION

226. The named Plaintiffs have exhausted all available administrative remedies..

CLAIMS FOR RELIEF

First Claim

Eighth Amendment Violations: Dangerously Violent Conditions of Confinement

By subjecting Plaintiffs to dangerously violent conditions of confinement and by exhibiting deliberate indifference to Plaintiffs' substantial risk of serious physical injury as a result of these

conditions Defendants GEO, WGCA, Tripp, Vinson, and Epps violate the Plaintiffs' rights to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments to the United States Constitution.

Second Claim

Eighth Amendment Violations: Protection from Harm and Deliberate Indifference to Excessive use of Force

By exhibiting deliberate indifference to the substantial risk of harm Plaintiffs face as a result of WGYCF's policy and practice of subjecting youth to excessive use of force and by failing to protect the Plaintiffs from this harm, Defendants GEO, WGCA, Tripp, Vinson, and Epps violate the Plaintiffs' rights to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments to the United States Constitution.

Third Claim

Eighth Amendment Violations: Punitive Isolation

By subjecting Plaintiffs to punitive isolation without penological justification and for the purpose of inflicting wanton and unnecessary discomfort, pain, and humiliation, and by knowingly allowing this practice to continue, Defendants WGCA, GEO, Tripp, Vinson, Kern, and Epps violate Plaintiffs' rights to be free from cruel and unusual punishment under the Eighth and Fourteenth Amendments to the United States Constitution.

Fourth Claim

Eighth Amendment Violations: Deliberate Indifference to Plaintiffs' Serious Medical and Mental Health Needs

By failing to provide constitutionally adequate medical and mental care to address the Plaintiffs' serious medical and mental health needs and by allowing the policies and practices of providing

grossly substandard healthcare to continue, Defendants HALLC, Walnut Grove Correctional Authority, GEO, Tripp, Kern, Hogue, and Epps violate the Plaintiffs' rights under the Eighth and Fourteenth Amendments to the United States Constitution.

Fifth Claim

IDEA Violations: Denial of Free and Appropriate Public Education

By failing to provide WGYCF youth who qualify as students with disabilities a free appropriate public education, Defendants GEO, WGCA, Burnham, Tripp, Kern, and Epps violate the Plaintiffs' rights under the Individuals with Disabilities Education Act, §§ 1400 *et seq.*.

Sixth Claim

Section 504 and ADA Violations: Unlawful Denials of Educational Services

By failing to ensure that WGYCF youth with disabilities have equal access to educational services, Defendants WGCA, GEO, Tripp, Kern, Burnham, and Epps violate the Plaintiffs' rights under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 and Title II of the .

Seventh Claim

State Law Violation: Denial of Educational Services

By failing to provide youth at WGYCF with continuing education throughout their incarceration and by failing to allow WGYCF youth to earn a high school diploma or a GED, Defendants Tripp, Kern, GEO, and WGCA violate the Plaintiffs rights under Miss. Code Ann. §47-5-949 (2010).

PRAYER FOR RELIEF

WHEREFORE, the Plaintiffs pray that this Honorable Court grant the following relief:

a. Declare that the acts and omissions of the Defendants violate Plaintiff's constitutional rights and federal law;

b. Enter a preliminary and permanent injunction requiring the Defendants, their agents, subordinates, employees and all others acting in concert with them to cease their unconstitutional and unlawful practices and to remedy their violations of the Constitution and the laws;

c. Award to the Plaintiffs reasonable costs and attorney's fees; and

d. Grant the Plaintiff such other relief as the Court may deem just and proper.

RESPECTFULLY SUBMITTED, this the 15th day of November, 2010.

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