
**Investigation of
Central Mississippi Correctional Facility,
South Mississippi Correctional Institution, and
Wilkinson County Correctional Facility**



United States Department of Justice
Civil Rights Division
and
United States Attorney's Offices
Northern and Southern Districts of Mississippi
Civil Divisions

February 28, 2024

TABLE OF CONTENTS

I. SUMMARY.....	1
II. THE INVESTIGATION.....	2
III. FACILITIES INVESTIGATED	3
A. Central Mississippi Correctional Facility	3
B. South Mississippi Correctional Institution	3
C. Wilkinson County Correctional Facility	3
IV. DEFICIENT CONDITIONS IDENTIFIED	4
A. MDOC Fails to Protect Incarcerated Persons from Violence	5
1. MDOC allows violence at Central Mississippi, South Mississippi, and Wilkinson to go unchecked.....	5
2. MDOC fails to control illegal and violent gang activity.....	8
3. MDOC fails to keep dangerous contraband out of its facilities.....	12
4. Gross understaffing leaves units unsupervised with little to no response to violence.	14
5. MDOC fails to investigate serious incidents of harm and dangerous activity.....	23
6. MDOC is deliberately indifferent to the risk of harm to incarcerated persons from MDOC’s failure to provide reasonable safety from violence.	31
B. MDOC Places Incarcerated Persons in Prolonged Restrictive Housing Despite the Substantial Risk of Serious Physical and Psychological Harm.....	33
1. The cumulative effects of harsh restrictive housing conditions at Central Mississippi and Wilkinson deprive incarcerated persons of basic human needs.	35
2. Incarcerated persons are held in harsh restrictive housing conditions for prolonged periods of time.	45
3. MDOC is deliberately indifferent to the significant physical and psychological harm that people in restrictive housing experience.	46
V. MINIMUM REMEDIAL MEASURES	52
A. Protection from harm.....	52
B. Sexual assault	56
C. Restrictive housing	56
D. Deaths and sentinel events.....	57
E. Policies, procedures, training, and quality assurance	57
VI. CONCLUSION.....	58

I. SUMMARY

The Department of Justice has reasonable cause to believe that the State of Mississippi and Mississippi Department of Corrections (MDOC) violate the constitutional rights of people incarcerated at Central Mississippi Correctional Facility (Central Mississippi), South Mississippi Correctional Institution (South Mississippi), and Wilkinson County Correctional Facility (Wilkinson).

- **MDOC fails to protect incarcerated persons from violence.** MDOC does not adequately supervise incarcerated people, control contraband, and investigate incidents of harm and misconduct. These basic safety failures and the poor living conditions inside the facilities promote violence, including sexual assault. Gangs operate in the void left by staff and use violence to control people and traffic contraband.
- **Restrictive housing practices create a substantial risk of serious harm.** MDOC holds hundreds of people at Central Mississippi and Wilkinson in restrictive housing for prolonged periods in appalling conditions. Restrictive housing units are unsanitary, hazardous, and chaotic, with little supervision. They are breeding grounds for suicide, self-inflicted injury, fires, and assaults.

These violations are systemic problems that have been going on for years. In April 2022, we found conditions at another MDOC facility, Mississippi State Penitentiary (Parchman), violated the Constitution.¹ Many of the conditions we identified at Parchman exist at Central Mississippi, South Mississippi, and Wilkinson. Across all these facilities, MDOC does not have enough staff to supervise the population. The mismatch between the size of the incarcerated population and the number of security staff means that gangs dominate much of prison life, and contraband and violence, including sexual violence, proliferate. Prison officials rely on ineffective and overly harsh restrictive housing practices for control.

This Report begins by explaining the methodology and scope of our investigation. It then describes the facilities we investigated. Next, the Report identifies the constitutional violations. We grouped the violations into two sections: failure to protect from violence and substantial risk of serious harm from restrictive housing practices. In each section, we highlight particular incidents of violence, gang activity, and misconduct as examples of the type of incidents that give rise to constitutional violations and to show the severity of the harm. We also examine MDOC's recent steps to address these concerns and why their efforts fall short. We end by outlining the minimum measures needed to remedy the violations.

¹ See U.S. Dep't of Justice, *Investigation of the Mississippi State Penitentiary (Parchman)* (Apr. 20, 2022), <https://www.justice.gov/crt/case-document/file/1495956/download> [https://perma.cc/5TMJ-HY5Z].

II. THE INVESTIGATION

In February 2020, the Department opened an investigation under the Civil Rights of Institutionalized Persons Act (CRIPA)² into conditions at Parchman, Central Mississippi, South Mississippi, and Wilkinson. The Special Litigation Section of the Department's Civil Rights Division and the United States Attorney's Offices for the Northern and Southern Districts of Mississippi jointly conducted this investigation. In April 2022, the Department reported on its investigation of Parchman and notified MDOC that it: fails to protect incarcerated persons from violence; fails to meet serious mental health needs; fails to take adequate suicide prevention measures; and that its use of prolonged restrictive housing at Parchman poses a risk of serious harm.

The investigation of Central Mississippi, South Mississippi, and Wilkinson examined whether MDOC failed to protect persons incarcerated in these three facilities from harm. Later, the Department expanded the investigation to look at whether prolonged isolation in restrictive housing units at Central Mississippi and Wilkinson poses a substantial risk of serious harm.

Two experienced consultants, both former high-ranking corrections officials with significant experience leading state corrections departments, aided this investigation. Together, both experts and Department representatives conducted week-long site visits at the three facilities in the Spring and Summer of 2022. We toured the grounds, including housing units, observed operations on all shifts, and interviewed staff and incarcerated persons. We viewed both general population and restrictive housing. We held exit conferences with MDOC officials after each tour, and our expert consultants shared preliminary concerns during these conferences. The experts led additional remote interviews of dozens of MDOC staff and administrators, reviewed thousands of pages of documents, and provided their expert opinions and insight to inform the investigation and its conclusions. Since then, we have continued to hear from advocates in Mississippi and have considered publicly available information and correspondence from incarcerated individuals about ongoing issues in these facilities.

The State and MDOC cooperated with our investigation. In November 2023, they provided an update on their efforts to improve conditions within the system, including efforts to reduce MDOC's use of restrictive housing, provide additional recreational programming, increase salaries to reduce staff vacancies, and plans to upgrade the physical plants of the facilities. The Department has considered all relevant information received, including actions the State and MDOC have taken in response to our investigation and Parchman findings.

² 42 U.S.C. § 1997.

III. FACILITIES INVESTIGATED

A. Central Mississippi Correctional Facility

Established in 1986, Central Mississippi is built on 171 acres in Rankin County, Mississippi. Central Mississippi is the initial orientation and classification facility for all individuals sentenced to MDOC. It has 18 housing units and can hold approximately 4,000 people. As of January 1, 2024, the Central Mississippi population was 3,731—over 600 people more than the average daily population in 2021.³ It has the largest number of incarcerated individuals of any MDOC correctional facility.

Central Mississippi houses men with minimum, medium, and close custody classifications.⁴ It also holds women at all classifications including close custody and death row.⁵ Central Mississippi houses young people (18 and under) in the Youthful Offender Unit. This unit has a capacity of 58 beds, and there were 23 young persons in the unit during our tour.

B. South Mississippi Correctional Institution

Established in 1989, South Mississippi is located on 360 acres in Greene County, Mississippi, in the city of Leakesville. South Mississippi holds a maximum of 2,882 people. As of March 2022, there were 2,199 individuals incarcerated there. As of January 1, 2024, there were 2,804. South Mississippi houses minimum, medium, and close custody men. It has the second largest number of incarcerated individuals of any MDOC correctional facility, after Central Mississippi.

C. Wilkinson County Correctional Facility

A private corporation, the Management and Training Corporation (MTC), contracts with MDOC to operate Wilkinson. The facility opened in January 1998, and sits on 97.5 acres in the southwestern corner of the state. It has a capacity of 949 beds. As of January 1, 2024, Wilkinson was near full capacity with 913 individuals. Wilkinson is one building and is predominantly restrictive housing. Most people housed there are classified as close custody or

³ This population data includes women in the Mississippi Correctional Institute for Women and young people in the Youthful Offender Unit.

⁴ MDOC classifies incarcerated people by custody level, which refers to “the type of housing and level of supervision required for an inmate.” MDOC, *Frequently Asked Questions*, <https://www.mdoc.ms.gov/family-friends/frequently-asked-questions> [https://perma.cc/WZ2V-L49P]. Minimum custody individuals require the least amount of supervision, and close custody individuals require the most supervision.

⁵ After our site inspection, MDOC moved some women to the Delta Correctional Facility, and re-organized the women’s portion of Central Mississippi into a separate facility named the Mississippi Correctional Institute for Women. The Mississippi Correctional Institute for Women is on the same complex as Central Mississippi and, for purposes of this report, we refer to both facilities as Central Mississippi.

maximum security. It is one of two private prisons operating in Mississippi and makes up about 4% of MDOC's total population.

Altogether, the three prisons (Central Mississippi, South Mississippi, and Wilkinson) house a third of MDOC's population.

IV. DEFICIENT CONDITIONS IDENTIFIED

Based on a thorough investigation, we conclude that MDOC violates the constitutional rights of incarcerated persons in Central Mississippi, South Mississippi, and Wilkinson "pursuant to a pattern or practice of resistance to the full enjoyment of such rights."⁶ Specifically, MDOC is deliberately indifferent to the substantial risk of harm from violence and the physical and mental harms from prolonged restrictive housing in violation of the Eighth Amendment.

The Eighth Amendment bans "cruel and unusual punishments." "Although the constitution does not mandate comfortable prisons, conditions of confinement must not involve the wanton and unnecessary infliction of pain."⁷ "[H]aving stripped [incarcerated persons] of virtually every means of self-protection and foreclosed their access to outside aid, the government and its officials are not free to let the state of nature take its course."⁸ The Constitution prohibits prison officials from looking the other way and being deliberately indifferent to conditions that subject incarcerated persons to a "substantial risk of serious harm," including an excessive risk of violence, illness, or injury.⁹

To determine whether conditions of confinement violate the Eighth Amendment, courts apply the same two-prong test, regardless of whether those conditions relate to violence or prolonged isolation. First, the conditions must pose a substantial risk of serious harm to incarcerated persons (objective prong).¹⁰ The determination that a condition is sufficiently serious requires an objective analysis that is "contextual and responsive to contemporary standards of decency."¹¹ Second, prison officials must act with "deliberate indifference" toward those conditions (subjective prong).¹² This second prong requires showing that prison officials

⁶ 42 U.S.C. § 1997a(a).

⁷ *Palmer v. Johnson*, 193 F.3d 346, 351 (5th Cir. 1999) (internal quotation marks omitted) (quoting *Rhodes v. Chapman*, 452 U.S. 337, 349, 347 (1981)).

⁸ *Farmer v. Brennan*, 511 U.S. 825, 833 (1994).

⁹ *Id.* at 834; *see also Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976).

¹⁰ *Farmer*, 511 U.S. at 834.

¹¹ *Hudson v. McMillian*, 503 U.S. 1, 8 (1992) (internal quotation marks omitted) (quoting *Estelle*, 429 U.S. at 103); *see also Wilson v. Seiter*, 501 U.S. 294, 298 (1991).

¹² *Farmer*, 511 U.S. at 834.

(1) are actually aware of “an excessive risk to inmate health or safety,”¹³ and (2) disregard that risk.¹⁴ Conditions may result in a constitutional violation “in combination when each would not do so alone” where they have a “mutually enforcing effect” that results in the deprivation of a basic human need.¹⁵

A. MDOC Fails to Protect Incarcerated Persons from Violence

Central Mississippi, South Mississippi, and Wilkinson are riddled with violence. As we found with Parchman, MDOC fails to protect incarcerated persons at these facilities from widespread violence by other incarcerated individuals. Gross understaffing, poor supervision, and inadequate investigations create an environment where violent gang activity and dangerous contraband trafficking proliferate. Given the frequency and flagrancy of violence recorded at Central Mississippi, South Mississippi, and Wilkinson, MDOC officials are aware that these conditions subject incarcerated persons to serious harm.¹⁶

1. MDOC allows violence at Central Mississippi, South Mississippi, and Wilkinson to go unchecked.

Violence among incarcerated persons is pervasive at Central Mississippi, South Mississippi, and Wilkinson. “[T]he Eighth Amendment imposes on prison officials a duty to protect prisoners from violence at the hands of other inmates.”¹⁷ Although this obligation does not require prison officials to prevent all violence in prisons, it does require “reasonable measures to guarantee the safety of the [incarcerated population].”¹⁸ Thus, when prison officials fail “to control or separate prisoners . . . who endanger the physical safety of other prisoners,” this can constitute cruel and unusual punishment.¹⁹ Despite this constitutional duty, MDOC does not take reasonable measures to prevent well-known, widespread violence at Central Mississippi, South Mississippi, and Wilkinson.

¹³ *Id.* at 842; *see also Blackmon v. Garza*, 484 F. App’x 866, 873 (5th Cir. 2012).

¹⁴ *Farmer*, 511 U.S. at 837; *accord Williams v. Hampton*, 797 F.3d 276, 280–82 (5th Cir. 2015) (en banc).

¹⁵ *Gates v. Cook*, 376 F.3d 323, 333 (5th Cir. 2004) (quoting *Wilson*, 501 U.S. at 304).

¹⁶ *See Farmer*, 511 U.S. at 842–43 (finding that evidence that a risk of attacks by incarcerated persons was “longstanding, pervasive, [or] well-documented” supports a conclusion that prison officials had actual knowledge of the risk).

¹⁷ *Adames v. Perez*, 331 F.3d 508, 512 (5th Cir. 2003).

¹⁸ *Farmer*, 511 U.S. at 832–33 (quoting *Hudson v. Palmer*, 468 U.S. 517, 526–27 (1984)).

¹⁹ *McCray v. Sullivan*, 509 F.2d 1332, 1334 (5th Cir. 1975); *see also Davis v. LeBlanc*, No. 10-cv-01920, 2011 WL 6965835, at *4 (W.D. La. Dec. 9, 2011) (citing *LaMarca v. Turner*, 995 F.2d 1526, 1537 (11th Cir. 1993) (“evidence of lack of prison safety measures, such as failure to provide inmate movement controls . . . is probative of the means available to the prison officials to protect inmate prison safety and whether they knowingly or recklessly disregarded solutions within their means”)).

At Central Mississippi, there were at least 325 assaults or fights between incarcerated individuals—on average one every other day from September 2020 to June 2022. Of these violent incidents, 23 resulted in serious bodily injuries requiring outside hospitalization. South Mississippi had nearly 100 reported assaults or fights, of which about 40 resulted in outside hospitalization, from June 2020 through June 2022. At Wilkinson, there were more than 150 assaults or fights reported, of which almost 30—approximately 20%—resulted in serious bodily injuries requiring outside hospitalization, from November 2020 through June 2022. Notably, Wilkinson reported more violence than South Mississippi reported over a longer period, even though South Mississippi has more than double Wilkinson’s population, and a large percentage of those housed at Wilkinson are locked in their cells 23 hours a day. In light of the large number of documented assaults at Central Mississippi, South Mississippi, and Wilkinson, MDOC officials cannot claim ignorance of the substantial threat of violence at these facilities.

These figures also likely underestimate the violence. Gross understaffing and poor supervision most likely cause assaults and fights to go unreported. Our review of documentation confirmed that the number of violent incidents at the facilities exceeds the number officially reported. Specifically, our review of transportation records suggests that multiple people required transport to outside hospitals for injuries from assaults that the facilities did not otherwise report. Examples of hospital transports for which there was no corresponding incident report, include: “face laceration and human bite to right thumb,” “head laceration,” and “mandible fracture.”

Poor supervision and security practices exacerbate the violence at Central Mississippi, South Mississippi, and Wilkinson. We document many examples throughout this report, but the following incidents exemplify the level of violence:

- An incarcerated person at Central Mississippi died of blunt force trauma to the head following a fight. Camera footage shows an assailant choking and kicking the victim in the head at 3:41 a.m. Over the next few hours, video shows the victim passing in and out of consciousness, as other incarcerated persons help him to and from his bed. Later, a different incarcerated person punched the victim in the face, and another person cleaned around the victim’s bunk. By 8:43 a.m., the victim’s body was rigid, and at 8:53 a.m. he began foaming at the mouth.

At about 8:45 a.m., five hours after the assault, an officer conducting morning meal found out about the victim and called for medical help. By the time help arrived about 20 minutes later, the victim was unresponsive, and he died. The Warden’s report makes no mention of an officer being present on the housing unit at any point during the five hours between the assault and the decedent foaming at the mouth. A supplemental report indicates that an officer turned off the lights in the housing unit around 4:30 a.m., but no officer walked through the housing unit. The supplemental report also indicates that the tower (where surveillance video should have been viewable) was unoccupied for at least some period.

