

**IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE**

G. MARIE NEWBY, individually, and as §
Administratrix of THE ESTATE OF §
TERRY CHILDRESS, §

Plaintiffs, §

v. §

CORECIVIC OF TENNESSEE, LLC, §
as owner and operator of TROUSDALE §
TURNER CORRECTIONAL CENTER, §
DAMON HININGER, STEVE CONRY, §
RAYMOND BYRD, and SHAWNA §
CURTIS, §

Defendants. §

Case No. _____

JURY DEMANDED

COMPLAINT

For their Complaint, the Plaintiffs state to the Court and the Jury as follows:

I. INTRODUCTION

1. This action arises from yet another preventable death at CoreCivic’s “severely understaffed” Trousdale Turner Correctional Center¹—Tennessee’s most dangerous and notorious prison.

2. According to one of its own former employees, CoreCivic—a private prison corporation that operates Trousdale Turner Correctional Center for profit—is driven by “the power of the almighty dollar.”² As a result, CoreCivic severely understaffs Trousdale

¹ See **Ex. 1**, Tr. of Treyton Lattimore Interview at 31:1.

² *Id.* at 33:19.

Turner Correctional Center while willfully disregarding inmate safety there. CoreCivic is also willing to tolerate preventable deaths at Trousdale Turner Correctional Center because adequately staffing the facility would exceed the cost of liability that CoreCivic faces when inmates die from CoreCivic's profit-motivated deliberate indifference.

3. In addition to being made aware of—and asked to adjudicate—claims arising from CoreCivic's chronic deliberate indifference to inmate safety at Trousdale Tuner Correctional Center specifically,³ this Court has been made aware of “inadequate medical staffing that was endemic of broader issues with staffing levels at CoreCivic facilities” generally, it has been made aware of CoreCivic's “failures to maintain accurate records of medication administrations,” and it has been made aware of at least one “inadequate emergency response in the case of an inmate who eventually died.”⁴ This Court is also privy to sealed communications among CoreCivic's executives and lobbyists that confirm CoreCivic's chronic, profit-motivated deliberate indifference to inmate safety.⁵

4. Among the results that CoreCivic has achieved through its profit-motivated deliberate indifference to inmate health and safety, Tennessee inmates who are housed at CoreCivic facilities are approximately twice as likely to die and more than four times as likely to be murdered—even though CoreCivic houses inmates with disproportionately low security designations.⁶

³ See, e.g., **Ex. 2**, First Amended Complaint, Pleasant-Bey v. State of Tennessee et al. No. 3:19-CV-486 (MDTN Dec. 21, 2020), ECF No. 68 at 9–15, 17.

⁴ See, e.g., **Ex. 3**, Memorandum, Grae v. Corrections Corporation of America, No. 3:16-cv-02267 (MDTN March 26, 2019), ECF No. 165.

⁵ See *id.* at 7, n. 2.

⁶ See, e.g., Cassandra Stephenson, *Inmate death ruled homicide in a Tennessee CoreCivic prison where rate is twice as high as TDOC's, records show*, JACKSON SUN (Jan. 28, 2020),

5. A scathing Performance Audit Report of Tennessee's CoreCivic facilities conducted by the Tennessee Comptroller of the Treasury recently determined that CoreCivic's management failed to "implement or enforce established internal controls to ensure state and CoreCivic correctional facilities staff collected and accurately reported incident information" regarding "inmate deaths, inmate assaults, inmate violence, correction officers' use of force, and inmate accidents and injuries," and it found that in many instances, CoreCivic had destroyed records and evidence in contravention of state law.⁷

6. Shortly before that, another state audit determined that Trousdale Turner Correctional Center, in particular, "operated with fewer than approved correctional staff, did not have all staffing rosters, did not follow staffing pattern guidelines, and left critical posts unstaffed"; that "CoreCivic staffing reports at Trousdale Turner Correctional Center contained numerous errors"; and that "Trousdale Turner Correctional Center management's noncompliance with contractual requirements and department policies relating to inmate services challenged the department's ability to effectively monitor the correctional facility."⁸

<https://www.jacksonsun.com/story/news/crime/2020/01/28/corecivics-tennessee-prisons-have-twice-homicide-rate-tdocs/2776928001/> ("The corporation's four Tennessee facilities hold roughly 35% of the state's prison population but accounted for about 63% of the state's prison homicides."); Prison Legal News, *CoreCivic Prisons in Tennessee Have Twice as Many Murders, Four Times the Homicide Rate as State-Run Facilities*, PLN (Aug. 6, 2019), <https://www.prisonlegalnews.org/news/2019/aug/6/corecivic-prisons-tennessee-have-twice-many-murders-four-times-homicide-rate-state-run-facilities/> ("from 2014 through June 2019, there were twice as many murders in the four Tennessee prisons operated by CoreCivic (formerly Corrections Corporation of America) than in the 10 prisons run by the Tennessee Department of Correction (TDOC). Also, the homicide rate in CoreCivic facilities was over four times higher than the rate for TDOC prisons.").

⁷ **Ex. 4**, Tennessee Comptroller of the Treasury, Performance Audit Report, Tennessee Department of Correction (Jan. 2020), available at <https://comptroller.tn.gov/content/dam/cot/sa/advanced-search/2020/pa19032.pdf>.

7. In addition to unlawfully failing to collect—and in many instances destroying—records and evidence bearing upon its potential liability, CoreCivic has recently been caught *fabricating* evidence in an effort to evade legal liability.⁹

8. The reality that CoreCivic chronically fails to comply with its legal obligations and is willing to conceal, destroy, or fabricate evidence that would expose its deliberate, profit-motivated indifference to inmate safety are not new revelations. Indeed, the State of Tennessee itself has all but stated directly that CoreCivic—and Trousdale Turner Correctional Center in particular—extensively engages in such behavior. In the Tennessee Comptroller’s January 2020 Performance Audit Report, for example, the Comptroller specifically found that “health services staff had not entered any serious accidents or injuries on the Accidents screen in TOMIS” at Trousdale Turner Correctional Center during *a one-and-a-half-year audit period*—something auditors found to be “questionable given the nature of the correctional environment” and determined was “unlikely” to be accurate. Trousdale Turner Correctional Center officials ultimately acknowledged that their incident reporting was, in fact, inaccurate, claiming not to have been “aware” of applicable state reporting requirements.

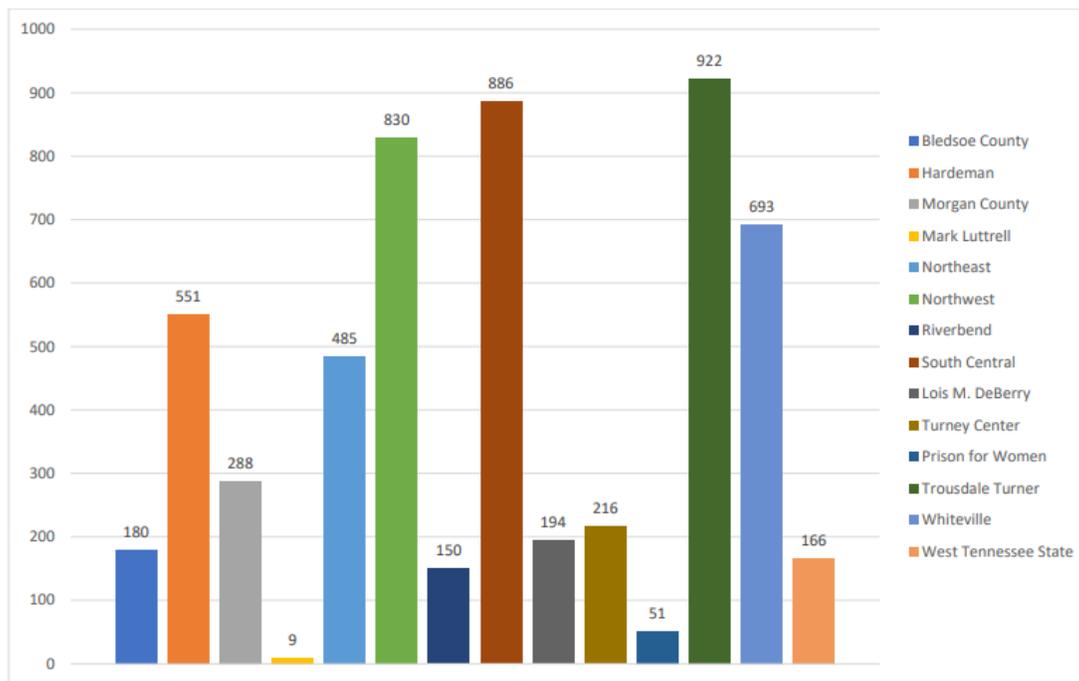
9. The data that ultimately was reported to regulators reflected that Trousdale Turner Correctional Center experienced the highest number of Class A incidents—defined as “life-threatening matters and breaches of security that are likely to cause serious operational problems,” including “escapes and attempted escapes, deaths, assaults,

⁸ Ex. 5, Tennessee Comptroller of the Treasury, Performance Audit Report, Tennessee Department of Correction (Nov. 2017), available at <https://comptroller.tn.gov/content/dam/cot/sa/advanced-search/2017/pa17275.pdf>.

⁹ See, e.g., Brinley Hineman, *After Tennessee prison suicide, CoreCivic counselor fabricated health records of treatment: TDOC, THE TENNESSEAN* (Aug. 25, 2020), <https://www.tennessean.com/story/news/crime/2020/08/26/after-tennessee-prisoners-suicide-corecivic-worker-faked-health-records/3404186001/>.

hostage situations, total institutional lockdowns, rapes, certain uses of force, and various weapons”—of any facility audited in the entire State of Tennessee. CoreCivic also managed to achieve that extraordinary result despite the fact that “CoreCivic correctional facilities staff did not appropriately maintain original documentation of Class A incidents.” The following graph, appended to the Comptroller’s 2020 report as Appendix-B-2, summarizes reported Class A incidents by each audited facility from October 1, 2017 through April 12, 2019:

Appendix B-2
Summary of Class A Incidents (Those Involving Serious Risk to the Facility or Community) Reported by Location
October 1, 2017, Through April 12, 2019



Source: Tennessee Offender Management Information System.