- Thirty-four pre-classification incarcerated men at Central Mississippi had a gang altercation with make-shift weapons that included broomsticks, crutches, shanks, and a microwave. The incident involved four gangs and followed the arrival of a high-ranking gang member who was purportedly trying to assume control over their housing unit. Multiple individuals required emergency transport to an outside hospital for injuries. Staff recovered six sharpened metal shanks and contraband including prepaid credit card (“green dot”) numbers and CashApp information (both for transferring money undetected), tattoo equipment, and unidentified pills. The Correctional Investigations Division (CID) Report recommended criminal prosecution for some of the incarcerated persons, but it did not review the internal failures that allowed for dangerous contraband and high gang tensions. Nor did the report propose measures to prevent this kind of violence from recurring. The Superintendent later acknowledged that leaving unclassified gang members in a large open dormitory for an extended period without frequent staff interaction, activities to reduce idleness, or a way to voice concerns, allowed the gang members to organize and contributed to the violence.
- A fight broke out involving as many as 20 incarcerated persons at Central Mississippi. Officers responded to the unit and found an individual in the hall with a gash on his forehead. The MDOC report indicates that officers reviewed camera footage to determine what happened and saw what “appeared to be a gang fight.” The video captured over a dozen persons striking other incarcerated people repeatedly in the face and body with sticks. Officers later found numerous mop handles and broomsticks in the unit. It appears that no officer was on the unit and possibly no officer was in the tower at the time of this gang fight; moreover, no one was monitoring the video surveillance in real time to alert staff to the disturbance.
- A tower officer in South Mississippi observed what she described as the whole zone fighting in one housing unit of Area II and radioed for all available staff to respond. The first responding staff member waited before going in the zone because weapons were involved. Once more staff arrived and they opened the unit door, they found rival gang members lined up on separate sides of the unit, with non-affiliated persons gathered in the bathroom area. A security captain fired a “flash-bang” distraction device to gain compliance. One person died from stab wounds to his chest, back and head sustained in this incident. Another two stabbing victims went to an outside hospital, one had 15 puncture wounds to his upper torso and head, and the other had 7 stab wounds to his back, arms, face, and head. A subsequent search found multiple shanks and phones.
- Three gang members orchestrated a stabbing and beating of someone in a long-term segregation pod at Wilkinson. The assault began as the four men were all in separate, locked showers. An officer had handcuffed one person and was taking him out of the shower, when someone yelled out to distract her, and the handcuffed person turned a shank on the officer and forced her to give up the keys. The person with the shank then forced three officers off the pod and used the keys to unlock the shower doors for the other two gang members. They then unlocked the victim’s shower door and attacked him

with shanks. They pulled him into the dayroom, continued to stab him, and hit him with a lock and a phone. When a response team reentered the unit, they found the victim unresponsive in a pool of blood. An airlift transported the victim to an outside hospital. Officers searched the unit and found a 9.5-inch plexiglass edged weapon, a 6.5-inch plexiglass edged weapon, a 7.5-inch pointed metal weapon, 2 other sharpened instruments, a lock, and a broken phone. Wilkinson staff verified this attack as gang related. The incident likely prompted a standoff between gangs on another pod later in the day, which led to a prison lockdown.

The violence at these facilities includes significant sexual violence. The Prison Rape Elimination Act (PREA) Manager for Central Mississippi estimated receiving between twenty and twenty-five PREA complaints per month.²⁰ However, it is difficult to quantify the amount of sexual violence in MDOC facilities, as the statewide PREA Coordinator for MDOC²¹ acknowledged that most of the sexual assaults occurring there are not reported.

In one extreme example of the sexual violence, we interviewed an individual who experienced a sexual assault at South Mississippi. The individual had experienced prior assaults at Central Mississippi and another MDOC facility. Officials transferred him to South Mississippi after gang members stabbed him multiple times, raped him with a piece of pipe, and put a “kill on site,” or “KOS” order on him. He reported that when he arrived at South Mississippi, he requested protective custody based on the prior assaults, but the South Mississippi administration initially denied his request. Instead, South Mississippi administrators housed him in general population, in a large, open-bay dormitory with gang members. While using the bathroom, someone held a lock-blade knife to his neck, escorted him into the shower, and raped him. The victim told us that he believes the attack was orchestrated, because gang members lined up around the bathroom to stop anyone from coming in while he was being assaulted.

MDOC’s widespread gang activity and a steady flow of dangerous contraband into the facilities, combined with gross understaffing, poor supervision, and inadequate investigations, all contribute to unacceptable levels of violence at Central Mississippi, South Mississippi, and Wilkinson.

2. MDOC fails to control illegal and violent gang activity.

Gangs are pervasive at Central Mississippi, South Mississippi, and Wilkinson, and they are a large contributor to the violence. The Chief CID Investigator at Central Mississippi estimated that between 20% and 40% of the population at Central Mississippi have a gang affiliation. A former gang intelligence officer estimated that more than half the Central Mississippi population was gang affiliated. MDOC staff acknowledged that formal gang

²⁰ PREA refers to the Prison Rape Elimination Act. 34 U.S.C. § 30301.

²¹ PREA requires that corrections agencies have an agency-wide PREA Coordinator who coordinates the agency’s PREA compliance activities. 28 C.F.R. § 115.11.

validations mostly occur during the intake process and so tallying validations does not include all individuals who join gangs while in prison, or who avoid identification as gang members during intake. Still, MDOC data show that as of May 2022, Central Mississippi had 656 validated gang members, representing 20% of the population. From July 2020 through November 2021, MDOC data show that the number of validated gang members in the South Mississippi population each month ranged from a high of 1055 (40% of the monthly population in September 2019) to a low of 244 (10% of the monthly population in November 2021). While this data reflects a decline in the number of validated gang members in South Mississippi, gangs retain significant influence there. The gang intelligence officer we spoke with from South Mississippi explained that their numbers declined as a result of closing a few housing units and a new effort to report affiliations only for people actively engaged in gang activity. A captain at Wilkinson estimated that between 35% and 65% of the population is gang affiliated. In May 2022, Wilkinson data show 374 validated gang members, representing 22 different gangs and making up 40% of the population. In recent years, the percentage of validated gang members reported in the Wilkinson population was as high as 90%.

Lack of staff presence in housing units creates a situation in which prison gangs, referred to by staff and incarcerated persons as “organizations,” exert their influence through criminal activity to control daily life inside the three facilities. Gangs maintain order in the housing units, make bed assignments, control the flow of contraband, and use violence as punishment.²² Both staff and incarcerated individuals report that gangs are responsible for the flow of drugs into the facilities, leading to violence, extortion, and drug overdoses. The strength of prison gangs inside the MDOC facilities that we investigated is so great that even some staff members have gang affiliations and are on the gangs’ payroll. We found that while MDOC has recently undertaken efforts to try to lessen gang influence in the prisons, including through faith-based initiatives and renunciation efforts, these efforts are inadequate. MDOC’s statewide gang coordinator could not share any metrics that assess the effectiveness of their gang control strategy. Nor do MDOC’s measures appear from our review to have broken the gangs’ stranglehold over MDOC facilities. MDOC’s failure to take reasonable measures to limit the influence of gangs inside its facilities contributes to the violence and danger incarcerated individuals endure and constitutes deliberate indifference to the risk of harm to those in MDOC custody.

Staff at Central Mississippi described gangs as “a government within the facility.” One of the Central Mississippi Internal Affairs (IA) coordinators told us that gangs have complete control of the prison dormitories. Gangs control the dormitory bed assignments at Central Mississippi and even make some individuals sleep on the floor. A South Mississippi officer confirmed that two gangs in particular control the housing units, and that the gangs “take care of business.” One incarcerated individual at South Mississippi reported that if someone is not affiliated with a gang, they must pay to use the shower. We learned that gang members at South Mississippi stay up at night to serve as lookouts and provide security for the gang, that they

²² See *Stokes v. Delcambre*, 710 F.2d 1120, 1124–25 (5th Cir. 1983) (concluding evidence “that self-appointed prison ‘leaders’ exercised their sovereignty by assigning prisoners to cells” supported finding that officials operated facility in a manner “virtually indifferent to the safety of prisoners”).

control access to the televisions and phones in the units, and that they assign people to specific beds irrespective of the official bed assignments given by MDOC. The staff at Wilkinson also acknowledged the influence that gangs hold at this facility. They told us that gang leaders have their own security, and that they manipulate cell assignments, shower access, and even seating in the dining hall. Staff also told us that gang members traffic contraband into Wilkinson, including drugs and cellphones. The MDOC administrator over prevention and detection of sexual abuse in all MDOC facilities suggested that gangs may actually play a positive role in prisons by preventing violence in housing units. This statement presents a disturbing view of gangs as “enforcers” of prison rules, and it fails to recognize that gangs rule through fear and perpetuate violence when it suits their leadership.

One IA Coordinator attributed the gangs’ strength to staff corruption and estimated that more than half the staff are on the payroll of gangs. South Mississippi administrators acknowledged that gangs remain a problem for the facility despite recent reduction in their numbers, and one South Mississippi administrator told us he did not doubt that some staff benefit financially from gang activity. The IA Coordinator reported that some staff seek work in corrections because of the potential for lucrative payments from gang members. Others may be coerced or pressured to affiliate with an organization. Staff members at Wilkinson described their colleagues as fearful of the gangs and reported that the gangs recruit staff members to work for them. Facility supervisors confirmed that some staff are affiliated with and assist the gangs in their activities. The South Mississippi Superintendent acknowledged his facility’s problem with gang activity and contraband, stating that staff cannot be discounted as a source for contraband entering the facility, while recognizing that others who frequent the facility, such as contractors and food delivery servicers, may also contribute to the influx. MDOC staff acknowledged that the existence of high levels of contraband at their facilities creates violent and dangerous situations for incarcerated persons under their care, including drug-induced overdoses, the presence of weapons at the facility, and owing a debt for contraband that leads to extortion and assault. The Superintendent at South Mississippi informed us that to take more decisive action to undermine gang influence, he would need to improve staffing levels.

Much of the violence at Central Mississippi, South Mississippi, and Wilkinson is connected to gang activity:

- Staff responded to a gang altercation in the Central Mississippi Quickbed building that involved three different gangs and 19 individuals. The altercation erupted out of a dispute about unpaid gambling debt. Responding staff used less-than-lethal shotgun rounds to quell the disturbance.
- Four gang members from two different gangs assaulted an incarcerated person at Central Mississippi over a dispute regarding phone usage. Review of video from the altercation showed several people stomping, punching, and kicking the victim as he attempted to enter the bathroom in the housing unit. One assailant was seen in the video waiting in the bathroom with a mop handle and then hitting and striking the victim with it. The victim suffered a broken jaw and required transportation to an outside hospital for treatment.

- Eight gang members assaulted an incarcerated man at Central Mississippi. They hit him with a push broom until he passed out.
- Central Mississippi staff responded to an incident in which multiple gang members were beating and punching another individual. One of the assailants stated, “You need to get this man out of here,” and tossed a bed mat toward the door of the housing unit.
- A gang member attacked an incarcerated man in a South Mississippi housing unit over canteen debt he owed to the gang. The victim required medical attention in the prison infirmary after the assault.
- There was a serious fight at South Mississippi involving multiple gang members. They punched and stomped a man for allegedly stealing from them. One of the assailants had to go to an outside hospital for stitches after the victim of the attack bit his face.
- Gang members attacked an incarcerated individual at South Mississippi over \$68 he owed to “the gang canteen box.” The assailants dragged the victim across different zones of the same housing unit, then after he lost consciousness, brought him to the showers and poured cold water from a garbage can on him to wake him up. Once the victim started coughing and spitting up water, the assailants continued the assault, pouring boiling hot water on him and beating him. The attackers reportedly prohibited anyone in the housing area from contacting medical following the assault. After conferring with other gang members, the assailants agreed to request a security check from officers, because of the severity of the victim’s injuries. Responding staff found the victim lying on the floor behind benches. He was unable to stand up and moaned when asked questions. He had burns over 10–20% of his body, a nasal fracture, head injury, lack of cognitive response and encephalopathy (brain injury).
- An individual incarcerated at Wilkinson reported that a gang had put a “KOS,” or kill-on-sight order, on him for “homosexual activity.” The individual said that as a result he could not live in any of the housing units. Wilkinson investigators verified the threat and confined him to restrictive housing.
- An altercation between two gang members at Wilkinson erupted into a melee involving five incarcerated individuals. A member of a rival gang suffered three stab wounds to the back and one stab wound to the jaw. The entire facility was placed on lockdown following this incident.
- Gang members coordinated a targeted assault on an incarcerated individual at Wilkinson. Two gang members stood outside the victim’s cell, presumably to ensure the victim could not leave the cell during the attack and to serve as lookouts. Several other gang members entered the cell to assault the victim. All of this was captured on camera.

MDOC's failure to protect incarcerated persons at Central Mississippi, South Mississippi, and Wilkinson from gang-related violence constitutes deliberate indifference to a serious risk of harm.

3. MDOC fails to keep dangerous contraband out of its facilities.

MDOC has a responsibility to interrupt the flow of dangerous contraband entering and moving about its facilities. The Constitution requires that MDOC officials take reasonable measures to do so, which includes thorough searches of persons entering and moving through MDOC facilities, as well as searches of housing and common areas.²³

MDOC fails to control both the entry of contraband into Central Mississippi, South Mississippi, and Wilkinson and the movement of contraband within these prisons. Our observation and review of staff screening procedures at all three facilities confirmed that staff can easily introduce contraband. MDOC's search procedures failed to separate personnel who had been searched from personnel who had not yet been searched. Some personnel were able to enter the facility and assume their post without being searched. At all three facilities, incarcerated individuals moved around freely between work assignments, various programs, and housing units—often with no officer escort. They also were not searched as they left areas vulnerable to contraband movement: the kitchens, maintenance and vocational education shops, and prison industry and warehouse areas. We also found that the prisons make insufficient use of technology like portable narcotics trace detectors, and that their K-9 units are understaffed and insufficient for narcotics detection.

Staff at Central Mississippi acknowledged they have a problem controlling the flow of contraband in the facility. One of the wardens at South Mississippi similarly acknowledged that contraband is “a huge problem.” Wilkinson officials also are aware that contraband is pervasive at their facility. One supervisor at Wilkinson reported to us that in a single month in 2022, they recovered 28 grams of crystal meth, 8–9 ounces of marijuana, and 10 cell phones.

Drugs, cell phones, and weapons are the most common type of contraband found in the facilities. Many of the assaultive incidents at Central Mississippi, South Mississippi, and Wilkinson, involve contraband weapons. During one altercation at Wilkinson, an incarcerated individual sustained a laceration to his chest. Security staff recovered a piece of a kitchen knife from the scene. After an assault at Wilkinson that sent an incarcerated person to the hospital, staff recovered an eight-inch implement. Incarcerated individuals fashion weapons from plexiglass and metal pieces, including window frames, fans, and fence wire. We found tool control at the Central Mississippi welding shop was particularly weak, with incarcerated individuals returning from there to the housing units without being searched despite having ample access to metal and tools.

²³ See *Hudson v. Palmer*, 468 U.S. 517, 527 (1984) (Prison officials “must prevent, so far as possible, the flow of illicit weapons into the prison.”).

Central Mississippi staff reported finding cell phones daily and confiscating 25–50 cell phones per month. South Mississippi staff found 1200 cell phones over a thirteen-month period, an average of 92 cell phones per month. Incarcerated individuals use cell phones to post on social media and conduct business, including contraband trafficking.

Contraband drugs recovered include marijuana, synthetic marijuana, methamphetamine, Xanax pills, and suboxone strips and alcohol. Contraband also includes large amounts of cash (for example, over \$2,000 found in a single month at South Mississippi) and information for transferring money (such as prepaid credit card numbers or CashApp numbers).

While contraband enters the facilities through visitation, vendors, mail, and from over the prison walls and fences, a significant portion of the contraband comes in with compromised staff. MDOC caught six Central Mississippi officers bringing contraband into the facility in 2019, another five staff members in 2020, and four more in 2021. In 2020, South Mississippi found five officers bringing in contraband, and a sixth was found to have received dozens of phone calls from an incarcerated person who wanted the officer to resume trafficking done by one of the officers previously caught. In 2021, South Mississippi caught eight officers trafficking contraband. In 2020, three officers were found to have introduced contraband into Wilkinson, with a fourth conspiring to do so. Two officers were found to have brought contraband into Wilkinson in 2021.

The volume of contraband drugs in circulation at the three facilities leads to extreme, drug-induced behaviors that contribute to violence and fatal overdoses. Staff at Central Mississippi responded to a fight between incarcerated individuals where one of the individuals was reportedly intoxicated on bath salts and the drug “ice” and had not slept in three days. The intoxicated individual allegedly attacked the other person while he was sleeping. The Superintendent of South Mississippi acknowledged that there are a fair amount of drugs coming into the facility, that drugs are a problem, and that he would like to do more random drug testing if he had more resources. An officer at South Mississippi told us that she has observed incarcerated individuals “wig out” and get sick on the drugs circulated inside the facility. She described an incident where someone under the influence of drugs took a homemade shank with him as he climbed up to the unit beams, began cutting himself, and threatened others. Officers sprayed him with chemical agent to get him back down. An individual who died at Wilkinson after cutting himself and assaulting and choking his cellmate was found to have amphetamine and methamphetamine in his system.

The pervasiveness of drugs inside these facilities also contributes to sexual violence and coerced sexual activity. Incarcerated people with drug dependency may be particularly likely to incur monetary debt. We heard from the MDOC PREA Coordinator that when incarcerated individuals incur monetary debt in MDOC facilities, there is a practice of demanding sexual favors as payment. We also reviewed multiple serious allegations of sexual violence involving illicit drug use. Although PREA investigators could not substantiate the allegations, the accounts nonetheless point to a pattern connecting drug use and sexual assault. For example:

- An individual incarcerated at South Mississippi reported that he went to sleep and woke up with stomach pain and pain in his rear. He reported difficulty making a bowel movement and seeing blood when he wiped. He further reported that there was talk on his housing unit about his having been anally penetrated with a toothbrush holder. Medical staff at South Mississippi planned to send him to an outside hospital for a sexual assault exam. However, the PREA Manager insisted that the complainant provide a urinalysis, as he had acknowledged being passed out for twelve hours when the incident occurred. Upon learning that he would have to do a urinalysis, the complainant refused further treatment, including transfer off-site for the sexual assault examination. The PREA Manager then deemed the complaint unfounded.
- The mother of an individual incarcerated at Wilkinson called the administration to report that her twenty-one-year-old son had been sexually assaulted by his cellmate. The victim told investigators that he went to sleep after using “ice,” and when he woke up his anal area was sore and there was blood on the toilet paper when he wiped. He went to an outside hospital for a forensic sexual assault examination, but two months later when we received the report about this incident, there were no lab results available and PREA investigators had not made a finding about the claim.

In sum, MDOC’s failure to prevent dangerous contraband from proliferating inside these facilities contributes to the grave risk of violence.

4. Gross understaffing leaves units unsupervised with little to no response to violence.

MDOC’s failure to adequately supervise the incarcerated population at Central Mississippi, South Mississippi, and Wilkinson contributes to the unreasonable risk of serious harm to people in MDOC custody. As explained below, security staff vacancy rates range from 30% to 50%. The few on-duty officers are usually assigned to watch towers with poor, often blocked sight lines, and required to cover multiple towers and housing units at the same time. Unsurprisingly, officers then fail to do basic security tasks such as making rounds, counting incarcerated persons, and keeping doors secure. MDOC has long known about this gross understaffing and the harm it causes, but has failed to take reasonable, effective measures to fix the problem.

a. All Three Facilities Operate at Dangerously Low Staffing Levels

High vacancy rates for security positions at Central Mississippi, South Mississippi, and Wilkinson mean these facilities operate with dangerously few staff. The high vacancy rates endure despite Commissioner Burl Cain’s changes, which include lowering eligibility requirements to become a correctional officer, expediting the hiring process, and shortening new officer training. Commissioner Cain, who assumed leadership of MDOC in May 2020, has also raised starting pay, although it remains lower than pay at other correctional agencies in the region and in other industries in Mississippi.

MDOC’s own data show the extent of the staffing deficiencies. The vacancy problem at Central Mississippi dates to at least December 2018, when MDOC records show the correctional officer vacancy rate was 42.3%.

The following MDOC report shows that between July 2021 and May 2022, the vacancy rate for full-time correctional officers at Central Mississippi varied from about 22% to about 56%:

	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Central Mississippi	2021	2021	2021	2021	2021	2021	2022	2022	2022	2022	2022
Number F/T Correctional Officers Authorized	437	437	358	358	358	358	358	358	358	358	358
Total F/T Correctional Officers	272	250	244	277	201	179	158	161	193	174	169
Number of Vacancies	165	187	114	81	157	179	200	197	165	184	189
Percent Vacant	37.76%	42.79%	31.84%	22.63%	43.85%	50.00%	55.87%	55.03%	46.09%	51.40%	52.79%
Number F/T Supervisory Staff Authorized	87	87	87	87	87	87	87	87	87	87	87
Total F/T Supervisory Staff	86	86	86	86	85	85	85	84	84	69	57
Number of vacancies	1	1	1	1	2	2	2	3	3	18	30
Percent vacant	1.15%	1.15%	1.15%	1.15%	2.3%	2.3%	2.3%	3.45%	3.45%	20.69%	34.48%

The vacancy rate at Central Mississippi increased over this period, even as MDOC reduced the number of authorized correctional officer positions at the facility. From September 2021, when MDOC reduced the number of authorized positions, to May 2022, the officer vacancy rate jumped from about 31% to about 53%. From December 2021 to May 2022, the vacancy rates averaged about 52%. Supervisor vacancy rates rose sharply in April and May 2022, from 3% to nearly 35%.

Thus, by MDOC’s own assessment, Central Mississippi regularly operates with fewer than half the staff it needs to supervise its 3500-person population. However, the most recent Central Mississippi staffing analysis commissioned by MDOC, conducted in November 2020, found that the facility requires 410 non-supervisory correctional officers—52 more officers than authorized—to operate safely. Using this staffing analysis, Central Mississippi’s non-supervisory officer vacancy rate for May 2022 is even more severe at about 60%.

Similar staffing deficiencies plague South Mississippi. According to South Mississippi’s reports for the year ending in November 2021, officer vacancy rates ranged from about 21% to 38%. Supervisor vacancy rates during this period ranged from about 41% to about 60%.

	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
South Mississippi	2020	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021	2021
Number F/T Correctional Officers Authorized	186	185	185	184	184	184	184	184	184	184	184	184
Total F/T Correctional Officers Employed	116	114	122	144	144	145	135	120	128	131	136	125
Number of Vacancies	70	71	63	40	40	39	49	64	56	53	48	58
Percent Vacant	37.63%	38.38%	34.05%	21.74%	21.74%	21.20%	26.63%	34.78%	30.43%	28.80%	26.09%	31.52%
Number F/T Supervisory Staff Authorized	57	57	47	48	48	48	49	59	59	58	58	58
Total F/T Supervisory Staff Employed	23	24	26	27	27	27	29	25	25	25	27	28
Number of Vacancies	34	33	21	21	21	21	20	31	33	32	31	30
Percent Vacant	59.65%	57.89%	44.68%	43.75%	43.75%	43.75%	40.82%	52.54%	55.93%	55.17%	53.45%	51.72%

A South Mississippi human resources officer confirmed these staffing deficiencies and indicated they have grown worse. In an April 2022 interview, the human resources officer reported 62 correctional officer vacancies out of 184 authorized positions, for a 34% vacancy rate.

As with Central Mississippi, these vacancy rates do not account for a recent MDOC-commissioned staffing analysis. The staffing analysis recommended a significant increase in

force at South Mississippi, finding 337 non-supervisory correctional officers—153 more than the 184 currently authorized—are needed to operate South Mississippi safely. Using this recommended staffing, South Mississippi’s April 2022 officer vacancies jump to 215 of 337 correctional officers, or a vacancy rate of about 64%.

Like Central Mississippi and South Mississippi, Wilkinson has high vacancy rates for security staff. However, Wilkinson’s documentation of its staffing rates is contradictory, contains clear mathematical errors, and consequently is unreliable.²⁴ Accordingly, we are unable to chart rates across months as we have for the two facilities above. During a May 2022 interview, the Wilkinson human resources manager said the officer vacancy rate has been about 50% since 2021.

Other evidence confirms understaffing at Wilkinson. A semi-annual report for the period ending in June 2021 relayed that “[i]t take[s] 28 Security Officers to operate each [of two] day shift[s], and 24 Security Officers to operate each [of two] night shift[s]. The facility has been operating under staff on all four shifts.” In our May 2022 interview, the Wilkinson warden said he usually has just 14 correctional officers and 1 shift commander on each shift. Wilkinson shift rosters reveal even more vacant posts. A May 2022 night shift roster shows that Wilkinson had 11 total staff, 3 of whom could not leave their posts, to watch over 925 incarcerated persons. Wilkinson assigned single officers to watch over groups of three or more pods and assigned zero staff for six of the pods. With these assignments, staff responding to an emergency would leave even more housing pods unsupervised. This dangerous staffing pattern is not an anomaly; another night shift roster for April 2022 shows just 11 correctional officers covering the entire facility.

Several factors contribute to low staffing levels at the three prisons. First, as one superintendent confirmed, recruitment is slow despite MDOC’s stated efforts to hire more staff. Another contributor is MDOC’s trouble keeping newly hired officers. A MDOC human resources officer said that Central Mississippi has a high turnover rate because new hires are not prepared for the job and do not understand its requirements. Another human resources officer reported that South Mississippi lost about 50% of its new hires from the previous year.

MDOC also loses many employees for cause, including many trainees. New hires have been found to have gang affiliations, and MDOC is forced to terminate (or accept the resignation of) multiple employees a year for rule violations, including bringing in contraband, having relationships with incarcerated individuals, and excessive force. Officers have claimed to bring

²⁴ For example, Wilkinson’s monthly human resources staffing memorandum for May 2022 reported a 7.7% staff vacancy rate for 56 vacancies, but 56 out of the 161.67 FTE budgeted positions equals a 34.63% staff vacancy rate. The vacancy rate jumps to 49.3% if one relies on the numbers Wilkinson’s human resources manager gave during their interview (68 vacancies out of 138 budgeted positions) instead of what is reported in Wilkinson’s documentation.

in contraband because of threats from incarcerated individuals and that they fear for their life. There is also significant money being paid to officers for introducing contraband.

These types of incidents are not surprising, as MDOC confirmed that it does no real screening of correctional officer applicants, does not drug test them, or check references. Commissioner Cain acknowledged that MDOC's lack of screening leads to a lot of "dirty" employees.

Finally, a foundational factor for understaffing is low pay. Although, effective July 1, 2022, MDOC increased salaries for correctional officers, Commissioner Cain acknowledged that MDOC still pays less than other state prison systems in the region. The low pay not only discourages highly qualified people from applying or staying on the job, but it also increases the temptation for officers to supplement their salaries by conspiring with gangs and trafficking contraband.

b. Understaffing Leads to Inadequate Supervision and Harm

MDOC's poor staffing means officers fail to carry out basic security practices.²⁵ As described below, correctional officers are rarely inside the housing units and instead sit in overlook towers where they cannot fully observe the people under their supervision. Security rounds and counts are missed, doors are left open, security posts are unfilled, and staff often fail to respond to incidents of violence or other harm until hours later. These conditions further contribute to the substantial risk of harm from violence at these facilities.

Housing units in all three facilities lack meaningful officer presence. In correctional facilities with open dormitory-style housing, like Central Mississippi and South Mississippi, floor presence is needed to deter misbehavior, help officers get to know people on the units, and recognize and respond to trouble before it escalates. In prisons with celled housing, like Wilkinson, floor presence is needed to ensure the welfare of people locked in cells and protect against behavior dangerous to themselves, cellmates, or staff. The lack of floor presence at Central Mississippi, South Mississippi, and Wilkinson allows for higher levels of assaults, contraband, suicides, and self-injury. This is especially true at South Mississippi, which is entirely dormitories, yet has few—if any—staff on the floor in housing units.

The significant understaffing leaves the facilities unable to perform essential security functions: ensure prison doors and gates are locked, conduct security rounds, and do counts to ensure people are in their assigned units. Failing to do these basic security practices contributes to the substantial risk of serious harm from violence.

At Central Mississippi, unit gates and doors are often unlocked and left open. It is not uncommon for incarcerated individuals to wander between units without consequence. A shift

²⁵ The juvenile unit at Central Mississippi is an exception. When we toured, it appeared that the unit, known as the Youthful Offender Unit, had sufficient staff numbers, given the low number of juveniles on the unit, and benefitted from the designation of staff dedicated to solely working that unit.

commander told us it is difficult to watch everyone and make sure they do not go from building to building. The Shift Commander admitted that “if we let them out for meals or medication[,] they can wander around.” We learned that multiple incarcerated men entered a female housing unit at Central Mississippi due to poor door security and lack of supervision and stayed for an extended period, engaging in sexual activity. In another incident, an incarcerated man was able to enter a Central Mississippi security tower.

We also found poor door security at South Mississippi. During our inspection, we often saw tower doors unclosed or unlocked while dormitory doors were open, allowing incarcerated persons tower access. In an incident described below, a trainee admitted that during an emergency, she panicked and opened doors to two zones. These serious security breaches could allow incarcerated individuals to overpower a tower officer and gain control of all entry and exit points for a housing unit. Poor door security undermines efforts to separate people—for example, sexual predators or gang members—and creates conditions for widespread violence and rioting.

Wilkinson has poor door security, as well. While onsite, we saw several electronic security doors to the pods propped open. Key security for manually locked doors is a problem, too. Wilkinson’s Chief of Security said the most serious incidents happen in long-term segregation, where incarcerated individuals snatch door keys from staff. In April 2022, an officer was running showers on the long-term segregation G-Pod when an incarcerated individual tried to take her keys. The individual attacked the officer, choking and punching her, and stabbed her in the head with a shank. The officer fell to the ground and waited for help. She suffered a gash to her head and required transport to an outside hospital. Following the attack, the incarcerated individual said “[w]hen I noticed that she wasn’t gonna put restraints on me, I took the opportunity and took the keys.”

Short staffing also often prevents officers from walking through the facilities to do unit checks and counts of incarcerated persons. Security checks and counts are basic, necessary correctional practices, and MDOC policy requires that they happen. Yet Central Mississippi, South Mississippi, and Wilkinson fail to perform these essential security functions.

MDOC policy requires 12 counts a day, but the facilities do not do this many. Central Mississippi comes nowhere close to this number, with officers often doing counts as infrequently as once a day. When they do conduct counts, officers at times have to abandon their towers and leave multiple units unsupervised, worsening supervision problems. And because of poor door security, incarcerated persons often are not in their assigned place when counts occur, throwing off the counts. Like Central Mississippi, South Mississippi’s understaffing often prevents officers from counting the number of people in their custody and doing security checks inside housing areas. As a result, it is common for officers to not know who is in each housing unit. The same problems exist at Wilkinson, where basic security checks and counts in units do not happen as required.

We found that officers fail to perform counts, perform counts improperly, and submit false counts to cover up these lapses. The circumstances of a death at South Mississippi

highlight this issue. Medical staff who went to the unit to perform CPR on the decedent found that he was cold to the touch and that rigor mortis had set in. One South Mississippi officer said that he counted the decedent twice during his shift, but he could not verify that the decedent was alive during the counts, because most people he counted had sheets covering their beds. The officer “knew he was supposed to count ‘living/breathing’ [people] and look at an ID[,] but he did not do so.” Another officer who called in the counts for the decedent’s unit on the previous shift told investigators he did not actually do the counts. The officer, a trainee, said he is supposed to count nine buildings every hour during nightshifts. He said that it is impossible to do so. In a second interview, he backtracked and said he did do the counts in the decedent’s unit, but records showed the officer was only in the unit for three minutes the entire shift, making that unlikely. The supervisor from the previous shift did not supervise rounds or go into the unit, even though he knew he was supposed to check the unit each shift and even though the officer responsible for count was a trainee. It appears that an officer last saw the decedent alive eight hours before reports that he was unresponsive.

One reason counts do not happen is that officers fear going inside units without enough staff. A Central Mississippi lieutenant submitted an extraordinary occurrence report stating:

The offenders in Quick Bed B and C buildings are becoming more and more hostile and aggressive. They will not get on their assigned beds as a whole. They also will not let the officers conduct a safe count on a regular routine basis. Officers can not [stet] even receive correct bed numbers or MDOC numbers for these infractions. They are refusing to rack down at night and remain on their assigned racks making it extremely difficult and unsafe when I [] try to conduct security checks or anytime when I come to the zone. I do not have the staff necessary to make these inmates comply.

When officers cannot safely enter housing units, they cannot do basic, essential tasks like security checks and counts.

South Mississippi does not have enough staff to routinely search its yards and housing units. The Superintendent said he would not want an officer to conduct searches alone in the dormitories where “it could go bad quick.” Without enough staff for routine searching, incarcerated individuals traffic and collect contraband undetected.

MDOC tries to fill the gaps in staffing in the three facilities by having supervisors and other specialized personnel, such as the K-9 Team or the Emergency Response Team (ERT), do basic security functions. However, this practice is insufficient to ensure adequate coverage of housing units and towers, and it prevents these fill-in officers from performing their specialized security duties, adding to unsafety. A member of Central Mississippi’s K-9 Team—whose primary job is to train and use search dogs to find drugs, contraband, and escapees—estimated that 80% to 85% of his unit’s time is taken away from doing these critical searches because Central Mississippi regularly calls on this five-member team to cover vacant correctional officer posts. An ERT supervisor at Wilkinson said that members of his team sometimes deliver food trays. A disciplinary officer at South Mississippi reported that she frequently fills in to staff

housing unit towers, and handles disciplinary matters for incarcerated persons at the same time. At times, even the Warden or Deputy Warden will fill a correctional officer post. Despite these attempts to fill in the staffing gaps, many essential posts still go uncovered, especially at night.

The gross understaffing means there is little to no officer presence in the housing units, and the facilities rely on watch towers as the primary form of supervision. But tower supervision is insufficient. The PREA Manager for Central Mississippi acknowledged that it is not safe to have a tower officer but no floor officer working in a housing unit. There often are not even enough officers to cover all the towers, and one tower officer cannot effectively monitor multiple units alone. Additionally, the towers' sightlines into the units are blocked.

At Central Mississippi, it is common for a single officer to cover multiple towers in one shift, leaving units completely unsupervised for extended periods. A day-shift commander at Central Mississippi told us that "more days than not" she cannot assign an officer to every tower. A correctional officer at South Mississippi told us that the week before our inspection, four buildings had no tower supervision. South Mississippi sometimes has one officer "float" between multiple buildings during their shift, leaving the housing units where that officer is not currently floating unsupervised. A single South Mississippi tower officer commonly oversees two dormitories without a dedicated floor officer. As discussed, without floor officers, tower officers must leave their post to do counts or security checks—leaving other housing units the tower officer is responsible for unsupervised. Staff and incarcerated people at Wilkinson told us that towers are often vacant with no one supervising the pod. When towers are vacant, sometimes an officer will float through multiple housing areas, meaning units are not continually supervised. While inspecting Wilkinson, we reviewed logbooks showing times when no one was supervising pods, and we saw a vacant tower.

Tower officers cannot effectively monitor or see into housing units from their posts. During our inspections of South Mississippi dormitories, we observed a significant amount of "tenting," where people use sheets to obscure the view of the tower officer. Tenting can hide assaults, sexual violence, drug use, and suicide attempts. Even without the tents, some dormitories hold more than 100 incarcerated people in multiple lines of bunks, making it difficult to observe everyone from the tower.