10. Despite all of the foregoing; despite multiple additional preventable deaths at Trousdale Turner Correctional Center since the aforementioned audits and even since Mr. Childress’s death in this case occurred; and despite near-constant reports of brutality, criminality, neglect, and death both at CoreCivic’s Tennessee facilities generally and at

Trousdale Turner Correctional Center in particular year after year after year;¹⁰ state

¹⁰ See Demetria Kalodimos, *Woman says she paid off gangs to keep son safe in prison*, WSMV (Oct. 5, 2017), https://www.wsmv.com/news/woman-says-she-paid-off-gangs-to-keep-son-safe-in-prison/article_a4e670ea-78be-5087-86e5-a65ecd485475.html; Joseph Wenzel, *Over 1,200 staff, inmates test positive for COVID-19 at Trousdale Turner Correctional Center*, WSMV (May 1, 2020), https://www.wsmv.com/news/over-1-200-staff-inmates-test-positive-for-covid-19-at-trousdale-turner-correctional-center/article_568c03d2-8bde-11ea-a447-4b7eaabeb67b.html; Adam Tamburin, *Tennessee prison inmate dies after fight at Trousdale Turner*, THE TENNESSEAN (Jan. 26, 2020), <https://www.tennessean.com/story/news/2020/01/26/tennessee-prison-inmate-dies-after-fight-trousdale-turner-correctional-center/4581013002/>; Dave Boucher, *New Tennessee CCA prison stops taking inmates amid 'serious issues'*, THE TENNESSEAN (May 24, 2016), <https://www.tennessean.com/story/news/politics/2016/05/24/new-tennessee-private-prison-stops-taking-inmates/84867834/>; Chris Conte, *Prisons for profit: Concerns mount about Trousdale Turner Correctional Center, operator CoreCivic*, WTVF (Jun. 13, 2019), <https://www.newschannel5.com/longform/prisons-for-profit-concerns-mount-about-trousdale-turner-correctional-center-operator-corecivic>; Staff Report, *Scathing state audit slams Tennessee prisons, CoreCivic for staffing, sexual assaults, and deaths in jails*, WTVF (Jan. 10, 2020), <https://www.newschannel5.com/news/scathing-state-audit-slams-tennessee-prisons-corecivic-for-staffing-sexual-assaults-and-deaths-in-jails>; Jamie McGee, *CoreCivic shareholders granted class action status in fraud lawsuit*, THE TENNESSEAN (May 27, 2019), <https://www.tennessean.com/story/money/2019/03/27/corecivic-class-action-securities-fraud-lawsuit/3289913002/>; Chris Gregory, *Family seeks answers in loved one's death at Trousdale prison*, LEBANON DEMOCRAT (Jan. 2, 2021), https://www.lebanondemocrat.com/hartsville/family-seeks-answers-in-loved-ones-death-at-trousdale-prison/article_1ffe90f7-0e9f-5021-bb94-9ec1b4d23139.html; Demetria Kalodimos, *Inmates at CoreCivic prisons say they sometimes go months without medical care*, WSMV (Jun. 22, 2017), https://www.wsmv.com/news/inmates-at-corecivic-prisons-say-they-sometimes-go-months-without-medical-care/article_8d28e630-bd12-5f1c-8b68-92b9336553e1.html; Prison Legal News, *Incorrect Cause of Tennessee Prisoner's Death Reported by CoreCivic Employees*, PLN (Jun. 7, 2018), <https://www.prisonlegalnews.org/news/2018/jun/7/incorrect-cause-tennessee-prisoners-death-reported-corecivic-employees/>; Staff Report, *Private prison company CoreCivic's history of problems in Tennessee*, THE TENNESSEAN (Jan. 16, 2020), <https://www.tennessean.com/story/news/local/2020/01/17/private-prison-corecivic-history-problems-tennessee/4470277002/>; Stephen Elliott, *State audit criticizes CoreCivic facilities*, THE NASHVILLE POST (Nov. 14, 2017), <https://www.nashvillepost.com/business/prison-management/article/20982796/state-audit-criticizes-corecivic-facilities>; Matt Blois, *CoreCivic reports \$25M in profits as COVID infects 2,500+ inmates*, THE NASHVILLE POST (Jun. 30, 2020), <https://www.nashvillepost.com/business/prison-management/article/21138792/corecivic-reports-25m-in-profits-as-covid-infects-2500-inmates>; Steven Hale, *Problems Persist at Tennessee's Mismanaged Prisons*, THE NASHVILLE SCENE (Jan. 22, 2020), <https://www.nashvillescene.com/news/features/article/2111586/problems-persist-at-tennessees-mismanaged-prisons>; Dave Boucher, *CoreCivic investigating ex-officer's allegations of negligent deaths at private prison*, THE TENNESSEAN (Dec. 12, 2017), <https://www.tennessean.com/story/news/2017/12/12/corecivic-investigating-ex-officers-allegations-negligent-deaths-private-prison/946196001/>; Elizabeth Weill-Greenberg, *'Just Let Him Kick'*, THE APPEAL (Sep. 6, 2018), <https://theappeal.org/just-let-him-kick/>; Brinley Hineman, *Murfreesboro man charged in prison cellmate's death at Trousdale*, DAILY NEWS JOURNAL (Feb. 20, 2020), <https://www.dnj.com/story/news/2020/02/20/murfreesboro-man-jacob-kado-charged-death-prison-cell-mate-ernest-hill-trousdale-turner/4818354002/>; Ethan Illers, *Man killed during inmate-on-inmate altercation at Trousdale Turner prison*, WSMV (Jun. 16, 2019), https://www.wsmv.com/news/man-killed-during-inmate-on-inmate-altercation-at-trousdale-turner-prison/article_8d8b6806-9066-11e9-b749-7b44cac1c002.html; Jeremy Finley, *Recorded conversations reveal life inside prison ravaged by COVID-19*, WSMV (May 6, 2020), https://www.wsmv.com/news/investigations/recorded-conversations-reveal-life-inside-prison-ravaged-by-covid-19/article_91ef5b06-8fe2-11ea-9b75-f36db06e1ab1.html; Demetria Kalodimos, *Gang activity, security a concern at Trousdale Turner facility*, WSMV (Jun. 21, 2017), <https://www.wsmv.com/news/gang-activity-security-a-concern-at-trousdale-turner>

regulators have failed to curb Trousdale Turner Correctional Center's worst abuses. Instead, in May of 2021—approximately 10 weeks after multiple murders at Trousdale Turner Correctional Center including the murder at issue in this Complaint occurred—the Trousdale County Commission approved a new, five-year contract with CoreCivic to operate Trousdale Turner Correctional Center.

11. To date, this Court, too, has been unable to remedy CoreCivic's operation of a chronically unsafe prison within the Middle District of Tennessee where inmates in CoreCivic's care die or incur serious bodily injury with enraging frequency.

[facility/article_df82a358-7073-552e-b5e4-9feb2e9cf8bc.html](https://www.nashvillescene.com/news/features/article/21047078/tennessees-largest-prison-still-appears-as-troubled-as-ever); Steven Hale, *Tennessee's Largest Prison Still Appears as Troubled as Ever*, THE NASHVILLE SCENE (Feb. 13, 2019), <https://www.nashvillescene.com/news/features/article/21047078/tennessees-largest-prison-still-appears-as-troubled-as-ever>; Jessie Williams, *Trousdale Turner Corrections Officer Arrested*, MACON COUNTY CHRONICLE (Feb. 5, 2019), <https://www.maconcountychronicle.com/news/5680-trousdale-turner-corrections-officer-arrested>; Brett Kelman, *At Tennessee's largest prison, diabetic inmates say they are denied insulin to 'maximize profits'*, THE TENNESSEAN (Aug. 7, 2018), <https://www.tennessean.com/story/news/2018/08/07/corecivic-diabetic-inmates-denied-insulin-trousdale-turner/925297002/>; Natalie Allison, *Lawmakers hear from prison rape survivor, parents of man who hanged himself in CoreCivic facility*, THE TENNESSEAN (Dec. 19, 2018), <https://www.tennessean.com/story/news/politics/2018/12/19/tennessee-legislators-hear-rape-suicide-corecivic-prison/2355556002/>; Dave Boucher, *Private prison chief: 'We've got work to do' at Trousdale facility*, THE TENNESSEAN (Dec. 13, 2016), <https://www.tennessean.com/story/news/2016/12/13/private-prison-chief-weve-got-work-do-trousdale-facility/95223230/>; Demetria Kalodimos, *Former chaplain describes conditions inside TN prison*, WSMV (Jun. 19, 2017), https://www.wsmv.com/news/former-chaplain-describes-conditions-inside-tn-prison/article_9b30af82-8297-5101-b11f-b5fd9270bf18.html; Chris Gregory, *Trousdale Turner employee charged with smuggling contraband*, LEBANON DEMOCRAT (Apr. 23, 2020), https://www.lebanondemocrat.com/hartsville/trousdale-turner-employee-charged-with-smuggling-contraband/article_6b865daf-fbc8-5a59-9a35-e84b61ace2e4.html; Andy Cordan, *Prison corrections officer in Trousdale County arrested carrying drugs*, WKRN (Jan. 20, 2021), <https://www.wkrn.com/news/prison-corrections-officer-in-trousdale-county-arrested-carrying-drugs/>; Dave Boucher, *Gangs, insufficient staffing plague troubled Tennessee private prison, state audit finds*, THE TENNESSEAN (Nov. 14, 2017), <https://www.tennessean.com/story/news/politics/2017/11/14/tennessee-private-prison-operated-by-corecivic-blasted-ongoing-problems-new-state-audit/858884001/>; Keith Sharon and Adam Tamburin, *'This is unreal': Family seeks answers in death of Trousdale Turner prison inmate*, THE TENNESSEAN (Feb. 2, 2021), <https://www.tennessean.com/story/news/2021/02/03/trousdale-turner-inmate-aaron-blayke-adams-dead-family-wants-answers/4290646001/>; Alex Corradetti, *Investigation underway following death of inmate at Trousdale Turner Correctional Center*, WKRN (Sep. 8, 2021), <https://www.wkrn.com/news/investigation-underway-following-death-of-inmate-at-trousdale-turner-correctional-center/>; Chris Gregory, *Former Trousdale Turner corrections officer indicted*, LEBANON DEMOCRAT (Oct. 7, 2021), https://www.lebanondemocrat.com/hartsville/former-trousdale-turner-corrections-officer-indicted/article_aac20d8d-16e5-5edc-9e7e-d5fd9f8bfd0e.html; Levi Ismail, *NAACP calls for closure of Trousdale Turner Correctional Center, cites 'barbaric treatment' of Black men*, WTVF (Nov. 11, 2021), <https://www.newschannel5.com/news/naACP-calls-for-closure-of-trousdale-turner-correctional-center-cites-barbaric-treatment-of-black-men> (all attached as Collective Ex. 6).

12. With each additional preventable death that occurs at Trousdale Turner Correctional Center that is not met with meaningful regulatory action, CoreCivic is emboldened by the knowledge that it may continue to act with deliberate indifference toward inmate safety and allow inmates to die needlessly in its care without fear of experiencing meaningful legal consequences.

13. This Complaint—filed by the mother of decedent Terry Childress, who was brutally assaulted and needlessly died at Trousdale Turner Correctional Center in February 2021—demands that this Court compensate the Plaintiffs for Mr. Childress’s preventable death; order CoreCivic to disgorge all profits arising from its chronically unconstitutional operation of Trousdale Turner Correctional Center; assess a punitive monetary sanction against CoreCivic sufficient to deter CoreCivic from maintaining its profit-motivated deliberate indifference to inmate safety; declare Trousdale Turner Correctional Center to be acting illegally and unconstitutionally; and appoint an independent monitor to audit and ensure Trousdale Turner Correctional Center’s compliance with minimum constitutional obligations. Alternatively, this Court should enjoin Trousdale Turner Correctional Center’s continued operation going forward.

II. PARTIES

14. Plaintiff G. Marie Newby is the mother of decedent Terry Childress, the personal representative of Mr. Childress’s estate, and Mr. Childress’s next-of-kin. Ms. Newby is a citizen of Alabama and may be contacted through her counsel.

15. Plaintiff the Estate of Terry Childress is the estate of decedent Terry Childress. At all times relevant to this Complaint, Mr. Childress resided at CoreCivic’s Trousdale Turner Correctional Facility in Trousdale County, Tennessee, where he was brutally murdered by his cellmate just a day after appearing for a parole hearing. The

Estate of Terry Childress is represented by its personal representative, Ms. Newby, and it may be contacted through its counsel.

16. Defendant CoreCivic of Tennessee, LLC—which went by the name “Corrections Corporation of America” before that name became synonymous with the most insidious aspects of America’s private prison industry—is a private, for-profit prison corporation that cages human beings for money. CoreCivic owns and operates Trousdale Turner Correctional Center, the private prison that enabled Mr. Childress’s preventable death through customs and policies of understaffing, misclassification, and profit-motivated deliberate indifference to inmate safety. CoreCivic is a citizen of Tennessee with its principal place of business and corporate headquarters located in Brentwood, Tennessee. CoreCivic may be served with process through its registered agent at CoreCivic of Tennessee, LLC, Registered Agent: C T CORPORATION SYSTEM, 300 MONTVUE RD., KNOXVILLE, TN 37919-5546.

17. Defendant Damon Hininger is the Chief Executive Officer of CoreCivic. Mr. Hininger’s commitment to prioritizing shareholder profit over inmate safety gave rise to the chronically unconstitutional understaffing and misclassification conditions that resulted in Mr. Childress’s preventable death. Defendant Hininger may be served at his residence or wherever he may be found.