At Wilkinson, tower officers have poor vision into the pod common areas. Some tower windows are tinted dark, some have poor line of sight into pods, and many common areas have poor lighting. Officers cannot see inside cells from the tower. Moreover, we saw many cells with poor lighting and cell door windows covered.

Many sexual assaults reported at Wilkinson allegedly occurred inside a cell, often between cellmates. Given Wilkinson's layout, which has celled housing units instead of open-bay dormitories, it is critically important to have officers on the tiers to prevent incidents, intervene, and, at the very least, attest to what happened. Yet, we found that housing units are often understaffed, leaving incarcerated individuals unsupervised and vulnerable. In one incident at Wilkinson, a victim alleged that a sexual assault happened on a Friday night, but he was locked in and could not leave his cell to report it until Sunday morning. We examined four

PREA investigations at Wilkinson in which reviewers found inadequate staffing levels in the area where the assault occurred.

At times, MDOC has incarcerated persons provide supervision. During our facility inspection, Central Mississippi had an incarcerated person working as a “field minister” supervise a small, low-occupancy unit, because there were not enough officers. A tower officer told us that if she has to go in the unit for an emergency, she will designate an incarcerated person as the “hall man” to stand at the door and watch her. Having incarcerated individuals supervise even small units and protect tower officers is not sound correctional practice, as it creates a dangerous power imbalance within the facilities.

The following incidents show the harm from understaffing and poor supervision at these facilities, including death:

- An incarcerated man at Central Mississippi was taken to an outside hospital for multiple stab wounds and contusions. Officers noticed the man going to the medical clinic with people scheduled for breathing treatments. Medical staff advised that he had several puncture wounds and contusions. The incarcerated man said someone assaulted him the day before, and when he tried to tell the tower officer about his injuries, the tower officer ignored him.
- A tower officer trainee at South Mississippi called for assistance for an unresponsive incarcerated person. When help arrived, the man was unconscious in a bloody bed wearing only wet and bloodied underwear. His legs were stiff, and medical staff needed a stretcher to transport him. He went first to the South Mississippi clinic and then to two outside hospitals. Hospital records show he had multiple scrapes, bruises to the head, face, neck, chest and abdomen, bloody urine, head fractures and multiple brain bleeds. Doctors found severe traumatic brain injury, and he died from blunt force head injuries. The CID investigation revealed that someone had assaulted him with a lock in the shower area. The investigation also found substantial evidence that the assault happened 1–2 days before the tower trainee officer noticed him.
- An incarcerated person died at South Mississippi under mysterious circumstances. Although the victim was assigned to B-zone of his housing unit, the CID investigation found evidence that gang members assaulted him in A-zone. Incarcerated persons then carried the unresponsive victim—possibly dead—from A-zone to B-zone inside a mattress cover, as the doors to both zones were open. A case manager was covering the tower at the time, while the trainee tower officer investigated a disturbance in B-zone. The case manager, whose official duties did not include tower supervision, apparently saw multiple people carry something from A-zone to B-zone but did not report it. The trainee officer resigned the next day. When we spoke with the case manager, she told us towers are often unmanned, and she has covered them before.
- In South Mississippi, several gang members attacked another incarcerated person for at least 15–20 minutes. They then moved the severely beaten person to the shower area for

a few hours, and afterwards to a bed where they threw a sheet over him. South Mississippi staff discovered him not because of the tower officer, rounds, or counts, but because other incarcerated persons had called his family, who called the facility. The beaten person's eyes were swollen shut, and an outside hospital determined that he suffered multiple facial fractures, a testicle contusion, and intracranial bleeding. The tower officer stated that she did not know anything about the incident, explaining that "normally the inmates all go behind the sheets that are hanging in the zone and she would not have been able to see anything if it took place behind the sheets."

- An incarcerated person called the Wilkinson central control room to report that people were fighting in a cell. Responding staff approached the cell and found one cellmate covered in blood, swinging a metal shank about 12 inches long from the food port. His cellmate was lying on the floor, also covered in blood. The person with the shank began to cut himself, stating that a gang was going to kill him in retaliation for him killing a gang member. The first responding officer radioed for additional help but got no response. Staff then could not open the jammed cell door, so they had to get another incarcerated person, a maintenance worker, to open it. Both cellmates required transport for outside medical care. The cellmate on the floor suffered multiple puncture wounds to his head and back. The cellmate who cut himself had large lacerations on both sides of his neck, as well as a deep laceration on his wrist. He died of his injuries.

An investigation revealed that the fight began after one cellmate struck the other with a metal bar. The surviving cellmate said it took 45 minutes for staff to arrive. The investigation found that a lot of time passed before gaining access to the cell, and that no staff were assigned to the unit on the night of the incident. The investigation also found that two officers signed false count sheets and did not conduct any rounds to count the people on the unit. The lack of supervision is particularly concerning because less than a month before the incident, Wilkinson's Chief of Security put the decedent on a "high alert list" as someone capable of making weapons.

These incidents show the real harm that results from MDOC continuing to incarcerate hundreds and thousands of people in facilities without meaningful supervision.

5. MDOC fails to investigate serious incidents of harm and dangerous activity.

MDOC does not effectively investigate or address dangerous activity at Central Mississippi, South Mississippi, and Wilkinson. CID has primary responsibility for conducting formal investigations at the three facilities. But CID fails to investigate many reported incidents of harm and misconduct, which include assaults by incarcerated persons on other incarcerated persons, contraband trafficking, gang activity, and other incidents of serious harm. When CID does investigate, it focuses on documenting events and evidence of criminal behavior. CID reports fail to identify or discuss underlying security failures, trends, root causes, or corrective action. Without adequate investigations, MDOC cannot determine why security failures persist or make needed changes. MDOC's failure to investigate repeated patterns of violence and harm at the three facilities shows deliberate indifference to the risk of harm.

MDOC assigns primary responsibility for conducting investigations to CID, which has a central office as well as investigators in the prisons. MDOC policy says CID is to “provide the Commissioner with information pertaining to administrative and/or criminal investigations of employees, offenders or other individuals[.]” CID should document the “how and why” of an incident, “findings and conclusions,” “recommendations for disciplinary actions,” and “[r]esolutions for corrective measures.”

The investigation policy further explains that “any MDOC employee may report an incident” to CID. CID screens complaints for investigation based on criteria including potential criminal charges, policy/procedure violations, and the “seriousness of [the] allegations.” The policy appears to require CID to investigate serious harm and misconduct, as well as misdemeanor type assaults that do not result in serious injuries, and staff policy/procedure violations that could lead to administrative action. An additional investigative policy applies to Wilkinson, as MTC manages day-to-day operations at that facility. MTC conducts its own investigations and issues reports through an entity called the Special Investigative Office. The MTC policy, which covers criminal and administrative investigations, requires investigations in the event of “possession or distribution of major contraband,” “deaths,” “staff misconduct as assigned by the warden” and “incidents determined by the warden to be investigated.” It also requires investigations of incidents “that appear[] to be a violation of an administrative rule or criminal statute.” Investigative reports must, among other things, identify potential operational security issues and “[d]etermin[e] if all policies and procedures were followed immediately before, during and after the incident.” MDOC may also have CID investigate serious incidents at Wilkinson.

There is also a MDOC policy requiring investigations into all allegations of sexual assault, defined as “[t]he physical coercion of any prohibited sexual act as imposed by one offender upon another offender.” MDOC has adopted the PREA policy of “zero tolerance for prison rape and other forms of sexual misconduct.” MDOC conducts its own administrative investigations into sexual assault, referred to as PREA investigations. The agency wide PREA coordinator reports to the CID Director. PREA managers are assigned to cover the MDOC facilities; they report to the agency-wide PREA coordinator and the facility superintendent, and lead PREA investigations. There is also a PREA coordinator at Wilkinson who reports to the Wilkinson Deputy Warden, and there are investigators at Wilkinson who conduct PREA investigations. PREA investigations can include interviewing witnesses, collecting physical evidence, and making findings.

Despite these policies, MDOC fails to investigate many serious incidents of harm and other dangerous activity at Central Mississippi, South Mississippi, and Wilkinson. Investigations that do occur fail to identify underlying causes, security failures, and steps to prevent future harm. PREA investigations at Central Mississippi, South Mississippi, and Wilkinson are poorly executed, with the result that they fail to serve a meaningful role in preventing sexual assault.

a. Incidents of Harm Routinely Go Without Any Investigation

CID fails to investigate many incidents involving assaults, contraband, dangerous gang activity, and other serious harm at the three facilities.

According to documents MDOC and MTC provided, CID formally investigated just seven incidents at Wilkinson from 2019–2022, most of which dealt with staffs’ improper fraternization and conspiracies to introduce contraband. We received only 11 investigative reports from MTC’s Special Investigative Office for the same time period. Given the high number of violent assaults and other serious incidents at Wilkinson, we expected to receive far more completed investigatory reports from this facility. Incident reports we reviewed from November 2020 through June 2022 indicate there were at least 150 assaults potentially meriting investigation, and at least 30 were serious enough that someone involved required outside hospitalization. This represents a gross failure to investigate many serious incidents at Wilkinson. Further, MTC could not find—and apparently never prepared—an investigation report about a 2021 suicide at Wilkinson. MTC reported “no investigation located (investigator out during that incident).”

A CID supervisor told us that while investigations may not always end in a Report of Investigation, there should be some official report documenting it. Yet, we found no written investigative reports—official or unofficial—for many serious incidents of harm and other dangerous activity months or years after the incidents occurred. For instance:

- Two people at Central Mississippi assaulted an incarcerated person at about 3 o’clock in the morning. A trainee officer supervising the zone did not file a report or alert her supervisor of the incident. She made the victim wait to go to the medical clinic until others left for their morning dialysis. The victim’s injuries were so severe that he required treatment at an outside hospital. The supervisor learned about the assault from another incarcerated person and wrote a report about it. But we found no investigation of the trainee officer’s actions.
- Security staff responding to an undescribed emergency “altercation” at Central Mississippi confiscated a load of contraband: 15 shanks, a sock with metal inside, a sock with a softball inside, a cell phone, concrete rock, 3 cash apps, a green dot number, a bag of green leafy substance, and tattoo and gang paraphernalia. The incident report assigned the contraband to individuals, and officers issued them disciplinary write-ups, or Rule Violation Reports. But we found no CID investigation for this contraband discovery or the “altercation” that led to it. There was no attempt to find out where the shanks came from or guidance on preventing this level of contraband from accumulating again.
- A K-9 officer at South Mississippi found that someone had cut the outer perimeter fence. The MDOC report of the incident notes the perimeter fence cutting and, in a handwritten disposition, says that “[u]pon investigation, a hole was found in the wall of Unit C1. The building was shaken down. A large amount of contraband was confiscated.” Another report documents a “random shakedown” in C1 but has no mention of a large amount of

contraband. About a month earlier, officers found two large packages of undescribed contraband wrapped in duct tape between perimeter fences near C1, and a third package outside these fences. Despite this apparent flow of contraband into C1, we found no CID investigation into these incidents. We interviewed the CID director, and he confirmed that CID had no investigations open on these matters.

b. Investigations Do Not Review Systemic Causes or Propose Corrective Action

CID investigations do not review the systemic causes, such as operational failures, that lead to serious incidents. Nor do the investigations recommend steps to prevent serious incidents from happening again. A CID supervisor told us that their investigation reports include corrective actions, but we found no such recommendations in our review. The following are examples of gaps in these reports:

- An incarcerated person stabbed someone at Central Mississippi over a debt. The victim suffered three puncture wounds to his back and one to his neck, and an ambulance took him to an outside hospital. The CID report focuses on the criminal charge against the individual who admitted to the stabbing, with no inquiry into how he got the knife, how he hid the weapon, or the knife's location. Investigators did not interview any staff. There is no inquiry into why staff failed to recover the weapon after the stabbing, and no recommendation for corrective action, even after an informant told investigators that the knife was still on the zone.
- Two cellmates at Central Mississippi got into a violent fight in their cell. Other people in the unit alerted security staff to the altercation by repeatedly beating on the walls and waving out their cell door windows. When two supervisors finally responded, they found one of the cellmates lying on the floor, which was "full of blood." They sent the injured cellmate to an outside hospital. The CID investigation says that the investigator could not interview him because he was on a ventilator. His cellmate said that they got into an argument, and the victim rushed him. In response, he punched the victim multiple times, and continued to punch him until the victim lost consciousness. The assailant claimed that security staff did not respond until an hour to an hour and a half later. The CID report focuses on the potential criminal charges and concludes that the attacker likely committed a criminal aggravated assault. The investigation does not address claims that other incarcerated persons were repeatedly banging on their cell doors to get staff's attention, that security staff responded at least an hour after the fight, or that the cellmates were rival gang members inappropriately housed together.
- Multiple incarcerated individuals attacked a person at South Mississippi, including stopping him from fleeing. The victim suffered multiple stab wounds and a collapsed lung. The CID investigation focused on criminal charges and found sufficient evidence that two incarcerated persons committed aggravated assault. Our review found that times on the reports from the tower officer and responding captain conflict with the surveillance footage, but the CID report does not note any conflict. The CID report does note multiple incarcerated persons involved in the attack had gang affiliations. However,

the report does not mention potential staff security failures, or the potential gang-related nature of the attack, and it makes no recommendations for remedial action.

- An incarcerated person at South Mississippi suffered multiple stab wounds to his arm, back, and head. According to the victim, several incarcerated persons assaulted him after an argument. Two other incarcerated persons assaulted him after he went to the bathroom to clean up, and one person stabbed him. Staff only learned of the assault when the victim came to the tower officer, who then let him out to get medical attention. Another incarcerated person admitted to the assault and handed over a knife that appeared unused. That person later recanted, telling investigators that gang members ordered him to take the blame and gave him the knife. Other gang members forced him to write a confession. The victim identified someone else as the person who stabbed him. Despite the apparent gang activity, false reporting, and security staff's failure to notice two significant fights among multiple incarcerated persons, the investigation report focuses solely on whether to recommend criminal charges for the stabbing. The investigation includes no systemic reviews or recommendations for remedial action.

As with CID investigations, we found that MTC's investigations at Wilkinson also focused on potential crimes. The investigation reports generally recount what happened without identifying security failures (unless corrupt staff was the target for criminal referral), tracking the origin of contraband, or recommending remedial measures to prevent future harm. For example:

- Two incarcerated persons at Wilkinson set fires outside their separate cell doors on J-pod. One person set a fire at 7:02 a.m., the second person set a fire at 7:09 a.m. A captain going through H, J, and K pods noticed "dark black smoke" and heard "[i]nmates yelling" about 13 minutes after the fires began. According to video of the incidents, at 7:33 a.m., the captain looked through the windows of the smoke-filled pod, but did not enter the pod until 7:46 a.m., once equipped with a fire extinguisher and breathing mask. Because of the extensive smoke, people had to be evacuated to the outside recreation cages. MTC wrote investigative reports about the two people who set the fires, focusing on criminal arson charges. Neither report looked at the role of contraband in the fires, or the lack of supervision that allowed the fires to fill the entire pod with smoke before staff noticed.
- During a routine count, staff found a man dead in his cell. The short investigation memorandum recounts medical staff statements and summarizes the pathological examination. Finding no evidence of recent physical injury, but citing the medical examiner's report, the investigation concludes that the person died of methamphetamine and synthetic cannabinoids toxicity. The investigation, however, makes no inquiry into security staff's supervision of the people housed on the pod, even though medical staff said the decedent was "cold to [the] touch" when they arrived, and the man's cellmate—who was not interviewed—said the person had been "laying that way for two hours." The investigation also did not look at apparent drug dealing on the pod, even though before the death, officers locked down the pod because they saw drug-intoxicated

individuals passing out and carrying each other back to their cells, and the death was drug related.

These examples and other investigations we reviewed show that MDOC routinely fails to investigate dangerous contraband and serious incidents of harm. MDOC investigations essentially summarize information without analyzing root causes, systemic failures, or recommending corrective action. At best, the investigative reports refer individuals for criminal prosecution, but CID's poor investigative techniques undermine even those aims. CID regularly drops investigations due to "investigator oversight and mishandling," including lost physical evidence and unsigned witness statements. MDOC's failure to investigate serious incidents contributes to the substantial risk of harm from violence.²⁶

c. MDOC's Sexual Assault Investigations Are Inadequate

At all three facilities, we found materially deficient sexual assault investigations. Without adequately investigating allegations of sexual abuse, MDOC has been unable to determine the factors that allow abuse to occur and the corrective measures needed to address the problem.

The PREA standards require correctional agencies to investigate all allegations of sexual abuse "promptly, thoroughly, and objectively."²⁷ Yet, the PREA investigations we reviewed from Central Mississippi, South Mississippi, and Wilkinson were of exceptionally poor quality. PREA Managers at Central Mississippi and South Mississippi conducted PREA investigations, but they acknowledged having no specialized training in investigation of sexual abuse.²⁸ PREA investigations consistently failed to include interviews of any witnesses other than the complainant and alleged perpetrator. When asked how she substantiates a sexual assault allegation, a CID investigator at South Mississippi told us that all she does is use the lab results from a rape to determine if someone else's semen is in the sample. But, this type of DNA evidence is not available in all instances of sexual assault; therefore, it should not be the only way investigators substantiate an allegation under PREA's preponderance of the evidence

²⁶ See *Farmer v. Brennan*, 511 U.S. 825, 842–43 (1994) (finding that evidence that a risk of attacks by incarcerated persons was "longstanding, pervasive, [or] well-documented" supports a conclusion that prison officials had actual knowledge of the risk).

²⁷ 28 C.F.R. § 115.71(a).

²⁸ The PREA Manager at Central Mississippi said that she can refer PREA cases to CID, and that CID investigators have specialized training in sexual assault investigations. However, she had not referred any PREA case involving incarcerated persons to CID in her one-year tenure as PREA Manager (though she had referred a case where the allegation was that an incarcerated individual assaulted prison staff). A CID investigator at South Mississippi said that she sits in on PREA interviews as a witness and does not usually ask any questions. The Wilkinson PREA Coordinator had no PREA training. She identified an investigator who she said conducts most of the PREA investigations at Wilkinson. That investigator told us she had received online PREA training but did not specify whether that training included training on how to conduct PREA investigations.

standard.²⁹ At Wilkinson, investigators routinely concluded that because an incident occurred inside of a cell there was no way to substantiate it, and they confused “unfounded” claims (determined not to have happened) with “unsubstantiated” claims (unable to make a determination). Overall, we found the investigations to be pro forma, perfunctory, incomplete, and conclusory.

For example:

- A 19-year-old individual incarcerated at Central Mississippi passed a note to the tower officer saying that he had been raped. He said that he remembered his assailant grabbing him and throwing him on his bed, that he had been high on the drug “spice” and blacked out, and that another individual with the job of “floor walker” later told him he had been sexually assaulted. The complainant expressed a strong fear of retaliation and stated that he did not want to go to the hospital or press charges. When later interviewed, the complainant withdrew his allegation, denying he had been sexually assaulted. The Central Mississippi PREA Manager found the complaint unsubstantiated based on the complainant’s retraction and decision not to pursue the matter. She did so without reviewing any video tape, and without interviewing the “floor walker” or any other witnesses. In dropping the matter without further investigation, the PREA Manager risked leaving a dangerous individual free to harm other individuals in a large, open-bay housing dormitory.
- An individual incarcerated at Central Mississippi reported that his cellmate raped him. He was taken to an outside hospital for a sexual assault forensic examination. In a later interview, the individual reportedly stated that he owed money to an incarcerated person in his housing unit and that he had lied about being raped to “get out of his situation.” The PREA Manager then interviewed the alleged perpetrator, who admitted to having sex with the complainant, saying that one time was consensual, and one time was “forced.” Despite this apparent confession, the PREA Manager deemed the complaint “unfounded” and closed it with no further investigation. There is no information about lab results from the sexual assault forensic examination in the investigation file.
- The South Mississippi Superintendent’s administrative assistant received a call from an attorney about an incarcerated individual. The attorney said that the individual had possibly been sexually assaulted but had not reported it for fear of retaliation. The attorney also said that the family was continually receiving calls from a female officer who was extorting them. Interviewed by the PREA Manager, the individual stated that one evening or morning he had been “drug off his bed” to the bathroom, had something black placed over his head, and was assaulted. He said he lost consciousness and woke up on his back in the shower. He said four other incarcerated individuals were responsible, and that he could identify two of them by nickname. He told the PREA

²⁹ 28 C.F.R. § 115.72 (requiring that agencies “impose no standard higher than a preponderance of the evidence in determining whether allegations of sexual abuse or sexual harassment are substantiated”).

Manager that the attackers anally penetrated him with a broomstick. He stated, "I felt embarrassed/ ashamed/ made to be a prison 'bitch' I felt there was nowhere to flee[.]"

The PREA Manager was unable to identify the alleged perpetrators. She closed the case the next day, deeming the claim "Unsubstantiated due to Offender unable to identify suspects." In a single-page report, she concluded that, "After conducting the interview, reviewing the reports and physical evidence and lack of video footage, this incident will be considered Unsubstantiated with no further investigation necessary." The investigation file does not include interviews with anyone other than the alleged victim; there is no evidence that the PREA Manager conferred with officers who worked in the unit; there is no evidence that any medical examination was done; and there is no reference to any follow-up on the allegation that a female officer was extorting the family.

- An individual incarcerated at South Mississippi reported that he suffered a sexual assault while showering. He gave a written statement to the South Mississippi PREA Manager providing the name of the assailant and stating that the individual had pinned him against the shower wall and penetrated him anally by force against his will. The victim further stated that when someone else heard his screams, his assailant punched him, then threw him to the floor. The victim explained that while medical staff were distributing medications in his unit, he tried to report the assault to a nurse, who in turn told him to report it to a captain, who then ordered him to return to his housing unit. He was finally sent to the medical unit after showing a correctional officer the blood leaking from his anus.

The medical provider noted that the victim had "blood in his boxers and on his hands" and sent him to an outside hospital for further evaluation. The medical provider also noted that according to the victim, the same individual had attacked him previously at Parchman. The victim also spoke to a mental health provider at South Mississippi, stating, "I'm going to be honest I'm gay. They think because I'm gay they can do whatever they want with me. I'm bleeding from behind[,] I spoke with the officer, he told me to go clean and they would return me to the building. She says I'm lying because it's canteen week. . . . He partially penetrated me I yelled and run away. . . . They put me in an area where they don't want gays. They extort me, rob me and take my food. They assault me because I am gay. I go through[] the same every time I get moved. I'm scared. If I'm going to be honest, I've been doing drugs because of the things that I'm going through. Help me. Thank you." The report from the outside hospital reflects that the victim had a small tear and blood around his anus. A rectal swab was taken, but there are no results of testing done. Despite these medical findings, which are consistent with the victim's allegations, the South Mississippi PREA Manager closed the investigation five days later and deemed it unsubstantiated. South Mississippi failed to produce any formal PREA report about this incident, and there is no indication investigators reviewed video or considered results from the sexual assault exam, or interviewed anyone aside from the alleged victim.

- An incarcerated individual alleged that his cellmate forced him to participate in oral and anal sex inside their cell at Wilkinson in March 2022. He told us in an interview that it took officers days to respond. According to the investigative report, the individual was removed from the cell five days after the alleged assault, because he had been physically attacked and had visible injuries, including a head wound, black eye, and facial bruising. He later reported that he had been sexually assaulted as well as physically assaulted, explaining that he did not report the sexual aspect of the assault at first because he feared officers would tell other incarcerated individuals. The investigator deemed the sexual assault claim “unfounded due to there is [sic] insufficient information to conduct a meaningful investigation.” However, the investigation failed to gather other potentially available evidence, including statements from individuals in adjacent cells, that might have substantiated the claim. Moreover, if the investigation was closed due to insufficient information, the correct finding should have been “unsubstantiated,” rather than “unfounded.”
- An incarcerated individual made a complaint against his cellmate at Wilkinson. He alleged that his cellmate threatened him with physical violence with a knife and raped him. The complainant claimed to be suicidal, and ultimately cut two lacerations in his forearm. Investigators did not interview any third party witnesses, including housing unit officers and individuals in nearby cells, and there is no evidence that the complainant was sent offsite for a forensic sexual assault examination.

Given the poor quality of PREA investigations, it is unsurprising that PREA investigators are unable to substantiate the vast majority of the PREA allegations inside these facilities.³⁰ MDOC’s failure to adequately investigate allegations of sexual assault contributes to its failure to protect incarcerated individuals from violence.

6. MDOC is deliberately indifferent to the risk of harm to incarcerated persons from MDOC’s failure to provide reasonable safety from violence.

MDOC has a constitutional obligation to “protect prisoners from violence at the hands of other prisoners.”³¹ MDOC is aware of the rampant violence in its facilities and the risk that this

³⁰ The Central Mississippi PREA Manager reported that in 2022 the facility had 62 PREA allegations and did not substantiate any of them. The South Mississippi PREA Manager said that out of 44 PREA allegations in 2021, only one was substantiated. When we met with Wilkinson officials in 2022, they provided documentation related to the 14 total PREA allegations at Wilkinson from January 1, 2022, to May 25, 2022; six were deemed unfounded, four were deemed unsubstantiated, and four were pending.

³¹ *Farmer*, 511 U.S. at 833 (quotations and citations omitted).

violence poses to incarcerated persons,³² yet has implemented partial measures that are not sufficient to reasonably protect people in its custody.

MDOC officials are aware of the harm posed by deficient supervision, contraband controls, and investigations. Indeed, their own documents report consistent violence in these facilities. The MDOC Commissioner has acknowledged that MDOC is “not where it need[s] to be” in terms of running a safe prison system. The Commissioner has also expressed awareness that contraband drugs are entering the facilities via corrupt staff. As recently as April 2023, MDOC publicized the arrest of an officer at Central Mississippi on charges of drug distribution, conspiracy, and introducing contraband into a correctional facility. Staffing analyses conducted in 2020 alerted MDOC that staffing vacancies in its facilities “must be addressed in both line staff and supervisory positions to promote overall stability within the institution.”

MDOC has made some efforts to resolve these issues. MDOC has raised pay for its correctional officers. However, the pay remains below where the MDOC Commissioner has said it needs to be in order to attract staff.³³ MDOC has also taken steps to limit gang control over prisons by moving gang members to other more secure facilities (primarily Walnut Grove Correctional Facility) and out-of-state. But without adequate supervision and staffing, new gang members are likely to emerge in their place.³⁴ MDOC is aware that these reforms have not resulted in a substantially reduced risk of harm. MDOC reported only “slight” increases in staffing despite these efforts, and the violence and contraband levels are still unacceptably high. The MDOC Commissioner took office in May of 2020 pledging change, but nearly all of the incidents of violence in this report occurred during his tenure.³⁵

MDOC has failed to adopt a proven strategy to reduce the violence in its facilities and to protect lives. The failure of MDOC officials to adopt sufficient, large-scale reform to match the needs of the prison system evidences their deliberate indifference.

³² See *id.* at 837 (holding that a prison official who is “aware of facts from which the inference could be drawn that a substantial risk of serious harm exists” and who “draw[s] the inference,” can be liable under the Eighth Amendment’s deliberate indifference standard).

³³ The current salary for a starting correctional officer is \$36,720.55 per year, or \$17.65 hourly. The average salary in Mississippi, which has the lowest average salary in the country, is \$45,180. The MDOC Commissioner noted that MDOC needs to raise starting salaries to \$19.50 an hour to attract officers.

³⁴ MDOC has reported significantly reducing the number of active gang members in its prisons. However, at least some of the reduction in numbers is a result of removing people who were validated gang members due to out-of-date information. This type of reduction in numbers does not suggest an improvement in safety and security inside the prisons.

³⁵ When we spoke with the MDOC Commissioner, he stated that he tracks violence in the facilities, and that his data shows the violence is trending down. We asked to be supplied with the data that he relied on, but over a year later, we have not received it.

B. MDOC Places Incarcerated Persons in Prolonged Restrictive Housing Despite the Substantial Risk of Serious Physical and Psychological Harm

MDOC holds hundreds of people in unsupervised, unsanitary, and dangerous restrictive housing³⁶ cells at Central Mississippi and Wilkinson for prolonged periods of time, without adequate access to meaningful programming or opportunities to exercise.³⁷ Indeed, some of the most egregious acts of violence and self-harm at these prisons occur in restrictive housing, where individuals are locked down in single-bed or double-bed cells, nearly 24 hours a day, without adequate supervision. Yet, despite the known risk of serious physical and mental harm, MDOC continues to engage in restrictive housing practices that violate the constitutional rights of persons incarcerated at Central Mississippi and Wilkinson. This includes a practice of holding people with known serious mental illness in unsafe conditions in restrictive housing.

The Eighth Amendment “proscribes more than physically barbarous punishments.”³⁸ It prohibits prison officials from being deliberately indifferent to conditions of confinement that pose “an excessive risk to inmate health or safety.”³⁹ Conditions may violate the Eighth Amendment “in combination,” even if each may not do so alone, “when they have a mutually enforcing effect that produces the deprivation of a single, identifiable human need”⁴⁰ Basic human needs include the need for food, warmth, safety, sanitation, exercise, human contact, and sensory stimulation.⁴¹

³⁶ For the purposes of this Findings Report, “restrictive housing” refers to any housing condition that involves removal from the general incarcerated population and placement in a locked room or cell, whether alone or with another incarcerated person, for the vast majority of the day, typically 22 hours or more. See U.S. Dep’t of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing Final Report 3* (2016), <https://www.justice.gov/archives/dag/file/815551/download>.

³⁷ South Mississippi primarily uses open, dormitory-style units, and not restrictive housing.

³⁸ *Estelle v. Gamble*, 429 U.S. 97, 102 (1976).

³⁹ *Farmer v. Brennan*, 511 U.S. 825, 837 (1994).

⁴⁰ *Wilson v. Seiter*, 501 U.S. 294, 304 (1991); see also *Gates v. Cook*, 376 F.3d 323, 333 (5th Cir. 2004).

⁴¹ See *Wilson*, 501 U.S. at 304 (food, warmth, exercise); *Gates*, 376 F.3d at 333–35 (finding conditions of excessive heat, poor sanitation, and inadequate lighting together created unconstitutional conditions in MDOC’s Death Row); see also *Brooks v. Warden*, 800 F.3d 1295, 1304 (11th Cir. 2015) (citing cases) (“[E]very sister circuit (except the Federal Circuit) has recognized that the deprivation of basic sanitary conditions can constitute an Eighth Amendment violation.”); *French v. Owens*, 777 F.2d 1250, 1255 (7th Cir. 1985) (“Lack of exercise may certainly rise to a constitutional violation. Where movement is denied and muscles are allowed to atrophy, the health of the individual is threatened and the state’s constitutional obligation is compromised.”); *Harvard v. Inch*, 411 F.Supp.3d 1220, 1239 (N.D. Fla. 2019) (citing cases) (“Courts have recognized exercise, social interaction, and environmental stimulation as basic human needs subject to deprivation.”); *G.H. ex rel. Henry v. Marstiller*, 424 F.Supp.3d 1109, 1117 (N.D. Fla. 2019) (“While some of these allegations in isolation may not result in violation of the Eighth Amendment, Plaintiffs have alleged sufficient facts to show that conditions of confinement, in combination, have a mutually enforcing effect that produces the deprivation of a single identifiable human need such as human contact,

Although solitary confinement, or restrictive housing, is “not *per se* cruel and unusual [under the Eighth Amendment], there are constitutional boundaries to its use.”⁴² Restrictive housing that poses an excessive risk of harm to the well-being of incarcerated individuals by depriving them of basic human needs is not permitted by the Eighth Amendment.⁴³ To meet this threshold, the conditions of confinement, either alone or in combination, must constitute an “unquestioned and serious deprivation” of basic human needs.⁴⁴ In assessing the constitutionality of restrictive housing, courts have considered various factors including unsafe or unsanitary living conditions, denial of physical exercise, lack of sensory or environmental stimulation, and duration.⁴⁵ For example, courts have found restrictive housing that significantly deprives a person of outdoor exercise violative of the Eighth Amendment.⁴⁶ Courts will consider cell size, time spent inside the cell each day, the overall duration of time spent in confinement,

environmental stimulation, recreation, and sanitation.” (quoting *Harvard*, 411 F. Supp. 3d at 1239–40) (internal quotation marks omitted)); *Piscitello v. Berge*, No. 02-C-0252-C, 2002 WL 32349400, at *3 (W.D. Wisc. June 13, 2002) (reviewing conditions in restrictive housing (24-hour cell confinement, constant illumination, lack of cell windows, limited use of the telephone, visits by video screen only, insufficient recreational time, and inadequately maintained facilities) and concluding that “[i]t is possible to draw the inference that these conditions have a mutually enforcing effect that produces the deprivation of a separate identifiable human need, such as the need for human contact and sensory stimulation”); *Horton v. Thompson*, No. 02-C-0470-C, 2002 WL 32345677, at *8 (W.D. Wisc. Sept. 23, 2002) (allowing plaintiff to proceed with claims that the combination of conditions in restrictive housing, including a windowless cell, no contact with other incarcerated persons, limited exercise and telephone, no-contact video visits, and lack of any meaningful programming “have a mutually enforcing effect that produces the deprivation of a separate identifiable human need, such as the need for human contact and sensory stimulation”).

⁴² *Gates v. Collier*, 501 F.2d 1291, 1304 (5th Cir. 1974) (emphasis added); see also *Hutto v. Finney*, 437 U.S. 678, 686 (1978) (noting that “length of confinement cannot be ignored” in assessing prison conditions).

⁴³ *Dockery v. Cain*, 7 F.4th 375, 378 (5th Cir. 2021); see also *Hope v. Harris*, 861 F. App’x 571, 582–83 (5th Cir. 2021).

⁴⁴ *Id.* at 582 (quoting *Rhodes v. Chapman*, 452 U.S. 337, 347–48 (1981)).

⁴⁵ See *Gates*, 376 F.3d at 343 (recognizing “evidence that the isolation and idleness of Death Row combined with the squalor, poor hygiene, temperature, and noise of extremely psychotic prisoners create[ed] an environment ‘toxic’ to the prisoners’ mental health”); *Collier*, 501 F.2d at 1305 (concluding that placement of incarcerated persons under solitary confinement conditions in Parchman’s dark holes without any hygienic materials, clothing, bedding, adequate food or heat, showers or cleaning materials, for longer than twenty-four hours continuously, violated the Eighth Amendment); *Hope*, 861 F. App’x at 583–84 (concluding that plaintiff, by alleging prolonged placement in solitary confinement “in sometimes unsanitary conditions, including urine, feces, and mold on the walls, floor, and showers, insufficient cleaning supplies” sufficiently pleaded objective prong of his Eighth Amendment claim).