18. Defendant Steve Conry is CoreCivic’s Vice President of Operations Administration. As the primary individual responsible for ensuring that CoreCivic’s facilities are adequately staffed and that staff are trained properly, Mr. Childress’s murder is directly attributable to Mr. Conry’s failed oversight and calculated, profit-motivated understaffing decisions. Defendant Conry may be served at his residence or wherever he may be found.

19. Defendant Raymond Byrd was the warden of Trowsdale Turner Correctional Center at all times relevant to this Complaint. As Trowsdale Turner Correctional Center's day-to-day overseer who was responsible for supervising its staff—including staff members who were responsible for maintaining adequate staffing and staff members who were responsible for inmate classification—Mr. Childress's murder is directly attributable to Mr. Byrd's deliberate indifference to Trowsdale Turner Correctional Center's chronically unconstitutional understaffing and misclassification conditions. Defendant Byrd may be served at his residence or wherever he may be found.

20. Defendant Shawna Curtis was a classification counselor at Trowsdale Turner Correctional Center at the time Mr. Childress was murdered and the individual who misclassified Mr. Childress's murderer. Despite inmate Tymothy Willis's violent criminal history and institutional history, Defendant Curtis misclassified Tymothy Willis as a low security risk and minimum custody inmate when he was not. As a result of that misclassification, Tymothy Willis was housed with Mr. Childress, a low security risk inmate whom Tymothy Willis brutally murdered. Defendant Curtis may be served at her residence or wherever she may be found.

III. JURISDICTION, VENUE, AND AUTHORITY

21. This Court has jurisdiction over the Plaintiffs' federal claims in this civil action pursuant to 28 U.S.C. § 1331.

22. This Court has supplemental jurisdiction to adjudicate the Plaintiffs' state law claims related to the Plaintiffs' federal claims in this action pursuant to 28 U.S.C. § 1367(a).

23. As the judicial district in which a substantial part of the events or omissions giving rise to the Plaintiffs' claims occurred, venue is proper in this Court pursuant to 28

U.S.C. § 1391(b)(2). Venue is independently proper in this Court pursuant to 28 U.S.C. § 1391(b)(1).

24. Plaintiff Newby has authority to maintain her own claims individually and to maintain this wrongful death action as next-of-kin to Mr. Childress and as the personal representative of Mr. Childress's estate pursuant to Tenn. Code Ann. § 20-5-107(a).

IV. FACTUAL ALLEGATIONS

25. On February 23, 2021, Terry Childress appeared for a parole hearing in advance of his forthcoming release date.

26. On February 24, 2021, Terry Childress was brutally murdered in his prison cell at Trousdale Turner Correctional Center by his violent and misclassified cellmate, Tymothy Willis.

27. The cause of Mr. Childress's death was "blunt force injuries of the head," and the manner of death was "homicide."¹¹ Mr. Childress also suffered two broken ribs as a result of Tymothy Willis's assault.

28. Mr. Childress was 37 years old at the time of his murder. He left behind his mother, siblings, and other family members and friends who loved him very much.

29. Video surveillance footage inside Trousdale Turner Correctional Center confirms that corrections officers were not making timely rounds at the time of Mr. Childress's murder. As a result, no corrections officers were nearby to hear Mr. Childress being viciously assaulted by Tymothy Willis, notwithstanding reports of "escalating arguments" between them.¹² Thus, no corrections officers were nearby to intervene and

¹¹ Ex. 7, Report of Investigation by County Medical Examiner at 5.

¹² *Id.*

prevent the assault from becoming fatal.

30. Timothy Willis did not have any serious injuries and was not defending himself when he murdered Mr. Childress. At the time he murdered Mr. Childress, Timothy Willis also sported a tattoo that simply stated: “Death.”



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31. The reason why officers were not making timely rounds at Trousdale Turner Correctional Center at the time of Mr. Childress’s murder and were unavailable to prevent Timothy Willis’s assault of Mr. Childress from becoming fatal is because Trousdale Turner Correctional Center—and the unit where Mr. Childress was housed in particular—was understaffed. The understaffed positions in Mr. Childress’s housing unit are “critical” positions that must be staffed under Tennessee Department of Correction policy.

32. Defendants CoreCivic, Hininger, Conry, and Byrd knew that Trousdale Turner Correctional Center was chronically understaffed and that critical posts routinely went unstaffed at the time of Mr. Childress’s murder. They also willfully understaffed Trousdale Turner Correctional Center because doing so was and remains more profitable.

33. According to a former Trousdale Turner Correctional Center officer, understaffing Trousdale Turner Correctional Center “definitely” helps CoreCivic save money, and “they would much rather pay, you know, eight officers on night shift a bunch of overtime to run that entire facility, you know, versus having three officers per unit 24 hours a day, which they’re supposed to.”¹³

34. At the time that Mr. Childress was murdered, he was a low security risk.

35. At the time that Mr. Childress was murdered, Tymothy Willis was misclassified as a low security risk inmate who should have been designated—at minimum—a medium security inmate.¹⁴

36. Even though Trousdale Turner Correctional Center was designed to be a minimum security facility and is “not supposed to house anybody with medium to maximum points,” it regularly and improperly accepts higher security level inmates, resulting in “a huge mix of different security levels under one roof.”¹⁵ This mixture of inmate security levels dramatically increases the risk of inmate-on-inmate violence. A former Trousdale Turner Correctional Center officer describes this situation as “like adding a gallon of gasoline to an open flame.”¹⁶

¹³ See **Ex. 1** at 34:3–10.

¹⁴ See generally **Ex. 8**, Decl. of Roy T. Gravette.

¹⁵ **Ex. 1**, at 13:18–14:2.

¹⁶ *Id.* at 14:4–5.

37. At the time Mr. Childress was murdered, CoreCivic had actual knowledge that Mr. Willis posed a heightened security risk and was a volatile, dangerous inmate with a history of violence.

38. At the time Mr. Childress was murdered, CoreCivic had actual knowledge that Mr. Willis was a violent offender who had been convicted of a violent offense involving the use of a deadly weapon and had a long history of felony convictions. Tymothy Willis’s “Offender Attributes” profile dated 7/31/2018 also designated Mr. Willis as a “High Risk: Violent” inmate with a “Maximum” custody level:

ETOMIS - Offender attributes Page 1 of 1

eTomis Menu Favorites Tools Other Applications Reports Help PROD

Offender Attributes

Links Suspend TCMIS ID 00574845 Willis, Tymothy B. Status ACTV Location RMS

Emergency Notif Military/Child Suprt License/ID Issuance

Physical Info Social Info Offender Summary Offender Location Offender Other ID

Alerts

Marital Status	Single	Religion	79	Muslim - Sunni
DL Number	133859985	DL State	TN	Tennessee
County of Birth	060 Maury	State of Birth	TN	Tennessee
Citizenship		Alien ID		
Place of Birth				
Jurisdiction	TN Tennessee			
Actual Site	RMSI Unit 1A1	Cell 01	Bed A	
Assigned Site	RMSI Unit 1A1	Cell 01	Bed A	
Custody Level	MAX Maximum	PREA Aggressor	N	
RNA Level	High Risk: Violent	Date 07/31/2018	Site NWCX	
Street	REDACTED			
City		State TN	Zip REDACTED	
Home Phone		Alternate Phone	REDACTED	
Email Address				

Reset key fields

Inquire

Modify

FastPath Go

<http://10.10.166.27:8100/Xhtml?JacadaApplicationName=ETOMIS&SessionId=-1189105762&ProcessId=...> 9/1/2021

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39. Based on generally accepted practices in prison management, a recent maximum custody level inmate like Tymothy Willis should not have been classified as a minimum custody level inmate a mere two-and-a-half years after receiving a maximum custody level classification.

40. Based on generally accepted practices in prison management, a recent maximum custody level inmate like Tymothy Willis should not have been housed in a Special Housing Unit with a minimum security inmate like Mr. Childress a mere two-and-a-half years after receiving a maximum custody level classification.

41. Based on generally accepted practices in prison management, a recent maximum custody level inmate like Tymothy Willis should not have been housed in a Special Housing Unit with a minimum security inmate like Mr. Childress in a cell with no windows or means of escape if one inmate attacks another.

42. Defendant CoreCivic's own reports regarding Mr. Childress's murderer expressly refer to Mr. Willis as a medium security inmate. Generally accepted practice in the prison management field also required classifying Mr. Willis as—at minimum—a medium security inmate considering his violent criminal and institutional history.

43. Despite Tymothy Willis's long history of violence, numerous felony convictions, and poor institutional record—including serious disciplinary reports and an institutional incident report in the previous six months before he murdered Mr. Childress—Defendant Curtis misclassified Tymothy Willis as a low security risk and minimum custody inmate who had just two “points.” Mr. Willis should instead have been classified as at least a medium custody inmate who had at least thirteen points.

44. In addition to Defendant Curtis misclassifying Tymothy Willis notwithstanding Willis's documented violent history and institutional record, at the time

of Mr. Childress's murder, Defendants CoreCivic and Byrd had specific knowledge that Mr. Willis was an informant on the compound—otherwise known as a “snitch”¹⁷—and that he posed a heightened danger to anyone with whom he was housed as a result.

45. Because Tymothy Willis had acted as an informant, shortly before Mr. Childress's murder, Tymothy Willis “had gotten a message from everybody in Segregation [that] was like, ‘Look, if you don’t take out your cellie, we’re going to take you out. But you have to leave this facility some way or another.’ And the only way out -- he could get out was killing somebody.”¹⁸

46. As a result of the threats that he received from other inmates at Trowsdale Turner Correctional Center, Tymothy Willis brutally murdered Mr. Childress in order to ensure his prompt transfer out of Trowsdale Turner Correctional Center.

47. Nobody employed by CoreCivic intervened while Tymothy Willis murdered Mr. Childress, because nobody employed by CoreCivic was around to hear it. Video surveillance reveals that corrections officers were not nearby at the time of Mr. Childress' murder and that they did not return to Mr. Childress's cell for an extended time period that was longer than normal rounds and adequate staffing required.

48. CoreCivic has actual knowledge that its surveillance footage proves its understaffing and associated liability arising from Mr. Childress's preventable murder. In an effort to conceal its liability and its actionable deliberate indifference, however, CoreCivic has withheld release of that footage to Plaintiffs under the pretense of security concerns that are not genuine.

49. On a routine basis, Trowsdale Turner Correctional Center's Special Housing

¹⁷ **Ex. 1** at 31:12–13.

¹⁸ *Id.* at 31:14–18.

Unit has only two of its positions staffed, requiring each of the officers on duty to do the work of three officers in addition to doing his or her individually assigned job. As a direct result of this understaffing, rounds were not conducted either properly or timely in the Special Housing Unit during the time period leading up to Mr. Childress' murder. When conducting rounds, officers routinely failed to verify the inmates' status properly in violation of TDOC policy and generally accepted practices in prison management. Neither were checks conducted with the frequency required by TDOC policy and generally accepted practices in prison management. As a result of these chronic failures, Timothy Willis was aware that he could murder Mr. Childress without intervention from any nearby officers, who would not discover the assault until after Mr. Childress was dead.

50. As of December 2020—approximately two months before Mr. Childress's murder—only two of the five positions in Trousdale Turner Correctional Center's Special Housing Unit were staffed. Trousdale Turner Correctional Center also continued to remain severely understaffed thereafter.

51. Adequate staffing would have enabled CoreCivic's officers to respond to Timothy Willis's assault of Mr. Childress and to prevent that assault from becoming fatal.

52. Trousdale Turner Correctional Center's understaffing is so severe that two units holding 360 inmates are often manned by just a single officer. Such severe understaffing is woefully insufficient to prevent serious injury to inmates resulting from inmate-on-inmate violence. It is also reasonably foreseeable that such gross understaffing will result in an increased number of inmate-on-inmate assaults and that those assaults will be more severe due to the absence of intervention from officers.