⁴⁶ *Hewitt v. Henderson*, 271 F. App’x 426, 428 (5th Cir. 2008) (“This court has held that deprivation of exercise may constitute an impairment of health, which is actionable under the Eighth Amendment, and that the absence of outdoor exercise opportunities may constitute an Eighth Amendment violation. . . . This court has suggested that deprivation of exercise claims should be evaluated on a case-by-case basis using, inter alia, the following criteria: (1) the size of the inmate’s cell; (2) the amount of time the inmate spends locked in his cell each day; and (3) the overall duration of the inmate’s confinement. (internal citations omitted)); see also, *Spain v. Procunier*, 600 F.2d 189, 199 (9th Cir. 1979).

and other conditions, such as living conditions (including window access, noise-levels, safety, and sanitation of the environment), access to programming and exercise alternatives, and opportunities for meaningful human contact, when determining whether an Eighth Amendment violation exists.⁴⁷ Furthermore, subjecting persons with serious mental illness to prolonged periods in restrictive housing under inadequate conditions and without appropriate services exposes them to a substantial risk of serious harm in violation of the Constitution.⁴⁸

1. The cumulative effects of harsh restrictive housing conditions at Central Mississippi and Wilkinson deprive incarcerated persons of basic human needs.

At both Central Mississippi and Wilkinson, people in restrictive housing are confined to cells that are cramped, dark, smokey, dilapidated, and dirtied with trash and other contraband that can be used for self-harm. Some cells were burned on the inside from in-cell fires, and many cells had no visible line of site into the cell from the outside for proper monitoring and supervision of incarcerated persons by security staff. The housing units themselves are loud and chaotic, and plagued with violence, including stabbings and suicides. Incarcerated persons in restrictive housing at these facilities are without meaningful access to the outdoors or recreation and have little to no structured programming for 23 to 24 hours a day. Staffing shortages result in inadequate supervision of the restrictive housing units, leading to unchecked violence between cellmates and a lack of response from staff during emergencies. These conditions deprive incarcerated individuals of their basic human needs and pose a substantial risk of serious harm.

a. Restrictive Housing Conditions at Central Mississippi

Restrictive housing at Central Mississippi is dangerous and fails to provide incarcerated persons with basic services such as safe and sanitary housing units, consistent access to exercise and recreation, productive programming, and meaningful human contact. Central Mississippi has three sections of its Reception and Classification building (R&C) that are restrictive housing units for men and a Maximum-Security Unit (MSU), which is exclusively restrictive housing for women.

One section of R&C restrictive housing is for individuals classified as close custody. Individuals in the close custody unit are double-celled, meaning there are two individuals assigned to each cell. They receive one hour out of cell per day, five days a week, inside the unit dayroom. To allow access to the dayroom, officers open three cells at a time for the out-of-cell period, meaning that a maximum of six people may use the dayroom at any one time. This same hour is also the only time that individuals are allowed to shower and make phone calls. People

⁴⁷ *Hewitt*, 271 F. App'x at 428.

⁴⁸ See *Palakovic v. Wetzel*, 854 F.3d 209, 216–17, 226, 230 (3d Cir. 2017) (holding that a person with serious mental illness who was held in a 100-square-foot restrictive housing cell 23 hours during the week and 24 hours during the weekend for “multiple 30-day stints,” and who received only mental health interviews through his cell door slot stated a plausible Eighth Amendment claim “in light of the increasingly obvious reality that extended stays in solitary confinement can cause serious damage to mental health”).

in close custody do not have access to any of the general population outdoor recreation areas for exercise. There is a small yard, which staff refer to as a “quasi-yard,” that individuals in close custody report accessing every other week for about 30 minutes. There is no recreation equipment in the quasi-yard.

The other two sections are called “Restrictive Housing” and “High Risk and Long-Term Security.”⁴⁹ Individuals in these two sections are single-celled, meaning there is only one person assigned to the cell. Both sections operate at a similar level of restriction and are characterized by social isolation. People are locked in their cells for 23 hours a day, with no more than one hour out of cell for recreation, five days a week. When recreation occurs, it takes place outdoors in recreation cages similar to dog runs. There is no recreation on weekends, meaning people spend well over 48 hours inside the four walls of their cell. A Central Mississippi warden acknowledged that while individuals in restrictive housing are supposed to receive an hour outside their cell each day, even that one hour can be restricted when there is short staffing.

Many people in these two sections at R&C are waiting for a determination that they are eligible for protective custody due to threats posed by other incarcerated individuals. For example, one incident report described that when an individual refused to kill someone at the direction of a gang, members from two separate gangs threatened his life. The individual said that Parchman CID was aware of the situation and sent him to Central Mississippi because of it. At Central Mississippi, officers placed him in restrictive housing in R&C “pending protective custody.” Thus, the individual was subjected to restrictive housing only because of MDOC’s inability to otherwise protect him from gang violence.

All the R&C restrictive housing cells have solid steel doors with a narrow window looking into the unit. The door windows are difficult to see out of, as they have a double layer of wire mesh in them. Showers are limited to no more than three times a week, and phone calls are available just twice a week. One person we spoke with in R&C’s restrictive housing described it as “a psych ward” and said of the other men in his unit: “All they do is beat, bang, and cry.” Another man said simply, “It’s chaos.”

Conditions are no better in the MSU. The environment there is loud, chaotic, and in summer months, stiflingly hot. The MSU can house up to 74 people, divided among three zones. At the time of our tour, one zone housed a woman on death row and others on psychiatric observation. A second zone was reserved for women in administrative segregation, including those waiting for protective custody, and close custody overflow. The third zone was for women classified as close custody. Women in the MSU close custody unit are double-celled in cramped quarters. One woman demonstrated that she could walk the length of her two-person cell in five

⁴⁹ MDOC uses restrictive housing referred to as “long-term security” or “long-term segregation” to refer to the “[s]eparation of an offender from the general population which requires transfer to a designated unit for long-term segregation (more than sixty (60) days).” Criteria for assignment to long-term segregation include aggressive and violent behavior, possession of major contraband, major gang activity, and escape. Policy requires that people in long-term segregation are reviewed for release every 90 days, and they must have no disciplinary violations for the previous six months to be released.

steps, and across it in six. Like the R&C cells, the MSU cells have solid steel doors with a food slot and narrow window. Recreation occurs in outdoor recreation cages. During our inspection, one woman asked us, “Why we got to be in cages like dogs?” Many women reported that officers do not regularly offer outdoor recreation. Dayroom access is limited to one hour per day, five days a week, and showers are limited to three days a week. Access to the phone is available for 20 minutes at a time only on the weekends, when staff is able to bring the portable phone directly to the cell door slot. During the weekend, the MSU is on total lockdown for 48 hours straight.



A woman’s only access to make a phone call from the restrictive housing unit in the MSU is when staff bring the phone to her cell side.

Several characteristics of restrictive housing are the same across units at Central Mississippi. Each unit has a single television that one can only watch from behind their cell door. MDOC offers no classes or programs to people in restrictive housing. There is essentially nothing productive for people in these units to do. One individual, who has a serious mental illness and survived multiple violent attacks, was in restrictive housing at Central Mississippi waiting for protective custody. He told us that he cannot read due to failing eyesight and is too scared to go outside to the recreation cages, so all day he does nothing but pace the inside of his cell.

Restrictive housing units at Central Mississippi are also dangerous. People double-celled in restrictive housing have been stabbed and assaulted by cell mates. Women reported setting fires inside their cells in the MSU in order to get staff attention to basic needs. Call buttons inside the cells do not work. In order to get officers' attention—even in emergencies—people have to stick pieces of paper out of their cell or beat on the cell door and hope that they are heard.

b. Restrictive Housing Conditions at Wilkinson

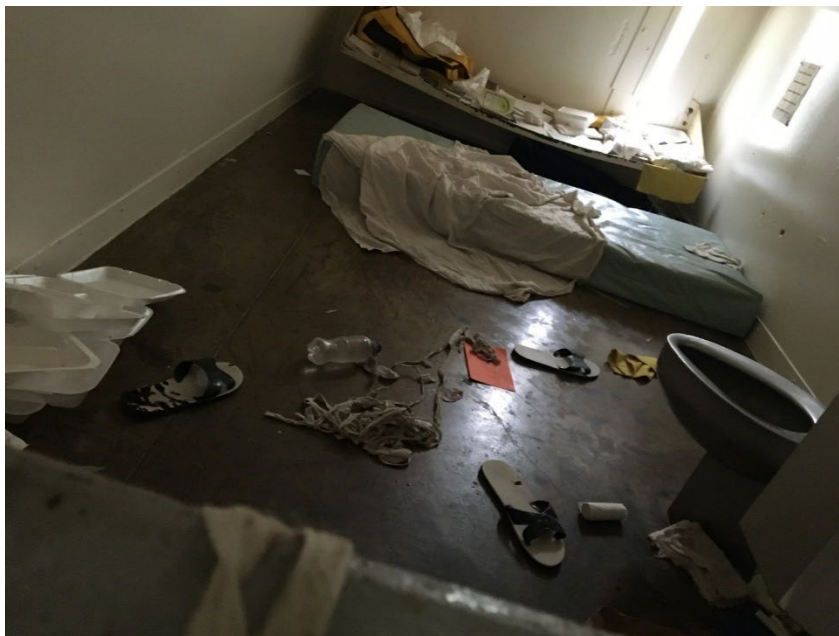
Restrictive Housing at Wilkinson is unconstitutional because incarcerated persons are subjected to prolonged periods of confinement in small cells, without opportunities for meaningful movement outside of their cell. In combination with chronic understaffing that allows for violence and chaos to flourish unchecked inside of these housing units, living conditions that undermine the physical and psychological health of those subjected to them, and virtually no meaningful human contact or programming to speak of, restrictive housing at Wilkinson serves to seriously deprive incarcerated persons of their basic needs for safety, mental stimulation, and physical exercise.

Most of the individuals incarcerated at Wilkinson are classified as maximum security or close custody confinement. Wilkinson is largely run as a lockdown facility, meaning that nearly 85% of the population is locked down in their cells for 23 to 24 hours a day. All housing is designed as single-bed or double-bed cells. The vast majority of individuals incarcerated at Wilkinson are in some form of restrictive housing.

During our onsite inspection of Wilkinson, we observed that cells in restrictive housing units were dark, smokey, unsanitary, and in dilapidated condition. Some cells had been burned to the point where there was no visibility through the cell window. Other cells had no exterior windows or were not lit at all. There were cells defaced with graffiti, littered with old food containers, torn mattresses, and rope crafted from bedsheets. Some incarcerated persons lacked basic amenities, such as clothes, mattresses, blankets, and light. Records corroborate these poor cell conditions. Audits of Wilkinson cite evidence of previous flooding, holes in the walls and ceiling, and a significant need for timely repair and painting.



A cell door that had been burned from a fire inside the cell. The damage to the door made it so there was no visibility into the occupied housing cell.



A restrictive housing cell at Wilkinson. The long, narrow window depicted at the upper right of the photo provides the only source of natural light inside the cell.

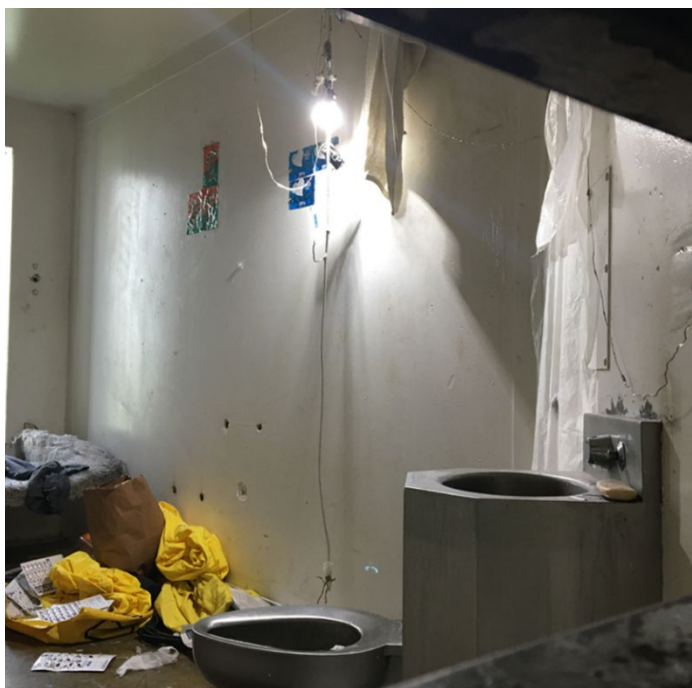


Another restrictive housing cell at Wilkinson. This photograph depicts a mattress stripped and torn apart on the floor, with scattered items around the floor and bedframe, including a prescription pill bottle.

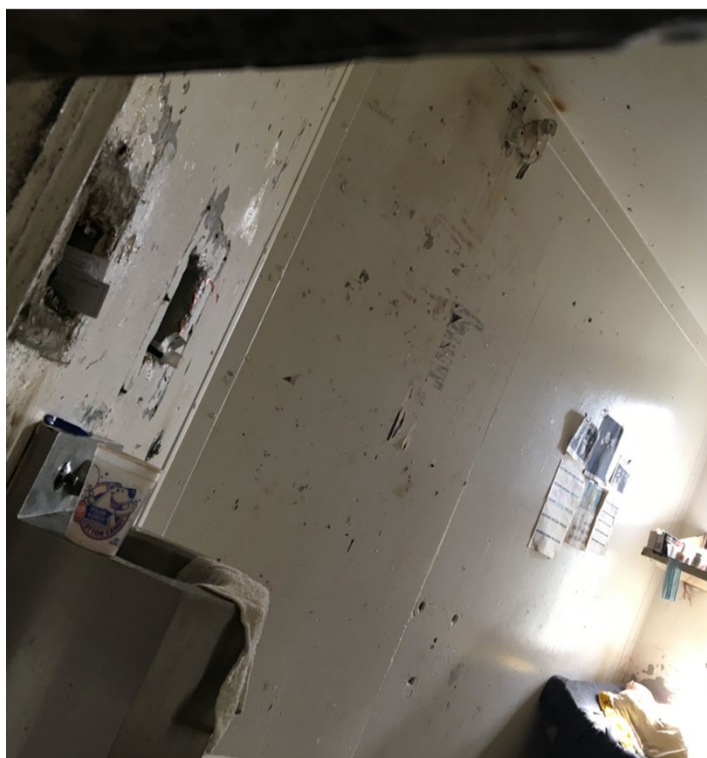


There were several old food containers, open food wrappers, rope, debris, and other items scattered about this occupied restrictive housing cell.⁵⁰

⁵⁰ For privacy reasons, the person residing inside of this cell is not depicted here. However, this individual was captured laying on a bare mattress, with the mattress material exposed, without a sheet.



A light fixture was taken apart and wires protruded from the lightbulb inside of this restrictive housing cell.



Holes in the wall of this restrictive housing cell were so large that the occupant used them as shelves for their belongings.

Recreation, privileges, and programming vary slightly across housing units at Wilkinson, but they are generally minimal and highly restricted. Those classified as long-term segregation receive any limited programming from inside their cells and are allowed recreation only once per week for five to six hours. Recreation takes place in outdoor cages roughly the size of two parking spaces. While there were basketballs inside the recreation cages when we toured, we learned that typically there is no recreation equipment inside the cages, and the only thing people do is stand or walk around the inside of the cage.

Individuals classified as maximum security or close custody are also in restrictive housing conditions, although double-celled. They have even less access to the outdoors compared to those in long-term segregation, as these individuals are only allowed out of their cells and into an enclosed dayroom (Monday through Friday, for one hour each day) and for recreation inside an enclosed gymnasium (one day per week). Individuals classified as protective custody are allowed out of their cells for about one to one and a half hours per day, five days a week. No out-of-cell time is allowed on weekends in any of the restrictive housing units, meaning individuals are confined to their cells for 48 hours straight.

Privileges are very limited in restrictive housing; one man described how he had no canteen for a year and a half, and that he lost sixty pounds as a result. Despite slight variations in privileges, the vast majority of individuals housed at Wilkinson receive minimal time to shower or make phone calls and mostly sit idly by with little to no programming or meaningful human contact throughout the week.

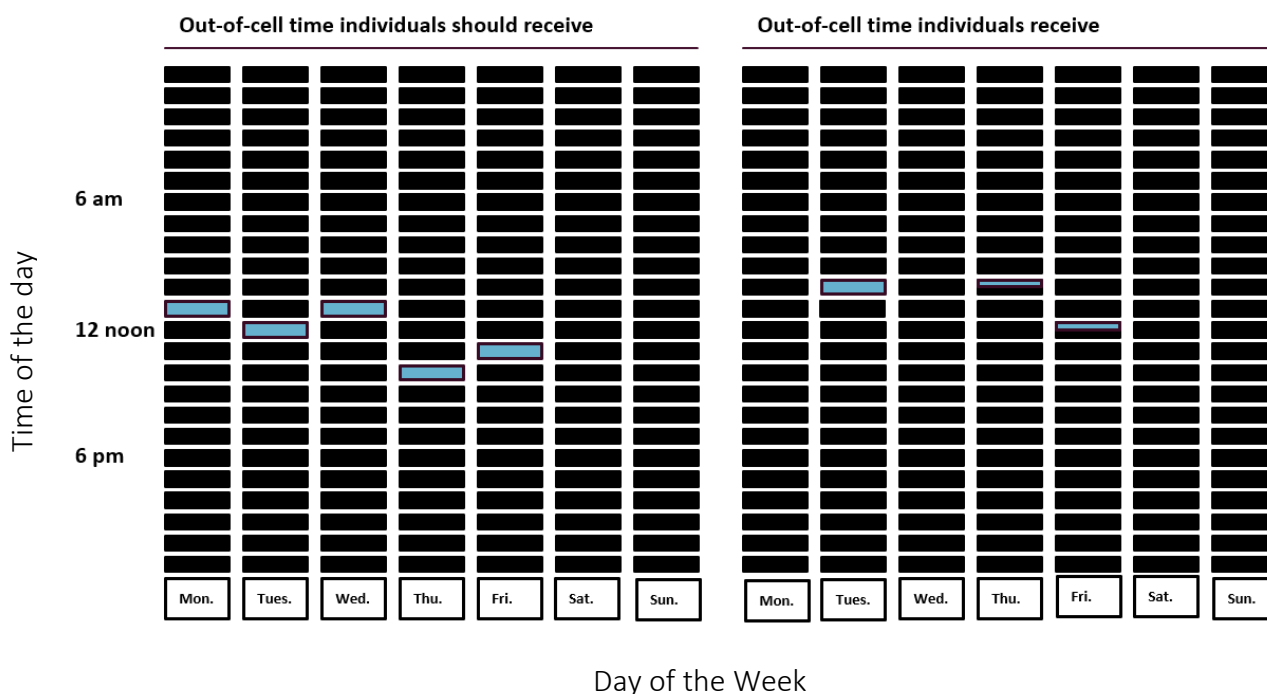
Actual out-of-cell time was reported to be even less than the minimal allowance. Per MDOC policy, people in restrictive housing should receive at least one hour of exercise per day, five days a week. However, “[e]xercise can be cancelled if security, safety or weather dictates otherwise.” Interviews of both staff and incarcerated persons at Wilkinson reflect that this exception is actually the normal practice.