53. CoreCivic routinely staffs Trousdale Turner Correctional Center with just a single officer per unit, which is woefully insufficient to maintain a constitutionally

adequate level of inmate safety in the facility.

54. CoreCivic has—and it has long had—actual knowledge that Trousdale Turner Correctional Center is severely understaffed. Indeed, Trousdale Turner Correctional Center is understaffed *deliberately*, because paying for sufficient staffing is expensive and understaffing is more profitable.

55. Generally speaking, the less money that CoreCivic spends on staff and inmate safety at Trousdale Turner Correctional Center, the higher CoreCivic's profit margin. In all instances, CoreCivic acts to maximize profit for the benefit of its shareholders.

56. Given its focus on maximizing profit, CoreCivic routinely fails to meet constitutionally adequate safety standards at Trousdale Turner Correctional Center, resulting in recurring, preventable, and disproportionately high instances of inmate-on-inmate assaults and deaths.

57. Inmates at Trousdale Turner Correctional Center—including Terry Childress—have died and continue to die needlessly as a result of Trousdale Turner Correctional Center's premeditated and profit-motivated understaffing choices.

58. Defendant Hininger—CoreCivic's Chief Executive Officer—has actual knowledge of Trousdale Turner Correctional Center's chronic understaffing. Even so, he has willfully failed to remedy Trousdale Turner Correctional Center's deliberate indifference to inmate safety, both because understaffing is more profitable and because he does not care when inmates in CoreCivic's care needlessly die.

59. Defendant Conry, CoreCivic's Vice President of Operations Administration, also has actual knowledge of Trousdale Turner Correctional Center's endemic understaffing. Even so, he has similarly failed to remedy Trousdale Turner Correctional

Center's understaffing and the heightened risk of fatal inmate-on-inmate violence resulting from it, because understaffing is profitable and because he, too, is unbothered when inmates in CoreCivic's care needlessly die.

60. Defendant Byrd—who was the warden of Trousdale Turner Correctional Center at the time of Mr. Childress's preventable murder—was similarly aware of Trousdale Turner Correctional Center's extreme understaffing problems. Indeed, he observed them personally almost every single day that he served as warden. Even so, Defendant Byrd consciously neglected to remedy Trousdale Turner Correctional Center's chronic understaffing despite his personal knowledge of the extraordinary and frequently fatal inmate-on-inmate violence enabled by it.

61. Owing to the fact that the Defendants' tortious misconduct caused Mr. Childress to die from his injuries, Mr. Childress was unable to exhaust administrative remedies regarding the causes of action at issue in this Complaint in advance of its filing.

V. CAUSES OF ACTION

CLAIM #1: 42 U.S.C. § 1983—DELIBERATE INDIFFERENCE TO AND FAILURE TO PREVENT FORESEEABLE INMATE-ON-INMATE VIOLENCE (AS TO ALL DEFENDANTS)

62. The Plaintiffs incorporate and reallege the foregoing allegations as if fully set forth herein.

63. At all times relevant to this Complaint, all Defendants had legal duties under the Eighth Amendment to protect Mr. Childress from violence at the hands of other prisoners and to ensure Mr. Childress's reasonable safety at Trousdale Turner Correctional Center.

64. CoreCivic has an unconstitutional policy or practice of maintaining staffing levels that are insufficient to ensure that inmates like Mr. Childress are protected from

inmate-on-inmate violence.

65. All Defendants are and may be held liable for acting with deliberate indifference to Mr. Childress's safety at Trowsdale Turner Correctional Center.

66. Defendants CoreCivic, Hininger, Conry, and Byrd failed to protect Mr. Childress from a known risk of violence at the hands of another prisoner.

67. All Defendants failed to ensure Mr. Childress's reasonable safety at Trowsdale Turner Correctional Center.

68. All Defendants acted with deliberate indifference to Mr. Childress's safety while he was an inmate at Trowsdale Turner Correctional Center.

69. Defendants CoreCivic, Hininger, Conry, and Byrd knew that Mr. Childress faced a substantial risk of serious harm at Trowsdale Turner Correctional Center as a result of its chronic understaffing. Similarly, Defendant Curtis knew that misclassifying a violent and dangerous inmate like Tymothy Willis as a low security risk created a heightened and specific risk of violence to any low security cellmate with whom Tymothy Willis was housed.

70. Defendants CoreCivic, Hininger, Conry, Byrd, and Conry disregarded known risks to Mr. Childress at Trowsdale Turner Correctional Center by failing to take reasonable measures to abate them.

71. Defendants CoreCivic, Hininger, Conry, and Byrd were actually aware of the specific and particularized risks of serious harm posed to inmates like Mr. Childress as a consequence of, *inter alia*, CoreCivic's deliberate understaffing of Trowsdale Turner Correctional Center; CoreCivic's failure to properly train and supervise the staff at Trowsdale Turner Correctional Center to ensure adequate staffing levels; Trowsdale Turner Correctional Center's failure to adhere to safety protocols; and Trowsdale Turner

Correctional Center's failure to classify and house inmates in its care correctly and in accordance with generally accepted practices in prison management.

72. At the time Mr. Childress was murdered, Trousdale Turner Correctional Center was plagued by constant and pervasive risks of physical harm to inmates.

73. At the time Mr. Childress was murdered, Trousdale Turner Correctional Center's pervasive risk of harm to inmates manifested in actual harm and a dramatically outsized number of serious inmate-on-inmate attacks, only a fraction of which were ever officially documented.

74. At the time Mr. Childress was murdered, Trousdale Turner Correctional Center was plagued by longstanding, pervasive, well-known, and expressly observed inmate-on-inmate attacks that routinely went unreported to state regulators.

75. At the time Mr. Childress was murdered, Defendants CoreCivic, Hininger, Conry, and Byrd had been exposed to information concerning the risk of physical harm to inmates housed at Trousdale Turner Correctional Center, including audits by regulators, and they must have known about it.

76. At the time Mr. Childress was murdered, Defendants CoreCivic, Hininger, Conry, and Byrd had actual or constructive knowledge of the constant and pervasive risk of physical harm to inmates generally and to Mr. Childress specifically at Trousdale Turner Correctional Center.

77. Defendants CoreCivic, Hininger, Conry, and Byrd were additionally aware of the specific and particularized risk of serious harm posed to inmates like Mr. Childress as a consequence of the fact that—rather than maintaining inmate safety—CoreCivic's officers facilitate violence within Trousdale Turner Correctional Center by smuggling in drugs and needles to enable the drug trade, drug use, and the spread of contraband within

the facility.

78. To the extent that CoreCivic attempts to segregate violent inmates from non-violent inmates at Trousdale Turner Correctional Center, such attempts are rendered ineffectual by the facts that inmates are misclassified; are not meaningfully secured in their cells; and that entire pods are often left unsecured—even during lockdowns—due to understaffing. In combination with these chronic failures, Defendant Curtis’s misclassification of Tymothy Willis proximately enabled Mr. Childress’s preventable murder.

79. Despite Defendants CoreCivic’s, Hininger’s, Conry’s, and Byrd’s actual awareness of the severe risks to inmate safety within Trousdale Turner Correctional Center, they consciously and deliberately failed to address those risks because deliberate indifference to inmate safety is more profitable.

80. Because so many previous deaths at Trousdale Turner Correctional Center have not been met with meaningful remedial action, CoreCivic continues to maintain a chronically unsafe and understaffed facility, because it does not expect that regulators or this Court will take any meaningful remedial action against it.

CLAIM #2: LIABILITY UNDER *MONELL V. DEPT. OF SOCIAL SERVICES*, 436 U.S. 658 (1978)
(AS TO DEFENDANT CORECIVIC)

81. The Plaintiffs incorporate and reallege the foregoing allegations as if fully set forth herein.

82. Defendant CoreCivic has adopted a policy and practice of severely understaffing its facilities, including Trousdale Turner Correctional Center, without regard to inmate safety because understaffing is more profitable.

83. As a result of multiple audits identifying Trousdale Turner Correctional

Center's severe understaffing issues and thousands of violent incidents—both reported and unreported—at the facility over a period of years, CoreCivic had actual knowledge of Trowsdale Turner Correctional Center's chronic understaffing problems, but it opted not to staff Trowsdale Turner Correctional Center adequately because doing so would have been less profitable.

84. At the time of Mr. Childress's murder, CoreCivic's employees—including Defendants Hininger, Conry, and Byrd—had actual knowledge that Trowsdale Turner Correctional Center's chronic understaffing problems resulted in an extraordinary and outsized level of inmate-on-inmate violence at the facility.

85. CoreCivic's policy and practice of understaffing is widespread, rampant, and endemic to CoreCivic's prison facilities, including Trowsdale Turner Correctional Center.

86. Defendants CoreCivic, Hininger, Conry, and Byrd knew of the heightened and chronic safety risks to inmates resulting from understaffing at Trowsdale Turner Correctional Center, but they tolerated, maintained, and promoted understaffing to generate greater profits for CoreCivic at the expense of the safety of inmates like Mr. Childress.

87. Mr. Childress's death is attributable to Defendant CoreCivic's policy and practice of failing to ensure adequate staffing at its prison facilities, including Trowsdale Turner Correctional Center, which was explicitly or impliedly authorized by Hininger, Conry, and Byrd, and in which they knowingly acquiesced in accordance with CoreCivic's policy, custom, and practice of prioritizing profit over inmate safety.

88. If Trowsdale Turner Correctional Center's Special Housing Unit had been properly supervised and staffed, Mr. Childress would not be dead.

89. Trowsdale Turner Correctional Center's chronic understaffing also

continues to remain unremedied even after Mr. Childress's death. Indeed, several more inmates have died at Trousdale Turner Correctional Center following Mr. Childress's death—including as recently as January 2022—and inmates continue to die there with dramatically outsized frequency. In many cases, such deaths are kept hidden from and unreported to the public.

CLAIM #3: TENNESSEE COMMON LAW NEGLIGENCE
(AS TO DEFENDANTS CORECIVIC, BYRD, AND CURTIS)

90. The Plaintiffs incorporate and reallege the foregoing allegations as if fully set forth herein.

91. Defendants CoreCivic, Byrd, and Curtis owed a legal duty of care to Mr. Childress to protect him from reasonably foreseeable harm.

92. Because Tymothy Willis was a known informant and violent inmate whose safety had been threatened if he did not murder his cellmate, Defendants CoreCivic and Byrd knew of or had reasons to anticipate an attack on Mr. Childress by Tymothy Willis, but they did not use reasonable care to prevent it.

93. Based on Tymothy Willis's violent and dangerous history and his institutional history, Defendant Curtis knew that misclassifying Tymothy Willis as a low security inmate posed a specific risk of physical harm to any low security cellmate with whom Tymothy Willis was housed. Similarly, based on Tymothy Willis's violent and dangerous history, his institutional history, his status as an informant on the compound, and specific threats communicated to Tymothy Willis by other inmates if he did not murder Mr. Childress, Defendants CoreCivic and Byrd had actual and constructive notice of the risk of foreseeable harm that Tymothy Willis posed to Mr. Childress specifically, and they had reason to anticipate the attack.

94. Accordingly, Defendants CoreCivic and Byrd knew or should have known that Mr. Childress would become the victim of an attack by Tymothy Willis, but they failed to use reasonable care to prevent it.

95. Defendants CoreCivic's, Byrd's, and Curtis's breaches of their duty of care to Mr. Childress proximately caused Mr. Childress to die at the hands of his violent, dangerous, and misclassified cellmate.

CLAIM #4: LOSS OF CONSORTIUM
(AS TO ALL DEFENDANTS)

96. The Plaintiffs incorporate and reallege the foregoing allegations as if fully set forth herein.

97. Tennessee allows for an award of damages for loss of filial consortium and other damages for the death of one's child under Tenn. Code Ann. § 20-5-113. *See Hancock v. Chattanooga-Hamilton Cty. Hosp. Auth.*, 54 S.W.3d 234, 236 (Tenn. 2001).

98. The Defendants' wrongful acts, faults, omissions, and tortious misconduct caused Ms. Newby to suffer a loss of filial consortium and other damages arising from the death of her beloved son.

99. Accordingly, Ms. Newby is entitled to an award of damages, including the pecuniary value of Mr. Childress's life and the loss of her son's attention, guidance, care, protection, companionship, cooperation, affection, and love.

CLAIM #5: TENN. CODE ANN. § 1-3-121
(AS TO DEFENDANT CORECIVIC)

100. The Plaintiffs incorporate and reallege the foregoing allegations as if fully set forth herein.

101. Defendant CoreCivic knowingly and deliberately fails to ensure a

constitutionally adequate level of inmate safety at its Tennessee-based facilities.

102. Defendant CoreCivic knowingly and deliberately fails to ensure a constitutionally adequate level of inmate safety at its Tennessee-based facilities because it is cheaper and more profitable not to do so and because it does not fear meaningful regulatory or judicial consequences if it maintains understaffed facilities.

103. In an effort to prevent the fact of its chronic, profit-motivated deliberate indifference to inmate safety from reaching Tennessee regulators, legislators, and others, Defendant CoreCivic fails to document, disposes of, takes measures to conceal, and falsifies records and evidence of its deliberate indifference to inmate safety.

104. Tenn. Code Ann. § 1-3-121 enables plaintiffs to vindicate claims for declaratory and injunctive relief in cases involving illegal and unconstitutional government action. It specifically provides that: “Notwithstanding any law to the contrary, a cause of action shall exist under this chapter for any affected person who seeks declaratory or injunctive relief in any action brought regarding the legality or constitutionality of a governmental action.”

105. Defendant CoreCivic’s chronic deliberate indifference to inmate safety contravenes the provisions of the Eighth Amendment to the United States Constitution.

106. Defendant CoreCivic’s actions additionally contravene Tenn. Const. art. I, § 32, which provides that: “That the erection of safe prisons, the inspection of prisons, and the humane treatment of prisoners, shall be provided for.”

107. Absent, at minimum, regular independent monitoring and unannounced inspections designed to determine whether Defendant CoreCivic has remedied its chronic and profit-motivated deliberate indifference to inmate safety and other unlawful conduct described above, CoreCivic will continue to act both illegally and unconstitutionally with

respect to its operation of Trousdale Turner Correctional Center.

108. To remedy CoreCivic's chronically illegal and unconstitutional actions at Trousdale Turner Correctional Center, this Court should appoint an independent monitor to conduct regular unannounced inspections of Trousdale Turner Correctional Center and report whether Defendant CoreCivic has remedied its chronic and profit-motivated unlawful conduct.

109. In the absence of CoreCivic coming into compliance with its obligation to ensure a constitutionally adequate level of inmate safety, this Court should issue an injunction permanently enjoining Defendant CoreCivic from continuing to operate Trousdale Turner Correctional Center going forward.

VI. PRAYER FOR RELIEF

WHEREFORE, the Plaintiffs pray for the following relief:

1. That proper process issue and be served upon the Defendants, and that the Defendants be required to appear and answer this Complaint within the time required by law;
2. That the Plaintiffs be awarded all compensatory, consequential, and incidental damages to which they are entitled in an amount not less than \$2,500,000.00;
3. That the Plaintiffs be awarded punitive damages of not less than \$7,500,000.00;
4. That Defendant CoreCivic's profits arising from its chronically unconstitutional understaffing at Trousdale Turner Correctional Center be disgorged;
5. That the Plaintiffs be awarded all costs and discretionary costs of trying this action;
6. That the Plaintiffs be awarded their reasonable attorney's fees pursuant to

42 U.S.C. § 1988(b) and an appropriate multiplier of said fees;

7. That a jury of 12 be empaneled to try this cause;
8. That pre-judgment and post-judgment interest be awarded to the Plaintiffs;
9. That this Court declare that CoreCivic acted illegally by failing to ensure a constitutionally adequate level of inmate safety at Trousdale Turner Correctional Center;
10. That this Court appoint an independent monitor to conduct regular unannounced inspections of Trousdale Turner Correctional Center and report whether Defendant CoreCivic has remedied its chronic and profit-motivated unlawful conduct, and that this Court issue an injunction permanently enjoining Defendant CoreCivic from continuing to operate Trousdale Turner Correctional Center if it fails to do so; and
11. That the Plaintiffs be awarded all further relief to which they are entitled.

Respectfully submitted,

/s/ Daniel A. Horwitz
Daniel A. Horwitz, BPR #032176
Lindsay E. Smith, BPR #035937
HORWITZ LAW, PLLC
4016 Westlawn Dr.
Nashville, TN 37209
daniel@horwitz.law
lindsay@horwitz.law
(615) 739-2888

Brice M. Timmons #29582
Craig A. Edgington #38205
DONATI LAW, PLLC
1545 Union Ave.
Memphis, Tennessee 38104
(901) 278-1004 – Telephone
(901) 278-3111 – Facsimile
brice@donatilaw.com
craig@donatilaw.com

Attorneys for Plaintiffs

Transcript of Telephone Interview
Daniel Horwitz interviewing Treyton Lattimore
Transcribed from a digital file entitled:
"ct59Vab6xw"
August 31, 2021

Transcribed by:

Laurie McClain
615-351-6293
lauriemcclainmusic@gmail.com

1 MR. HORWITZ: -- so much. I -- I know this wasn't
2 easy. But --

3 MR. LATTIMORE: Oh, no, it's all good, man. I
4 would have gotten back to you sooner, but I've had a lot of
5 stuff going on with work and stuff, so [indiscernible].

6 MR. HORWITZ: No. I -- I understand. And you're
7 doing us a huge favor here. I -- I'm just trying to figure
8 out what happened. Can you -- can you tell me about that,
9 or tell me who -- who might know?

10 MR. LATTIMORE: Well, the only person who knows
11 what happened in the cell with Adams would be Elledge. And
12 Elledge now, I believe, is at Riverbend Maximum Security.

13 MR. HORWITZ: Right. And indicted, right?

14 MR. LATTIMORE: Yes. He's been charged -- like
15 the day that that stuff happened [indiscernible]. And so
16 the only thing that I can speak on is from the time I got
17 the call on the radio, because I was an officer in another
18 unit that night.

19 MR. HORWITZ: Okay.

20 MR. LATTIMORE: But I was what was known as ERT,
21 which is the emergency response team. And so whenever I got
22 the call, I just responded to it.

23 MR. HORWITZ: Okay. So do you still work there?

24 MR. LATTIMORE: No, I don't.

25 MR. HORWITZ: Okay. When -- can you -- can you

1 tell me when you stopped working there?

2 MR. LATTIMORE: I stopped working there in May.

3 MR. HORWITZ: All right.

4 MR. LATTIMORE: Yeah, so it was pretty recent.

5 MR. HORWITZ: So you're the first one who got the
6 call that -- that what, there was an assault, or somebody
7 was injured?

8 MR. LATTIMORE: Well -- well, we didn't know that
9 it was an assault, because the call that we got over the
10 radio -- because the officers that were down there, they
11 didn't actually physically see the assault. What we got a
12 call over the radio was we had a medical emergency, because
13 there was an inmate face down in a pool of blood.

14 MR. HORWITZ: Okay.

15 MR. LATTIMORE: And from there -- I was over in
16 Bravo Unit, which is right next to Segregation on that
17 compound.

18 MR. HORWITZ: Okay.

19 MR. LATTIMORE: And whenever I got there there was
20 a member of SORT (phonetic) that was already there, there
21 was one other officer, and the two officers that were
22 responsible for Alpha Unit that night.

23 MR. HORWITZ: Okay. And this happened in
24 Alpha Unit?

25 MR. LATTIMORE: Yes, this happened in Alpha Echo.

1 MR. HORWITZ: So where -- where were the officers
2 who were responsible for that unit? That's part of why I'm
3 [indiscernible].

4 MR. LATTIMORE: They were -- they were actually in
5 -- whenever they discovered the inmate, doing count.

6 MR. HORWITZ: Okay. So the --

7 MR. LATTIMORE: And --

8 MR. HORWITZ: -- no -- nobody saw the fight take
9 place --

10 MR. LATTIMORE: Correct.

11 MR. HORWITZ: -- or anything?

12 MR. LATTIMORE: No.

13 MR. HORWITZ: And do we know how long -- how much
14 time elapsed between when he was -- when he was hit and when
15 he was discovered?

16 MR. LATTIMORE: On that one, I'm not sure. But
17 what I can say is, I was one of the first officers -- I was
18 the officer that had like a front-row seat whenever we
19 opened the door. And the blood that was around his head was
20 dried.

21 MR. HORWITZ: Was dry.

22 MR. LATTIMORE: Yes.

23 MR. HORWITZ: Got it. So we're talking about --

24 MR. LATTIMORE: So it had -- it had been a while.
25 Yeah, it had been a while. And I was the officer that

1 started CPR.

2 MR. HORWITZ: Okay.

3 MR. LATTIMORE: And I'm not a doctor or anything,
4 but once I started CPR, he was dead.

5 MR. HORWITZ: Got it. First of all, thank you for
6 -- for --

7 MR. LATTIMORE: Oh, yeah, of course, of course.

8 MR. HORWITZ: -- talking through this. I
9 imagine --

10 MR. LATTIMORE: Yeah [indiscernible].

11 MR. HORWITZ: -- just how traumatic for you to --

12 MR. LATTIMORE: I meant to -- like I meant to do
13 it like earlier. Because I was talking to the lady who runs
14 the -- the Trousdale site -- the Trousdale "shut it down"
15 site.

16 MR. HORWITZ: Right.

17 MR. LATTIMORE: And -- and like I meant to
18 -- like I've been meaning to get back to her as well, and
19 then your private investigator, too. But I've just had a
20 lot of stuff like get dropped on me at home, and stuff like
21 that. So --

22 MR. HORWITZ: No, I understand.

23 MR. LATTIMORE: -- like I apologize for -- for my
24 procrastination on it. I should have got it done sooner.

25 MR. HORWITZ: It's -- it's -- it's okay. I -- I

1 really appreciate it. And I'm -- I'm sure that it's --

2 MR. LATTIMORE: Oh, yes, sir.

3 MR. HORWITZ: -- traumatic for you as well.

4 MR. LATTIMORE: Well, I mean -- and this -- this
5 is going to sound a little jacked up, but it's honestly not,
6 because I was a military police officer. So I was exposed
7 to like stuff like this before. That's why I'm able to tell
8 you this stuff in a calm demeanor, because I'm -- it -- it
9 sounds like [indiscernible] it sounds really jacked up, but
10 I'm used to it.

11 MR. HORWITZ: Okay. Are there no cameras or
12 anything that would have shown what happened?

13 MR. LATTIMORE: Within the cell, no.

14 MR. HORWITZ: Okay.

15 MR. LATTIMORE: The only cameras that are in --
16 there are two cameras in Alpha Echo. There's one at the
17 beginning of the pod, and there's one on the backside of the
18 pod.

19 Where they were at, they were in Alpha Echo 213.
20 And right there, there are no cameras that can view inside
21 of that cell. Plus for privacy reasons, we can't put
22 cameras in the cell, unless they are a suicide risk, and
23 they're on suicide watch. Other than that, there are no
24 cameras in the cells.

25 MR. HORWITZ: Okay. How -- how often does

1 something like this happen? I mean, that it --

2 MR. LATTIMORE: Depending, generally speaking,
3 usually with Trousdale there's a high number of assaults and
4 homicides and overdoses, and stuff like that. Like
5 Trousdale-Turner is a very rough prison to work in and be
6 housed in.

7 MR. HORWITZ: Got it. I mean, I -- I guess what
8 I'm trying to figure out is it seems like there was a
9 significant delay between when he was -- when he was injured
10 and when he was discovered.