Wilkinson’s own documentation also shows that people receive a fraction of the out-of-cell time required by policy. Wilkinson shared individual activity logs that make a daily and weekly record of all activities for each person in restrictive housing. We reviewed a sample of 534 activity logs representing 2,541 days in restrictive housing, covering the period from December 27, 2021, to July 14, 2022. The logs reflect that people in restrictive housing did not regularly receive out-of-cell recreation, often without explanation. Most days we reviewed (86%) did not show any out-of-cell recreation.⁵¹ Looking solely at weekdays, when recreation

⁵¹ MTC’s documentation indicated that individuals in restrictive housing “refused” to engage in recreation 20% of the time. Our interviews with incarcerated persons question this documentation, but even accounting for alleged refusals, MTC documentation confirms that recreation is not available in restrictive housing at least 66% of the time. As discussed below, prior audits of Wilkinson’s restrictive housing data noted inaccuracies.

should be offered at least one hour per day, still only 19% of the days we reviewed showed any recreation. For 80% of the 1,834 weekdays we reviewed, there was no recreation.

We also found that the average person in restrictive housing at Wilkinson spends a total of 1 hour and 50 minutes out-of-cell per week, compared to the 5-hour minimum requirement per policy. The visual below compares the minimum out-of-cell time that people in restrictive housing should receive by MDOC policy, as compared to the actual average time people in restrictive housing spend out of cell. For purposes of this visual, we include recreation and shower as out-of-cell activity.



This data confirms that the average person in restrictive housing at Wilkinson is extremely isolated. Indeed, we reviewed activity logs for two individuals who spent at least 91 consecutive days in restrictive housing at Wilkinson. One of these individuals participated in out-of-cell recreation 12 times; the other person went to recreation 5–6 times. While their records also reflect multiple refusals, their reasons for refusing are not mentioned. It is also likely that both men spent more time in restrictive housing that was not included in the sample of activity logs that we reviewed.

Wilkinson has a history of failing to provide recreation to people in restrictive housing. A 2018 internal audit reviewed individual activity logs for three long-term segregation units and found that the logs indicated people were offered recreation and showers, although not as often as required. However, when auditors reviewed video surveillance, they found that none of the recreation reflected in the logs actually occurred, except for one time when officers left people in recreation cages for seven hours while they searched the unit for contraband. The auditors

determined that men in two of the units had not been offered any recreation for at least 60 days, and that men in the third unit had received only one day of recreation during the search. The auditors also found that people in these units were not receiving the three showers per week that policy requires. Auditors further found it likely that people in other units at Wilkinson had not had access to the gymnasium or outdoor yard for several months.

The gross understaffing at Wilkinson, as described in Section IV.A.4 above, contributes to both the overuse of restrictive housing and to violent, in-cell attacks between incarcerated persons. Because there is not enough staff to provide adequate supervision, prison officials at Wilkinson frequently resort to facility-wide lockdowns in an attempt to exert order and control. With little to no opportunity for programming or recreation, facility lockdowns can pressurize tensions between cellmates and result in violence. The lack of staff supervision also means that staff cannot readily intervene to protect people from attacks when they occur. As one example of the kind of violence that happens in restrictive housing at Wilkinson, an incarcerated person stabbed his cellmate multiple times with a nine-inch knife that was clearly store bought, and not a “shank” or weapon made from other materials inside of the facility. At the time of the attack, the assailant had been in restrictive housing for over 1,700 days. In another example, an incarcerated person in restrictive housing used a shank to overpower a correctional officer who was escorting him from the shower and obtained the officer’s door keys. The incarcerated person then proceeded to open the shower doors of two other incarcerated persons and together the three of them stabbed and beat a fourth incarcerated person so severely he required air evacuation to the hospital. In a third example, an incarcerated person suffered noticeable burns to his face from hot liquid thrown on him from another incarcerated person in restrictive housing.

Individuals in restrictive housing at Wilkinson use extreme behaviors to get staff attention and emergency help. Beyond persistent shouting and banging on cell doors, this extreme behavior includes setting fires, flooding cells, and acts of self-harm. Wilkinson staff then penalize these behaviors with disciplinary charges, meaning that the people who struggle the most with the conditions in restrictive housing are likely to have the hardest time getting out of restrictive housing.

For example:

- An incarcerated individual in close custody cut himself with a razor, set fire to his clothing, and flooded his cell. When staff ordered him to turn over the razor and submit to restraints for transfer to medical, he refused and became combative. Staff used OC spray to gain compliance, but he continued to resist and attempted to swallow the razor. After a second use of OC spray, staff were able to restrain him and take him to medical for evaluation. According to the medical progress note from the incident, the individual self-harmed in order to get out of fights in his housing unit. He received disciplinary infractions for self-harming, threatening to swallow the razor, setting the fire, destroying state issued property, refusing to obey an order by not turning over the razor blade, and refusing to obey an order by refusing to be restrained—all of which likely lengthened his stay in restrictive housing.

- An incarcerated person self-harmed by cutting while in restrictive housing. He told staff that he did this because he was not getting along with his cellmate. He was treated for cuts to his wrists, placed on suicide watch, and given a disciplinary charge for self-mutilation.
- Staff observed an incarcerated individual smearing blood on his cell window in a restrictive housing unit. When staff attempted to unlock the man’s cell door, it would not open because it had been jammed with batteries and other objects. Once staff were able to open the door and restrain him for escort to medical, his cellmate began cutting his own arm to get out of the cell, as well. Both cellmates were removed from their cell and put on suicide watch.

Taken together, the conditions at Central Mississippi and Wilkinson are extreme, deprive incarcerated individuals of basic human needs for safety, sanitation, exercise, social interaction, and sensory or environmental stimulation, and pose a substantial risk of serious harm.

2. Incarcerated persons are held in harsh restrictive housing conditions for prolonged periods of time.

“[T]he length of confinement cannot be ignored in deciding whether the confinement meets constitutional standards.”⁵² Many people at Central Mississippi and Wilkinson endure the conditions described for consecutive months or years. People in close custody are generally in restrictive housing at least six months, as they must be discipline-free for six months before moving to medium custody. The same is true for people in long-term segregation.

Of the restrictive housing assignments made at Central Mississippi between January 1, 2018, and October 26, 2021, we found that nearly two dozen people spent more than a year in restrictive housing. This includes some people who were in restrictive housing for terms ranging from 500 to more than 1000 days. For people at Central Mississippi classified to long-term segregation, we reviewed data showing that on average people there spent nearly two years in restrictive housing.

Wilkinson operates largely as a lockdown facility, with a majority of the population experiencing restrictive housing under one of MDOC’s segregation statuses. Indeed, over the last several years, Wilkinson’s restrictive housing population has grown. As of May 2022, over

⁵² *Hutto v. Finney*, 437 U.S. 678, 686 (1978).

80% of Wilkinson’s population was in some form of restrictive housing. This reflects a 12-percentage point increase from November 2021.

With respect to duration, records show that nearly 15% of Wilkinson’s total population had been held in restrictive housing for over a year. Of the people identified as long-term segregation at Wilkinson, 78% had been in restrictive housing for more than one year, and over 25% had been in restrictive housing for more than four years. The average duration in long-term segregation among this group was nearly three years.

3. MDOC is deliberately indifferent to the significant physical and psychological harm that people in restrictive housing experience.

Prison officials violate the Eighth Amendment when they exhibit deliberate indifference to conditions that pose a significant risk of serious harm to incarcerated persons.⁵³ Evidence of prison officials’ subjective knowledge necessary to prove deliberate indifference includes “inference from circumstantial evidence, and a factfinder may conclude that a prison official knew of a substantial risk from the very fact that the risk was obvious.”⁵⁴

Increasingly, courts have recognized the growing body of medical and scientific research that confirms the harms caused by prolonged isolation—harms the Supreme Court first identified over a century ago: “A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide[.]”⁵⁵ In recent years, advancements in research have provided further evidence of the risk of physical and mental harm from restrictive housing.⁵⁶ People exposed to prolonged isolation in restrictive housing experience psychological symptoms including increased anxiety, depression, anger, insomnia, paranoia, post-traumatic

⁵³ *Gates v. Cook*, 376 F.3d at 333.

⁵⁴ *Id.*

⁵⁵ *In re Medley*, 134 U.S. 160, 168 (1890). See also *Davis v. Ayala*, 576 U.S. 257, 289 (2015) (Kennedy, J., concurring) (internal quotation marks omitted) (citing a number of recent scientific studies by penology and psychology experts, concluding that the “research still confirms what this Court suggested over a century ago: Years on end of near-total isolation exact a terrible price”); *Porter v. Clarke*, 923 F.3d 348, 355 (4th Cir. 2019) (“In recent years, advances in our understanding of psychology and new empirical methods have allowed researchers to characterize and quantify the nature and severity of the adverse psychological effects attributable to prolonged placement of inmates in isolated conditions materially indistinguishable from the challenged conditions on Virginia’s death row.”); *Williams v. Sec’y Penn. Dep’t of Corr.*, 848 F.3d 549, 566–67, 569 (3d Cir. 2017) (internal quotation marks omitted) (citing studies and noting the “scientific consensus” that restrictive housing is “psychologically painful, can be traumatic and harmful, and puts many of those who have been subjected to it at risk of long-term . . . damage”).

⁵⁶ See *Grissom v. Roberts*, 902 F.3d 1162, 1177 (10th Cir. 2018) (Lucero, J., concurring) (“Given our society’s present understanding that prolonged solitary confinement inflicts progressive brain injury, we cannot consider such prolonged, unjustified confinement as anything other than extreme and atypical.”).

stress disorder, psychosis, and self-harm.⁵⁷ They suffer physical harms including lethargy, weight loss, insomnia, gastrointestinal and cardiovascular problems.⁵⁸ Research also suggests that prolonged isolation causes neurological changes that results in symptoms including disrupted circadian rhythms and sleep, altered mood, and depression.⁵⁹ Numerous studies confirm increased mortality rates among people who experienced restrictive housing, even after their release from incarceration.⁶⁰

“[T]he extensive scholarly literature describing and quantifying the adverse mental health effects of prolonged solitary confinement that has emerged in recent years provides circumstantial evidence that the risk of such harm ‘was so obvious that it had to have been known.’”⁶¹ Additionally, as courts and recent studies have established, incidents of suicide and self-harm are evidence of the harms caused by restrictive housing. We found that people who live in harsh restrictive housing conditions at Central Mississippi and Wilkinson experience significant physical and psychological harm, as indicated by numerous incidents of apparent psychological deterioration, self-injury, suicides and attempted suicides, and violence.

All five of the completed suicides at Central Mississippi and Wilkinson since 2019 have occurred in restrictive housing. Both men who died at Central Mississippi had serious mental illnesses that made confining them to restrictive housing particularly dangerous.

- A 24-year-old incarcerated individual was found in his restrictive housing cell unresponsive, with a white sheet around his neck. The Postmortem report indicated the cause of death was hanging, and the manner of death was suicide. Five days before his

⁵⁷ See *Porter*, 923 F.3d at 356 (internal quotation marks and alterations omitted) (citing “[n]umerous studies” and recognizing expert evidence “that the associated adverse psychological reactions to solitary confinement detailed in th[e] literature include psychotic-spectrum symptoms of paranoia and hallucinations; mood-spectrum symptoms of depression, withdrawal, appetite and sleep disturbance, fatigue and lethargy, and suicidal ideation; anxiety spectrum symptoms of subjective distress, feelings of impending doom, somatic complaints, dissociative experience, and ruminative thoughts; affective lability characterized by irritability, rage, and aggressive impulses; and behavioral self-control symptoms of aggression, assaults, and self-mutilation”).

⁵⁸ See *id.*; see also *Palakovic v. Wetzel*, 854 F.3d 209, 226 (3d Cir. 2017) (“And the damage does not stop at mental harm: Physical harm can also result.”); Brie A. Williams, et al., *The Cardiovascular Health Burdens of Solitary Confinement*, 34 J. of Gen. Internal Med. 1977 (2019), https://link.springer.com/article/10.1007/s11606-019-05103-6?utm_source=getftr&utm_medium=getftr&utm_campaign=getftr_pilot [https://perma.cc/NN4A-L63K].

⁵⁹ Huda Akil, *The Brain in Isolation: A Neuroscientist’s Perspective on Solitary Confinement in SOLITARY CONFINEMENT: EFFECTS, PRACTICES, AND PATHWAYS TOWARD REFORM* 199, 209–10 (Jules Lobel & Peter Scharff Smith eds. 2019).

⁶⁰ See, e.g., Andrea Fenster, *Briefing: New data: Solitary Confinement Increases Risk of Premature Death After Release*, PRISON POLICY INITIATIVE (Oct. 13, 2020), https://www.prisonpolicy.org/blog/2020/10/13/solitary_mortality_risk/ [https://perma.cc/53SS-JJA3].

⁶¹ *Porter*, 923 F.3d at 361 (quoting *Makdessi v. Fields*, 789 F.3d 126, 136 (4th Cir. 2015)).

death, the decedent was taken off psychiatric observation and temporarily placed in Reception and Classification (R&C) restrictive housing “due to MDOC delays.” This individual was diagnosed with unspecified schizophrenia spectrum disorder, other hallucinogen use disorder, unknown substance use disorder, induced psychotic disorder, cannabis use disorder, and stimulant use disorder (methamphetamine type substance).

- A 31-year-old incarcerated individual died by suicide after being found hanging from a homemade rope in his restrictive housing cell. The Postmortem report indicated that there was a metal spring and a piece of glasses frame in the individual’s intestine at the time of his death. According to medical records, he had mental illness, a history of ingesting foreign bodies, a noted record of non-compliance with medication, and a history of self-injurious behavior. About a month before his death, he was placed on suicide precaution, following the death of a family member. Eighteen days before his death, he ingested razor blades and screws and required transport to an outside hospital. He was removed from suicide precautions five days before his death.

Similarly, the individuals who died by suicide at Wilkinson’s restrictive housing units had previously exhibited signs of mental deterioration and self-harm.

- A 25-year-old individual died by suicide following an intense incident of self-harm in restrictive housing. The individual had one long laceration along his forearm and several cuts under his neck. The cell door was jammed, complicating efforts to extract him. After officers responded, the individual attacked his cellmate, striking and attempting to choke him. A captain administered chemical agents into the individual’s cell, and officers then opened the cell door. The individual ran out of the cell and towards the door of the housing unit. He then grabbed a broomstick handle and swung it at the officers. Staff left the housing unit to regroup, then reentered with less-lethal weapons. By that time, the individual was lying on the floor of the housing unit. He was later pronounced dead. Earlier that year, staff responded to the same individual cutting his own throat in his cell. He suffered life-threatening injuries at that time and had to be transported to an outside facility.
- A man in restrictive housing died after fighting with his cellmate and cutting himself around his neck and wrist area.
- A close custody individual with major depressive disorder died by suicide, following multiple episodes of self-harm in a single day. While medical staff were on the unit to distribute medications, staff observed the man bleeding profusely from his wrist area. The individual was seen by medical and mental health staff for two self-inflicted lacerations and received stitches. He told mental health that he had been having auditory hallucinations for the past two months and experiencing near total insomnia. He was then released back to his cell. A little more than an hour later, a maintenance technician heard “faint screams” coming from the man’s cell and found him with self-inflicted neck wounds. The man received further stitches for the injury to his throat but did not see a mental health professional. He was again released back to his cell. Soon after, an officer

found the man bleeding from the other side of his neck during a security check. He died of his injuries. His cellmate later reported that the man “had been up for a few days, and wouldn’t go to sleep, and had said ‘someone was trying to get him.’” Another individual in the unit said that the man told him through his door that “voices were telling him to kill himself.”

MDOC officials are aware of the harms from restrictive housing. After numerous incidents of violence between incarcerated persons—including homicides—in a particular restrictive housing unit at Parchman, MDOC’s former commissioner implemented programs to reduce administrative segregation and ultimately close that unit altogether.⁶² In addition to completed suicides in restrictive housing at Central Mississippi and Wilkinson, there have been numerous incidents of self-harm and violence that have put MDOC officials on notice of the harms from prolonged confinement in the restrictive housing units. The ERT Supervisor at Central Mississippi said self-injurious cutting is common in the restrictive housing units at that facility. Thirty-one of fifty-two incidents of self-harm or attempted suicide at Central Mississippi (63%) between September 2020 and June 2022 occurred in the restrictive housing units.