11 MR. LATTIMORE: Yes.

12 MR. HORWITZ: And --

13 MR. LATTIMORE: And -- and what I can say about
14 that is that particular night -- it was December 14th, 2020,
15 that particular night there was two officers working
16 Alpha Unit. There's supposed to be five.

17 MR. HORWITZ: Okay.

18 MR. LATTIMORE: But there was --

19 MR. HORWITZ: Do you -- do you know why the other
20 three weren't there?

21 MR. LATTIMORE: Staffing issues. There -- there
22 was no one that we could put on the schedule to take -- to
23 like man those posts, because we literally did not have the
24 staff.

25 MR. HORWITZ: Got it. Is there --

1 MR. LATTIMORE: Like that night, like that
2 particular night, the officer that I was training was a
3 brand-new officer. And whenever that stuff happened, you
4 know, I had to leave him in Bravo Unit by himself. And I
5 was also one of the officers that had to go to the hospital
6 with [indiscernible] Adams.

7 MR. HORWITZ: Got it.

8 MR. LATTIMORE: And so literally -- so whenever I
9 left and another officer left, that left two other pods with
10 two other units with one officer in it. So that was two
11 units with 360 inmates, with one officer.

12 MR. HORWITZ: Jeez.

13 MR. LATTIMORE: Yeah.

14 MR. HORWITZ: So that -- in -- in this unit where
15 this happened, there were 360 inmates?

16 MR. LATTIMORE: I'm not sure of the exact numbers,
17 because I wasn't counting that.

18 MR. HORWITZ: But around there?

19 MR. LATTIMORE: [indiscernible] but generally
20 speaking that's the capacity, yes, 360 inmates.

21 MR. HORWITZ: Got it. So I -- I assume like with
22 five officers [indiscernible] might be able to hear a fight,
23 or something like that?

24 MR. LATTIMORE: Oh, yeah, definitely, definitely.
25 Because with five officers that means that there's one

1 officer per pod, and officers are like sitting in the pod.
2 You know, so if there was an officer in there when the fight
3 was happening, yes, it would have been heard, and they would
4 have been dealt with it.

5 But in my honest opinion, Adams died because of
6 the lack of staffing. If someone was there, then it could
7 have been prevented -- or at least, you know, like --
8 because I'm not sure of why they fought.

9 I know Elledge, he already kind of had a
10 reputation as being kind of crazy, because from like my
11 understanding, Elledge had already killed cellmates before,
12 so he shouldn't have been housed with anyone in the first
13 place.

14 But [indiscernible] like it was -- it was pretty
15 -- like it was -- it was a very -- like that night was
16 already stressful as it was, because we had had like a
17 couple overdoses and stuff like that. So we were already --
18 everybody was already running around like a chicken with
19 their head cut off, you know. And then that just kind of
20 compounded everything else.

21 And plus man, Adams was a good guy. Like I never
22 had a single issue with Adams. I knew he was getting out
23 soon, you know. And -- and then all of a sudden, you know,
24 we got that call. And I'm like, "Wait, no way," you know.
25 Like that's the first thing that went through my head.

1 Because like with -- with the amount of time that
2 I worked there, like you get -- you know, you get to know
3 these inmates. You get to know where they're at. You get
4 to know their situations. You know? And so it was one of
5 those to where it was like, "No, okay, let's go see what's
6 going on."

7 And then whenever I got there, it was like,
8 "Holy crap," you know, like "Wow." And -- and like a lot of
9 people were thinking that there was a weapon involved.
10 There was not a weapon there, like at all.

11 Hello? Can you hear me? Can you hear me?

12 Oh, hold on. I'm texting you, because I can't
13 hear you now.

14 Hello? Hello? I hear something knocking.

15 Hello? I can't hear you.

16 Hello?

17 I can't hear you.

18 MR. HORWITZ: Sir, can you hear me now?

19 Hello? Hello, sir? Sir, I'm going to -- I'm
20 going to...

21 MR. LATTIMORE: Hello?

22 MR. HORWITZ: Hey, I can hear you now.

23 MR. LATTIMORE: Okay. Cool, cool, cool. There we
24 go.

25 MR. HORWITZ: I'm so sorry. I think I might have

1 [indiscernible] connected to my bluetooth headset. My
2 apologies.

3 MR. LATTIMORE: Oh, it's all good, man. It's all
4 good.

5 MR. HORWITZ: What I was going to ask is: Is
6 there documentation that would demonstrate the staffing
7 issues?

8 MR. LATTIMORE: There should be. As far as like
9 from that night, there should be a roster.

10 MR. HORWITZ: Okay.

11 MR. LATTIMORE: Because I know every night the
12 lieutenants and the captains have to create a roster that
13 gets sent up the chain of command. So --

14 MR. HORWITZ: Okay.

15 MR. LATTIMORE: -- yes, there is some paperwork as
16 to who was scheduled to what pod.

17 MR. HORWITZ: Okay. And there were just three
18 people who didn't show up?

19 MR. LATTIMORE: No. There wasn't anyone that we
20 had to place on the shift.

21 MR. HORWITZ: Got it.

22 MR. LATTIMORE: And as it was, like we were --
23 like every officer was already working six 16-hour shifts a
24 week at that particular time. So if the officers were off,
25 it was literally one of those where they earned it, because

1 we had been busting our butts like -- like God knows what.

2 MR. HORWITZ: Got it. So they -- the -- the
3 warden would just put two people in the unit?

4 MR. LATTIMORE: No. It wasn't the warden. It was
5 the captain or the lieutenant that was on shift, based on
6 the amount of staff that we had.

7 And in that particular instance, every other unit
8 except for my unit and Whiskey Unit, and Alpha Unit, and I
9 believe Delta Unit -- every other unit has one officer. So
10 you had Foxtrot with one officer, Charlie with one officer,
11 and Echo with one officer.

12 Now after that incident happened, everywhere
13 except for Alpha and Whiskey had one officer.

14 MR. HORWITZ: Got it.

15 MR. LATTIMORE: Yeah [indiscernible] that was
16 horrible at that time.

17 MR. HORWITZ: So I mean, isn't there like a yearly
18 audit that happens in January, where they -- they go back
19 through and they look through this to make sure that people
20 are compliant?

21 MR. LATTIMORE: Yes.

22 MR. HORWITZ: And they were -- they just weren't
23 worried about being in noncompliance?

24 MR. LATTIMORE: I mean, like, it was one of those
25 to where like we prepared for what we could handle and what

1 we could help. You know, like, with the fact of, you know,
2 not enough officers are hired on, you know what I mean, that
3 doesn't necessarily fall on the captains and the
4 lieutenants; that's an HR issue.

5 You know, because the captains and the
6 lieutenants, they're literally given a list of people, like
7 okay, these are the people that are going to be on, you have
8 to put these people, you know, where they can fill the best
9 needs.

10 MR. HORWITZ: Got it. All right.

11 I mean, it -- it just seems like -- with this
12 prison it seems like there are so many issues unique to this
13 prison.

14 MR. LATTIMORE: Yes.

15 MR. HORWITZ: I'm -- I'm sort of confused at the
16 -- what about Trousdale is -- is so much worse than all the
17 other facilities?

18 MR. LATTIMORE: Well, the thing with Trousdale is,
19 Trousdale was designed to be a minimum security facility, to
20 where we're not supposed to house anybody with medium to
21 maximum points, none of that.

22 MR. HORWITZ: Okay.

23 MR. LATTIMORE: Trousdale-Turner has, in essence,
24 become the trash can of TDOC, meaning, if prisons won't
25 accept these inmates, they literally just send them to

1 Trousdale. So you've got an -- you've got a huge mix of
2 different security levels under one roof.

3 MR. HORWITZ: Got it.

4 MR. LATTIMORE: That -- that is like adding a
5 gallon of gasoline to an open flame.

6 MR. HORWITZ: Right, right. And you pair that
7 with understaffing, I imagine it's --

8 MR. LATTIMORE: Exactly. And --

9 MR. HORWITZ: -- [indiscernible].

10 MR. LATTIMORE: -- not just because of staffing,
11 but then with the drug cases, and drug overdoses and stuff
12 like that. So not only are you understaffed, but you've got
13 a majority of your inmates intoxicated on either
14 methamphetamine or heroin. [indiscernible] --

15 MR. HORWITZ: So I was going to ask about that.
16 Because we -- I got a tip that -- that this fight had
17 something to do with -- with meth. And the -- the entire
18 prison would have been locked down for almost a year because
19 of Covid. Do you -- I mean, do you have any sense of how
20 they would have gotten it?

21 MR. LATTIMORE: Well, on that instance, I'm not
22 100 percent sure, because at that point, yeah, you're right,
23 the prison was locked down from the outside. Now, on the
24 inside, it's not locked down. You know, the inmates were
25 kind of like more or less quarantined to their pods.

1 MR. HORWITZ: Uh-huh.

2 MR. LATTIMORE: Now, in Segregation they weren't
3 allowed to come out. But I do know that like say for
4 instance if someone has drugs from another pod, right, and
5 they come into Segregation, and one of the officers that
6 went through their stuff happened to miss something that was
7 in their stuff, then they would have to [indiscernible] --

8 MR. HORWITZ: [indiscernible] can get to another
9 pod.

10 MR. LATTIMORE: -- that way, yeah. And then --

11 MR. HORWITZ: But --

12 MR. LATTIMORE: -- they would do what's called
13 "fish," where they throw contraband back and forth to each
14 other, connected to strings, and then they could pull it in,
15 you know.

16 Now what I do know is whenever I was there, no
17 drugs were discovered or found. But I also was not a part
18 of the search procedures for that cell, because once the
19 EMTs arrived, I literally sat with the inmate the entire
20 time until the county coroner came to take jurisdiction over
21 his body.

22 MR. HORWITZ: Okay. Do -- do you know if Elledge
23 said anything?

24 MR. LATTIMORE: Elledge -- Elledge literally
25 refused to talk about it. The only thing that Elledge had

1 said was once we opened the door, all he said was, "I'm
2 sorry." For the rest of the night he acted like as if
3 nothing happened. That was also how I knew that dude was
4 crazy.

5 MR. HORWITZ: Got it. Do you --

6 MR. LATTIMORE: [indiscernible].

7 MR. HORWITZ: -- know anything about his security
8 designation?

9 MR. LATTIMORE: His security designation should
10 have been "max," because with Elledge [indiscernible] you'll
11 see Elledge has been to Trousdale a few different times.

12 MR. HORWITZ: Right.

13 MR. LATTIMORE: And he keeps getting shipped out
14 to Riverbend, which is maximum security. But Riverbend
15 doesn't want to deal with him, so they ship him back to
16 Trousdale. And it's like a constant cycle of him bouncing
17 back and forth.

18 MR. HORWITZ: Got it. When -- when you say
19 "should have been max," what -- do you know if he was?

20 MR. LATTIMORE: I believe that he was, but I'm not
21 100 percent sure, because I didn't deal in classifications.

22 MR. HORWITZ: Got it.

23 MR. LATTIMORE: [indiscernible].

24 MR. HORWITZ: All right. Do you know why he was
25 housed with Mr. Adams?

1 MR. LATTIMORE: I do not know. I know Mr. Adams
2 was in Segregation for protective custody.

3 MR. HORWITZ: Got it. Do you know -- and do you
4 know what [indiscernible]?

5 MR. LATTIMORE: (No audible response.)

6 MR. HORWITZ: Okay. Segregation, you're alone,
7 right?

8 MR. LATTIMORE: What do you mean, like in your
9 cell?

10 MR. HORWITZ: Right. Like he -- like he doesn't
11 have a -- like a cellmate?

12 MR. LATTIMORE: No. That's -- that's not the
13 case. In Segregation it's still two-per.

14 MR. HORWITZ: Okay.

15 MR. LATTIMORE: Now, Elledge should have been by
16 himself. [indiscernible] --

17 MR. HORWITZ: Is that because of his security
18 designation?

19 MR. LATTIMORE: Yes.

20 MR. HORWITZ: Okay.

21 MR. LATTIMORE: Elledge should have been by
22 himself, because there's even -- like even the officers will
23 tell you, Elledge was coo-coo for Cocoa Puffs.

24 MR. HORWITZ: Got it. Like violent, and getting
25 into trouble, that sort of thing?

1 MR. LATTIMORE: Yes. Like violent, like
2 boisterous talk to them and stuff, and always had weapons on
3 him. He was known for attacking officers, known for
4 attacking other inmates.

5 MR. HORWITZ: And would it -- I -- I guess I'm
6 trying to figure out why if somebody is in protective
7 custody they would -- they would be matched up with somebody
8 like that.

9 MR. LATTIMORE: I honestly think they just put him
10 where an empty bed was, because how it usually goes in
11 Segregation. Once the inmate is going to Segregation, first
12 we take him to intake. And once we get him in intake, then
13 the count room looks for an empty bed in Seg. Once they
14 find an empty bed in Seg, just plug and go.

15 MR. HORWITZ: Got it. Do you know if they had
16 been housed together for while?

17 MR. LATTIMORE: On that one I am not sure. Once
18 again, that would be something that the count room at
19 Trousdale could address, because the count room was
20 responsible for placing all of the inmates in their assigned
21 cells.

22 MR. HORWITZ: Got it. I mean, I -- I assume
23 whatever evidence of negligence there was in -- in
24 documentation is gone by this point. But that's probably --

25 MR. LATTIMORE: On that one, I'm not 100 percent

1 sure. Because what I do know is the counts, they're turned
2 in to TDOC after every count. And with those counts also
3 are the cell assignments with those counts as well. And at
4 the beginning of every shift, that opening count, we go
5 through and we do what's called a E-TOMIS check, which is
6 making sure that all the inmates are in their assigned
7 cells, per E-TOMIS.

8 E-TOMIS is the -- is the Tennessee system that has
9 all the inmates' information, from their security level to
10 their housing assignments, to their good times, to their job
11 assignments, pretty much -- it's -- it's pretty much like
12 the Google for inmates. You know, you look up an inmate
13 based on their TDOC number, you can see everything about
14 them.

15 MR. HORWITZ: Got it. Got -- is there like a risk
16 manager or a compliance officer who's -- who's preventing
17 this sort of thing from happening? Because I know there was
18 another murder just, you know, like six weeks or eight weeks
19 later.

20 MR. LATTIMORE: Yes. Now with that, the only --
21 the only type of compliance officer that I was aware of, it
22 was like the ethics liaison. But that was more or less for
23 officers making sure we were doing what we were supposed to
24 do.

25 As far as like risk management and stuff like

1 that, that was way above my pay grade, so I can't answer
2 that, because I don't know.

3 MR. HORWITZ: Got it. And like the warden is not
4 worried about being sued or anything? I mean, it just seems
5 like are so many incidents at this prison.

6 MR. LATTIMORE: Oh, well, on that case, man, like
7 CoreCivic is all privatized. So the warden himself, it --
8 he wouldn't get sued for it. It would fall on CoreCivic.
9 And then CoreCivic would deal with it however they see fit
10 to deal with it.

11 MR. HORWITZ: Okay. And even like bring everybody
12 in, do a debrief as to how this happened, how to prevent it?

13 MR. LATTIMORE: On that one, no. I know that day
14 -- like the day -- the morning after it all happened, they
15 called all the officers that witnessed it, they called us in
16 to speak to the investigator. But the investigator never
17 spoke to me.

18 MR. HORWITZ: This is a CoreCivic investigator?

19 MR. LATTIMORE: Yes. She works at CoreCivic,
20 Investigator Woods (phonetic).

21 MR. HORWITZ: Okay. And when you say "all the
22 officers" that saw it, you're talking about after -- after
23 he was dead, right?

24 MR. LATTIMORE: Yes. I'm talking about the
25 officers that responded, and the other officer that was with

1 me in the hospital with the inmate.

2 MR. HORWITZ: Got it. Did -- I guess did the --
3 did the docs at the hospital -- did anyone say anything that
4 would be important to know?

5 MR. LATTIMORE: Well, they pronounced him dead on
6 the scene --

7 MR. HORWITZ: Okay.

8 MR. LATTIMORE: -- which is the first time I'd
9 ever seen that happen. Because Trousdale at night, there's
10 no doctors there, and only doctors can pronounce a person
11 dead. But the EMT that was there, I guess he was the
12 captain, and he pronounced him DOA.

13 And once we got to the hospital, they kind of put
14 us in a storage room with him. Like -- like -- because this
15 hospital is very small, so they didn't necessarily have a
16 morgue.

17 So it was literally me, one other officer, and the
18 deceased. The deceased was restrained to the bed, and he
19 was not placed in a body bag until the county coroner came
20 to take jurisdiction over the body.

21 MR. HORWITZ: Got it.

22 MR. LATTIMORE: Because once we got into the
23 hospital, we could not do anything to him. We couldn't
24 cover him up. We couldn't uncuff him. We literally could
25 not touch him because at that point he was evidence.

1 MR. HORWITZ: Got it. And every -- this is
2 blunt-force trauma, right?

3 MR. LATTIMORE: Yes.

4 MR. HORWITZ: Okay.

5 MR. LATTIMORE: It was ruled blunt-force trauma.

6 MR. HORWITZ: Whew. God. I guess that's all I
7 can think of to ask.

8 Is there anything else that I -- that I need to
9 know about this?

10 MR. LATTIMORE: With that particular incidence,
11 I'm not 100 percent sure. Yeah, I've told you everything
12 that I know. I've told you my involvement in it.
13 Everything else, I'm not 100 percent sure on.

14 MR. HORWITZ: Okay. They -- they don't --
15 CoreCivic doesn't encourage people to, you know, destroy
16 documents or anything, do they?

17 MR. LATTIMORE: Oh, negative. No. We've never
18 been told to destroy or tamper anything. Now, as far as
19 writing reports go, they will tell us, you know, to kind of
20 word things differently. But that's only on like uses of
21 force and stuff like that, like getting technical with it.

22 Like we can't say that "the guy threw a punch."
23 We can say that "he took his left arm -- or left hand with a
24 clenched fist and struck so-and-so's body part," like what
25 body part they hit or like --

1 MR. HORWITZ: Okay. For -- for something like
2 this, though, I guess what I'm concerned about is I -- I
3 sent a records request to -- to CoreCivic and got like
4 nothing back.

5 MR. LATTIMORE: Yes.

6 MR. HORWITZ: Or very, very little back. I just
7 -- I'm surprised, you'd think with a -- you know, a murder
8 in the facility there would be -- there would be a lot more,
9 and there wasn't.

10 MR. LATTIMORE: Oh, yeah, definitely. Definitely.
11 Now, I think, honestly, on that one, I think CoreCivic is
12 trying to cover their butt --

13 MR. HORWITZ: Right.

14 MR. LATTIMORE: -- because the fact of us being,
15 you know, not properly staffed. Like if -- like I said, if
16 we were staffed, that incident would have turned out way
17 different.

18 But you know, like at the end of the day,
19 CoreCivic is the one, in my opinion, that is responsible for
20 that happening, because number one, they knew Elledge's
21 track record. Number two, they knew Adams' security level.
22 And number three, they should have known that at any point
23 in time -- you know, Elledge has already harmed other
24 inmates -- he shouldn't be around anybody.

25 MR. HORWITZ: Got it. When you say, turned out

1 differ -- could have turned out differently if they were
2 properly staffed, what -- what do you mean by that?

3 MR. LATTIMORE: I mean, I'm saying that I think
4 Adams would be alive --

5 MR. HORWITZ: Got it. Do you -- do you think --

6 MR. LATTIMORE: -- like no -- no doubt in my mind.

7 MR. HORWITZ: Do you think your -- your coworkers
8 would agree with that -- or your former coworkers?

9 MR. LATTIMORE: I think the ones -- I think the
10 ones that still work for CoreCivic would not comment on
11 it --

12 MR. HORWITZ: Right.

13 MR. LATTIMORE: -- because they would probably lose
14 their job. But if they weren't still employed with
15 CoreCivic, I do think that they would agree.

16 [indiscernible] --

17 MR. HORWITZ: Like CoreCivic would fire people for
18 -- for testifying against them?

19 MR. LATTIMORE: Pretty much, yes, because whenever
20 we worked for CoreCivic, we are assigned -- we have to sign,
21 of course, an NDA that the stuff that happens there, we
22 can't speak to media about it unless, you know, there's a
23 CoreCivic spokesperson there. We can't comment on anything
24 to medias while we're still employed by CoreCivic.

25 We can't even go on a Facebook post unless it's

1 making CoreCivic look good, you know. We can't say anything
2 about what goes on in the prison, or we will be fired.

3 MR. HORWITZ: Got it. That -- and they make
4 people sign that up front?

5 MR. LATTIMORE: Yes.

6 MR. HORWITZ: Jeez.

7 MR. LATTIMORE: That's apart of your entrance
8 paperwork.

9 MR. HORWITZ: Got it.

10 MR. LATTIMORE: They have -- they have a class on
11 it in the training academy.

12 MR. HORWITZ: Got it. Is that unique to
13 CoreCivic? Did they make you do that at TDOC?

14 MR. LATTIMORE: I'm not sure. I didn't do
15 corrections with TDOC, I did corrections with the
16 United States Army.

17 MR. HORWITZ: Got it. Got it. But once -- once
18 you get to CoreCivic, they -- they put that thing in front
19 of you and they make you sign it?

20 MR. LATTIMORE: Oh, yeah, definitely. Definitely.
21 Now, of course, I mean, in the military, it's kind of the
22 same thing. You know, like you can't say anything that
23 could be a detriment to the military. But with CoreCivic,
24 yeah, that thing goes on.

25 Because like there was -- there was one incident

1 where I was with an inmate at the hospital, and he had died
2 and come back. Right? Because he had -- he had already
3 health complications, and he was getting up there in age.
4 And like he died and he came back. And like that -- that
5 experience like kind of shook me a little bit, right?

6 So I was talking about it on Facebook and one of
7 my coworkers was like, "Hey, you need to take this down,
8 because if somebody from HR sees it, they're going to fire
9 you."

10 MR. HORWITZ: Got it. Is that common? Do people
11 get fired for doing that?

12 MR. LATTIMORE: Yes.

13 MR. HORWITZ: Wow. Can you think of anybody who
14 might talk to me about this other than you?

15 MR. LATTIMORE: About this particular incidence?

16 MR. HORWITZ: Yes.

17 MR. LATTIMORE: I don't have his phone number, but
18 I know you can look him up on Facebook, because he was there
19 with me. Now, I'm not sure that he'll talk to you, because
20 he was kind of a jerk. But [indiscernible] yeah, his name
21 is Tristan Morgan (phonetic). And --

22 MR. HORWITZ: And this is a former
23 [indiscernible]?

24 MR. LATTIMORE: Yes. Yes, he's a former CO. He
25 was one of the officers that responded to it with me. He

1 actually threw up whenever we opened the door. Like he was
2 very shook. After that incident, he refused to work in
3 Segregation --

4 MR. HORWITZ: Got it.

5 MR. LATTIMORE: -- like would not go back.

6 MR. HORWITZ: Got it. Do you know if he spoke to
7 the investigator?

8 MR. LATTIMORE: I'm not sure if he did.

9 MR. HORWITZ: Okay.

10 MR. LATTIMORE: Because I know we sat around and
11 we waited. The investigator never showed up. And me and a
12 few of the other officers, once that stuff happened, we
13 actually -- this is going to sound a little jacked up --
14 this is like at 11:00 in the morning, we went out and got
15 drunk.

16 MR. HORWITZ: Got it.

17 MR. LATTIMORE: Because we kind of had -- you
18 know, it was -- it was very -- it was rough for all of us.
19 Especially because, I mean, like we knew how Elledge was,
20 and we knew the type of person that Adams was. Adams was
21 not -- you know, he was not an aggressive person. You know,
22 he wasn't -- he wasn't a bad dude. But Elledge was just
23 psycho.