At Wilkinson, there were 60 violent cellmate assaults from November 2020 through June 2022. During this same timeframe, there were also 11 sexual assault allegations involving cellmates. There were 20 incidents of self-injury from November 2021 through June 2022. Given the highly restrictive nature of Wilkinson’s operations, all of these incidents likely involved people who were locked inside their cell, alone or with a cellmate, 23-to-24 hours a day.

The following case summaries show not only the harm that people in prolonged isolation in restrictive housing at Central Mississippi and Wilkinson experience, but also MDOC’s deliberate indifference to the known and obvious risks of harm from restrictive housing:

Mr. A

Mr. A experienced restrictive housing at several MDOC facilities, including Central Mississippi and Wilkinson. Prior to his transfer to Wilkinson in November 2019, Mr. A had already spent over 1,000 consecutive days in restrictive housing at another MDOC facility, where he filed grievances challenging poor living conditions and requesting outdoor recreation. While in restrictive housing at this other facility, Mr. A engaged in self-cutting, set a fire in his cell, and was placed on suicide precautions. A little over a week after his transfer to Wilkinson, another incarcerated person stabbed Mr. A in the long-term segregation unit. Documents then show a cycle of Mr. A throwing or threatening to throw bodily fluids, then being sprayed with

⁶² See Senate Public Hearing, Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences, Written Testimony of Commissioner Christopher Epps 2 (June 12, 2012), <https://www.judiciary.senate.gov/imo/media/doc/12-6-19EppsTestimony.pdf> [https://perma.cc/SK5L-A9MW].

OC spray for refusing orders to close the food flap. Following one such incident, staff denied Mr. A medical examination and decontamination, citing his disruptive behavior.

After nearly 250 days in restrictive housing at Wilkinson, Mr. A transferred to Central Mississippi, where he remained in restrictive housing. The cycle continued at Central Mississippi, with additional incidents of OC spray in response to Mr. A's threats of throwing bodily fluids and refusals to remove his arms from the food flap. Medical staff documented lacerations on both of Mr. A's arms. Mr. A attempted to set himself on fire in his restrictive housing cell at Central Mississippi. Staff used OC spray to bring him under control. When he resisted being placed on suicide watch following this incident, staff used force to bring him into compliance. After nearly five years in restrictive housing, Mr. A was transferred to East Mississippi Correctional Facility—a facility designated to provide higher levels of treatment for individuals with serious mental illness—in March 2021.

Mr. B

In December 2021, Mr. B began yelling at staff through his food port in close custody at Wilkinson, saying that he needed to see a nurse or he would start cutting himself. When mental health staff assessed Mr. B, they discovered that he already had several self-inflicted wounds to his arm, and they concluded that he should be on suicide watch. Records show that Mr. B had a history of cutting in restrictive housing at Central Mississippi, where he was also placed on suicide watch and received disciplinary infractions for self-mutilation. After the December 2021 incident of self-harm, Mr. B returned to restrictive housing at Wilkinson. Two weeks later, Mr. B cut his wrists again and swallowed a razor, spitting up blood. He received another disciplinary infraction for self-mutilation.

Mr. C

During our August 2022 tour of Central Mississippi, we met Mr. C, who reported being in restrictive housing for two years. Records confirm that he was in restrictive housing units at various points over the course of 19 months between November 2020 and May 2022. Mr. C told us that he was in restrictive housing as punishment for threatening to harm himself or others, and for cutting himself. He also received a disciplinary infraction for “lying . . . about being raped” after retracting a rape allegation, despite a hospital rape kit indicating a bruise and laceration in his anal area. Mr. C told our team that he has various mental disorders and had been taking psychotropic medications. Medical staff have described Mr. C as “switching from irritability to laughing within seconds.”

Records indicate, for example, that on approximately November 19, 2020, staff observed Mr. C in the R&C Holding Tank “loud talking and pacing back and forward.” He was waiting to be seen by mental health staff due to erratic behavior in his unit, but when staff tried to speak with him, he refused and screamed, “[A]in’t nothing wrong with me, I want to go home, I ain’t leaving!” When staff advised him that he would need to leave the holding tank, he threatened to kill anyone who made him leave. Mr. C was then placed on administrative segregation status for threatening staff.

Records include more signs of Mr. C's mental decompensation in restrictive housing. In our review, we found that during those 19 months in restrictive housing, Mr. C self-harmed by cutting or otherwise wounding himself on at least four different occasions, all of which resulted in outside hospitalizations. He also was assaulted at least once by a cellmate, and he set several fires in his cell. In one instance of self-harm in February 2021, he reopened the wound from a previous act of self-harm and was bleeding so "tremendously," that blood was seen coming out from under his cell door. When staff walked up to the door, there was "blood and feces everywhere." Inside, they found that Mr. C had written, "Fuck Life Man," in feces on his cell wall. Mr. C told us that when staff is available, he can talk to a counselor through his cell door. No educational or group activities have been provided to him. Regarding his experience in restrictive housing, he said: "I don't wish this on nobody. . . . It ain't no place to be. . . ."

Ms. D

Ms. D has been in restrictive housing in the MSU at Central Mississippi for almost all of her 10-year incarceration. She has attempted suicide numerous times while in restrictive housing. In January 2021, security staff found Ms. D in her cell with a cut wrist threatening suicide, and they called the medical clinic for help. Medical staff, however, were unavailable. Security staff then found her tying what looked like a shoelace or rope around her neck. Nearly 30 minutes after the initial call, security staff again called the medical clinic for help. Records show that ultimately, security staff took Ms. D to the clinic themselves, where she received care for lacerations, contusions, and bruises. Records show that as a result of this incident, Ms. D received a disciplinary infraction for "Inflicting Injury to Self." It appears that staff cleared her to return to the MSU the same day.

A year later, Ms. D attempted suicide again when she tied torn bed sheets around her neck. She told security staff that she wanted to kill herself because she could not be in a cell alone. She was taken to the clinic and then placed on suicide precaution in the MSU.

In a separate incident several months later, Ms. D allegedly assaulted an officer and refused to lock down in her MSU restrictive housing cell following 20 minutes in the dayroom. Ms. D "stat[ed] it was not time for them to lockdown yet and [security staff] always take time from them." She set a fire in her cell later that same day.

Ms. D told our team that she had not been outside in months, and that MDOC had only started allowing people in the MSU time in the dayroom a week before our onsite visit. She told our team that she has tried to hang herself three times.

Ms. E

We met Ms. E in August 2022 at Central Mississippi. Ms. E reported that she had been in the MSU for one year. She described the unit as horrible, unsafe, and inhumane. She told us that she was losing her mind in maximum security and that she had attempted suicide several times, including once when she tried to hang herself with a t-shirt and another time when she slit her wrists. Incident reports confirm that Ms. E hanged herself in May 2022, with a shirt, inside

her cell. Later that month, Ms. E deliberately set fire to a t-shirt and mattress foam in her cell. According to Ms. E, she set the fire because she and other women in the MSU were in their rooms too long, and fires got them yard call. Ms. E again set fire to her mattress in June 2022. Ms. E told us that she had never tried to end her life before going to the MSU and that being in a cell 24 hours a day, 7 days a week is hard.

Although MDOC is aware of these and other serious harms to persons in restrictive housing, it has failed to remedy these conditions or otherwise change restrictive housing practices to reduce harm.

V. MINIMUM REMEDIAL MEASURES

To remedy the constitutional violations we identify in this Findings Report, we recommend that MDOC implement, at minimum, the remedial measures below:

A. Protection from harm

1. Correctional Officer Staffing

- a) Conduct a staffing study and ensure that correctional officer staffing and supervision levels are appropriate to adequately supervise incarcerated persons.
- b) Contact the National Institute of Corrections (“NIC”) to request technical assistance to develop a strategy and timeframes for increasing the number of correctional officers, including correctional officers in both line and supervisory positions.
- c) Based on the results of the staffing study, properly screen, hire, and fully train sufficient numbers of corrections officers to ensure reasonable safety at Central Mississippi, South Mississippi, and Wilkinson. Within twelve months, staff Central Mississippi, South Mississippi, and Wilkinson with sufficient additional correctional officers to provide adequate security.
- d) Establish competitive base starting salaries and benefits packages for correctional officers.
- e) Ensure that applicants for correctional officer positions can apply and interview in their local area, and provide frequent testing for applicants.
- f) Ensure that applicants for correctional officer positions are adequately screened during a background investigation process to identify and, where necessary, eliminate any candidates who may pose a threat to facility security.

- g) Continuously track correctional officer turnover by year, breaking out exits by years of service, age, gender, race, ethnicity, and facility, and use information learned through this tracking to remedy reasons for attrition.
- h) Conduct systematic exit interviews of correctional officers and report annually on reasons for departures, cross-tabulated by age, gender, race, ethnicity, and facility. Use information learned through interviews to remedy reasons for attrition.
- i) Assess the need for and feasibility of providing staff who work in units with a location-enabled emergency notification device that they can activate in case of an emergency.
- j) Expand opportunities for incarcerated persons to participate in a variety of prison programming to reduce the risk of violence and abuse from idle time.
- k) Implement anti-retaliation measures to protect incarcerated persons who report misconduct and who renounce gang membership from retaliation from other incarcerated persons.

2. Safety and Supervision

- a) Implement an appropriate, objective classification system that separates incarcerated persons in housing units by classification levels that correspond to level of risk, to protect incarcerated persons from unreasonable risk of harm.
- b) Ensure that housing and common areas are adequately supervised through direct supervision.
- c) Ensure that staff monitor surveillance footage in real time and alert appropriate staff to disturbances. Ensure that all surveillance cameras are operational and that when cameras are down, they are repaired in a timely fashion.
- d) Ensure frequent, irregularly timed, and documented security rounds by correctional officers inside each housing unit.
- e) Conduct regular, documented inspections of cells and common areas of the housing units to identify and prevent rule violations by incarcerated persons.
- f) Enforce a no-tenting policy in all dormitories, cells, and housing areas.
- g) Repair or replace broken/burned windows to allow visibility into all cells.

- h) Implement a plan to prevent incarcerated persons from entering housing units other than the one to which they are assigned, or entering secure areas of the facility, including control towers.
- i) Electronically monitor, and otherwise deploy resources to staff to facilitate monitoring of, the facility perimeter and entry/exit points, as well as screen all individuals entering the facility.
- j) Identify areas in the facility where incarcerated persons are housed or work where cameras should be installed to facilitate supervision and surveillance, and implement a documented plan for camera installation, repair/replacement, and video review and preservation, especially during Correctional Investigations Division investigations.
- k) Identify all broken or jammed locks and document a plan with timeframes for their repair or replacement. Ensure that all lock repairs and replacements are conducted timely.
- l) Identify all malfunctioning security equipment, including but not limited to perimeter fencing, cameras, and BOSS Chairs or Rapid Scan machines, and document a plan with timeframes for their repair or replacement. Ensure that all malfunctioning security equipment repairs and replacements are performed timely.
- m) Ban the use of incarcerated persons for security observations.

3. Contraband

- a) Develop and implement a policy and plan for detecting and reducing the amount of contraband, including the appointment of a Chief Interdiction Officer for contraband interdiction.
- b) Conduct regular, documented inspections of cells and common areas to prevent, identify, and remove contraband.
- c) Implement unannounced shakedowns or total searches such that at least 15% of all housing units are searched every day, with congregate areas searched weekly; maintain written documentation showing the results of those shakedowns.
- d) Ensure that the facility has working metal detectors at every entry point and implement a procedure to use metal detectors to screen all persons entering the facility.
- e) Implement reasonable screening procedures for illegal drugs, weapons, or other contraband, especially those that cannot be detected by a metal detector.

- f) Ensure that all incarcerated persons detoxifying from illegal substances receive adequate medical treatment as contraband is reduced and eventually eliminated from the facility.
- g) Ensure that all confiscated contraband is documented/logged and preserved in evidence pending investigation and analysis by the Correctional Investigations Division.

4. Reporting and Investigations

- a) Ensure that staff promptly and adequately report and investigate incidents of contraband, violence, gang activity, extortion, deaths, suicide attempts, and other incidents of serious harm.
- b) Ensure that incarcerated persons are able to report incidents of harm and other misconduct and that such reports are promptly reviewed and investigated.
- c) Ensure that all allegations of staff misconduct are timely and adequately investigated.
- d) Ensure that all reports by incarcerated persons, incident reports, and investigations are complete and thoroughly documented by MDOC.
- e) Develop and implement a centralized system that compiles incidents of harm, examines them for patterns and trends, and identifies remedial measures to correct any identified issues.

5. Gang Influence and Extortion

- a) Develop and implement a comprehensive, effective strategy to prevent, detect, report, and investigate extortion of incarcerated persons and their families by other incarcerated persons and staff.
- b) Ensure that incarcerated persons and staff found to have engaged in extortion or illegal gang activity are disciplined and referred for prosecution.
- c) Ensure that gang intelligence officers are adequately trained in gang prevention tactics.
- d) Provide regular opportunities for gang intelligence officers to receive information from officers in the housing units and ensure that housing officers have appropriate information about suspected gang activity in their housing units.

B. Sexual assault

1. Comply with PREA and its implementing regulations, the National Standards to Prevent, Detect, and Respond to Prison Rape (28 C.F.R. § 115 et seq.).
2. Ensure that all staff who investigate sexual abuse allegations receive specialized training in sexual abuse investigations. Specialized training shall include techniques for interviewing sexual abuse victims, sexual abuse evidence collection in confinement settings, and the criteria and evidence required to substantiate a case for administrative action or prosecution referral.
3. Ensure that administrators have access to investigative files and regular briefings of PREA investigations that include sufficient details so that administrators have sufficient information to devise and implement any necessary movement, discipline, or corrective action.

C. Restrictive housing

1. Ensure that policies, procedures, and practices regarding the use of restrictive housing, including the use of restrictive housing for incarcerated persons with serious mental illness, comport with the U.S. Constitution.
2. Ensure that incarcerated persons are housed in the least restrictive setting necessary to ensure their own safety, as well as the safety of staff, other incarcerated persons, and the public.
3. Ensure incarcerated persons in restrictive housing have access to adequate medical and mental health care.
4. Ensure that if an incarcerated person shows credible signs of decompensation in restrictive housing, the individual's mental health needs are assessed by a qualified mental health professional and promptly addressed.
5. Ensure that incarcerated persons expressing suicidality or engaging in self-harming behavior are not placed, by reason of their suicidal ideation or self-harming behavior, in restrictive housing and instead are provided clinically appropriate mental health care, except as provided by remedial measure C.6.
6. Ensure that custody staff consult with mental health staff before placing an incarcerated person in restrictive housing or discipline, to determine whether the placement is appropriate in light of the individual's mental health. If it is impracticable to consult with mental health staff before the placement, mental health staff should evaluate the person as soon as possible after placement to determine the appropriateness of the placement.

7. Conduct periodic review of all persons in restrictive housing to determine whether their housing is appropriate.
8. Report and review data regarding lengths of stay in restrictive housing, particularly with respect to persons with serious mental illness, and take appropriate corrective action to avoid prolonged restrictive housing.
9. Ensure sanitary and safe environmental conditions in restrictive housing, including proper temperature regulation.
10. Ensure appropriate opportunities for daily recreation and sufficient time out of cell.

D. Deaths and sentinel events

1. Ensure staff conduct appropriate and timely emergency procedures and provide life-saving measures to incarcerated persons experiencing life-threatening emergencies.
2. Develop a centralized system to timely obtain and review autopsies for all deaths. Ensure that all deaths of incarcerated persons are completely and adequately investigated.
3. Implement a quality assurance program that includes complete, interdisciplinary morbidity/mortality reviews of all deaths, attempted suicides, or other sentinel events. Ensure that the quality assurance program is adequately maintained, examines for patterns and trends, and identifies and corrects systemic deficiencies.

E. Policies, procedures, training, and quality assurance

1. Implement appropriate policies, procedures, and training to ensure the implementation of the minimum remedial measures identified above.
2. Ensure that policies, procedures, and training are reviewed and updated on at least an annual basis.
3. Ensure that all staff training is documented to demonstrate compliance with training requirements and that corrective action is taken for staff who fail to complete required training.
4. Develop and implement a quality assurance program that identifies and corrects deficiencies with facility security, classification, supervision of incarcerated persons, incident reporting, investigations, and restrictive housing.

5. Ensure that all corrective action is documented, adequate, and timely implemented.

VI. CONCLUSION

In summary, our investigation found reasonable cause to believe that MDOC violates the constitutional rights of incarcerated persons by failing to protect incarcerated persons at Central Mississippi, South Mississippi, and Wilkinson from violence and sexual assault, and by holding incarcerated individuals at Central Mississippi and Wilkinson in prolonged restrictive housing under harsh environmental conditions and with deliberate indifference to a substantial risk of serious psychological and physical harm.

We are obligated to advise you that 49 days after issuance of this letter, the Attorney General may initiate a lawsuit pursuant to CRIPA to correct deficiencies identified in this Findings Report if State officials have not satisfactorily addressed our concerns. 42 U.S.C. § 1997b(a)(1). The Attorney General may also move to intervene in related private suits 15 days after issuance of this Report. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Findings Report is a public document. It will be posted on the Civil Rights Division's website.

We look forward to working cooperatively with you and MDOC administrators and staff to ensure that the violations are remedied.