24 MR. HORWITZ: Got it. You said -- you said
25 Tristan Morgan?

1 MR. LATTIMORE: Yes. Tristan Morgan.

2 MR. HORWITZ: Okay. And the -- and the other
3 people who would know something about this still work there?

4 MR. LATTIMORE: Yes. They -- they are all still
5 currently employed.

6 MR. HORWITZ: At -- at Trousdale, or --

7 MR. LATTIMORE: Yes.

8 MR. HORWITZ: -- or CoreCivic generally?

9 MR. LATTIMORE: At -- at Trousdale.

10 MR. HORWITZ: Okay. Well, I may have to try to
11 talk -- were -- were there a bunch of people that -- that
12 got involved after he --

13 MR. LATTIMORE: There was -- well, the -- the ERT
14 is five officers, plus the other two officers that was
15 there.

16 MR. HORWITZ: Okay.

17 MR. LATTIMORE: Now, I know some of the ERTs --
18 excuse me -- they couldn't leave their units because they
19 were the only ones in their units. So I know there was me,
20 Lucas (phonetic), Morgan -- Lucas was the one that initially
21 discovered him. He's the one that made the call.

22 MR. HORWITZ: Okay.

23 MR. LATTIMORE: Harmon (phonetic) was down there.
24 Williams -- but Williams was SORT (phonetic), and Williams
25 is from Georgia. And the rest was SORT. I know, of course,

1 Captain Beaver (phonetic) and Lieutenant Murray (phonetic)
2 responded as well. And Officer Roberts (phonetic) was the
3 officer that was with me at the hospital.

4 MR. HORWITZ: Got it. Did --

5 MR. LATTIMORE: And at the point that --

6 MR. HORWITZ: Did everybody have to write a
7 report?

8 MR. LATTIMORE: Yes. We had to write what's
9 called a 51C, because all of the reports at Trousdale are
10 labeled under 51 documentation. But 51C is the officers
11 incident report. So we had to write literally what we seen.

12 So in my report was, after I had finished count --
13 because I had just got back to my unit from returning the
14 count paperwork to the count room, we got the call, "Got an
15 inmate face down in a puddle of blood."

16 We did everything we could to subdue Elledge,
17 because at first he was refusing to cuff up. But once we
18 got him cuffed, once I made entrance in through the door, I
19 flipped the body over and started CPR.

20 MR. HORWITZ: Got it. [indiscernible].

21 MR. LATTIMORE: So yeah, one thing that I can say,
22 the officers that were on scene, we did everything per --
23 per CoreCivic and TDOC policy. [indiscernible].

24 MR. HORWITZ: Got it.

25 MR. LATTIMORE: Yeah. Like the only -- the only

1 people who are at fault here is CoreCivic for, you know,
2 them housing him with him, and the fact that we did not have
3 adequate staff.

4 MR. HORWITZ: Got it. And that's -- that's
5 somebody in the classification department and then somebody
6 in HR who's just not --

7 MR. LATTIMORE: Yes.

8 MR. HORWITZ: -- giving you enough officers?

9 MR. LATTIMORE: Yes. Because --

10 MR. HORWITZ: Got it.

11 MR. LATTIMORE: -- [indiscernible] plus in
12 Segregation, you're supposed to make rounds every
13 30 minutes, which it takes you about 15 minutes to make a
14 good round and physically check on living, breathing bodies.
15 But whenever you've only got two officers having to do that
16 to five pods, it -- it takes a long time.

17 MR. HORWITZ: Got it. How much -- how much, if
18 you had to estimate it?

19 MR. LATTIMORE: At least double.

20 MR. HORWITZ: At least double.

21 MR. LATTIMORE: Yes. Because you're -- you're
22 literally doing three other people's jobs.

23 MR. HORWITZ: Got it. Do you know if they fixed
24 the staffing issues after this happened?

25 MR. LATTIMORE: I know for a little bit, yes, but

1 even as it stands now, they're still severely understaffed.
2 I've still got tons of my former coworkers asking me to come
3 back because [indiscernible] enough staff.

4 MR. HORWITZ: Got it. Yeah, because right after
5 this, Mr. Childress died, right?

6 MR. LATTIMORE: Yes.

7 MR. HORWITZ: And that was a classification issue,
8 too, as I understood it.

9 MR. LATTIMORE: Yes, with Mr. Childress, that was
10 -- again, that's something that happened in Segregation.
11 And with that one, from what I had heard, his cellmate had
12 gotten a [indiscernible]. Because his cellmate was a snitch
13 on the compound.

14 And his cellmate had gotten a message from
15 everybody in Segregation was like, "Look, if you don't take
16 out your cellie, we're going to take you out. But you have
17 to leave this facility someday or another. And the only way
18 out" -- he could get out was killing somebody.

19 MR. HORWITZ: Jesus Christ.

20 MR. LATTIMORE: Oh, yeah. Like the inmates at
21 Trousdale are ruthless.

22 MR. HORWITZ: When you say --

23 MR. LATTIMORE: Like --

24 MR. HORWITZ: -- "snitch" of the facility, you're
25 talking about like reporting people for drugs or whatever?

1 MR. LATTIMORE: Yes. Like he told on somebody for
2 something, that's how he got into Segregation. Like if you
3 get into PC, that's because you told on somebody. Like that
4 -- that's really the only -- that's one of the only ways
5 that the captains and the lieutenants will move you to
6 protective custody.

7 Because there's a lot of inmates, you know, they
8 get themselves into trouble, you know, they'll make deals
9 with the wrong people. And then the first thing they'll do
10 is, "Oh, I want to hurt myself, or I want to hurt somebody
11 else," just to go to protective custody because of a mess
12 that they got themselves into. You know?

13 MR. HORWITZ: Got it.

14 MR. LATTIMORE: And so like if an inmate comes to
15 staff and is like, "Hey, I want an RCA," all we can do is,
16 number one, we -- we can try to remove them from the pod,
17 and then we call for assistance.

18 And then nine times out of ten, when the captain
19 or the lieutenant comes, they're either going to take the
20 inmate back into the cell and secure him into his door, or
21 they're going to say, "Look, you have to tell me something
22 and make me know -- to let me know that, okay, this is
23 something for real, like you are serious, you're really
24 going to get hurt if we don't do something." And then
25 they'll get moved to Seg.

1 MR. HORWITZ: Is that -- is that why Adams was
2 there?

3 MR. LATTIMORE: Adams, I'm not sure why he was
4 there. I just know that he was there for protective
5 custody. I'm not sure how he got there, or anything like
6 that.

7 Because me, as an officer, I try to, you know,
8 like not necessarily look at inmates' convictions and their
9 security levels, because some people do things, and you
10 know, I don't necessarily agree with it, and I don't want to
11 take that fight into it. You know?

12 MR. HORWITZ: Got it. Got it. And is no one in
13 CoreCivic's like corporate office or HR or whatever worried
14 about the blowback for something like this? It -- it just
15 seems like not being in compliance, being understaffed, and
16 having people murdered would be a huge problem, but they
17 just don't seem to care.

18 MR. LATTIMORE: I think that it's one of those
19 things to where it's the power of the almighty dollar. You
20 know? Because CoreCivic gets 200 million from State of
21 Tennessee, and they want to keep that money. They want to
22 keep it coming in.

23 Like we got paid based off of bodies. You know,
24 we'd like -- whenever we counted and we finished count,
25 that's when they cash the check.

1 MR. HORWITZ: Got it. And understaffing helps
2 them save money?

3 MR. LATTIMORE: Definitely. Because what they'll
4 do is, like they'll higher a bunch of people, and then
5 they'll start firing a bunch of people. And then they'll
6 higher a bunch more and then they'll fire a bunch more.

7 And then, you know, they would much rather pay,
8 you know, eight officers on night shift a bunch of overtime
9 to run that entire facility, you know, versus having three
10 officers per unit 24 hours a day, which they're supposed to.

11 MR. HORWITZ: And -- and the people who -- who
12 regulate the prisons, they don't -- they don't pop them for
13 this sort of thing?

14 MR. LATTIMORE: If they do, I don't know.

15 MR. HORWITZ: Got it. Well, thank you so much.
16 This has been extremely valuable. I -- I really, really
17 appreciate it. I know this is -- this is probably not easy.
18 I would traumatized if -- if I had to experience what you
19 did here.

20 MR. LATTIMORE: Well, yes. But I mean, like with
21 three deployments under my belt, and I was military police,
22 so I was a combat MOS, you know, like for me it -- I mean,
23 yeah, it sucks, but I mean, that's -- that's the nature of
24 the beast, you know. Like you don't -- you don't sign up to
25 work in corrections if you're not expecting to see some

1 stuff like that.

2 MR. HORWITZ: Got it. Got it. Why did you get
3 out, just out of curiosity?

4 MR. LATTIMORE: Oh, I got out because I got tired
5 of working 16-hour shifts and not having anything to show
6 for it.

7 MR. HORWITZ: Got it.

8 MR. LATTIMORE: And I got tired of seeing less
9 qualified officers getting promoted.

10 MR. HORWITZ: Got it.

11 MR. LATTIMORE: Yeah, because I was -- whenever I
12 got out of the military, I was an E-6, I got out right after
13 I did two tours as a drill sergeant. And so I'm thinking,
14 you know, at least my military experience enough would be
15 enough for, you know, some type of promotion after being
16 there for 9 months working six days a week. But they seen
17 it otherwise, and you know, crooked unit managers and
18 crooked captains, and I was like, "Yeah, you know what?
19 This ain't for me."

20 MR. HORWITZ: Well, good for you. What are you
21 doing now?

22 MR. LATTIMORE: Now, I'm actually -- I'm actually
23 what I was doing before I went back into corrections. I am
24 what's called a spray technician. I treat weeds and lawns.

25 MR. HORWITZ: Good for you.

1 MR. LATTIMORE: So I make [indiscernible] lawns
2 look really pretty.

3 MR. HORWITZ: That's wonderful.

4 MR. LATTIMORE: Yeah.

5 MR. HORWITZ: Well, good for you for getting out
6 of this business. It seems awfully grisly.

7 MR. LATTIMORE: Oh, yeah. Grisly is an
8 understatement. Like it's -- like Trousdale-Turner is
9 rough, man.

10 MR. HORWITZ: Well --

11 MR. LATTIMORE: [indiscernible].

12 MR. HORWITZ: -- it certainly seems that way.

13 Then core -- CoreCivic doesn't -- do they do
14 anything to discourage people from -- from talking to people
15 like me after they leave?

16 MR. LATTIMORE: Oh, after they leave, no.

17 MR. HORWITZ: No.

18 MR. LATTIMORE: Like how I left, I told them that
19 I might have had Covid, and I did. And I just never came
20 back.

21 MR. HORWITZ: Got it. Got it. Well, thank you.
22 Thank you for your time. Thank you for just --

23 MR. LATTIMORE: Oh yes, sir.

24 MR. HORWITZ: -- talking through this with me.
25 This is enormously valuable, and I'm -- I'm really grateful.

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**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION**

BOAZ PLEASANT-BEY,)	
)	
Plaintiff,)	
)	
v.)	Civil Action Number 3:19-CV-486
)	District Judge Aleta A. Trauger
STATE OF TENNESSEE,)	Jury Demand
TENNESSEE DEPARTMENT)	
OF CORRECTION, REVEREND)	
BRIAN DARNELL, TONY)	
PARKER, CORECIVIC, INC.,)	
JON SHONEBARGER,)	
and RUSSELL WASHBURN,)	
)	
Defendants.)	

FIRST AMENDED COMPLAINT

1. Plaintiff Boaz Pleasant-Bey (“Plaintiff” or “Pleasant-Bey”) is incarcerated in the Trousdale Tuner Correctional Center (“Trousdale”), a facility operated by CoreCivic to house prisoners serving state charges for the Tennessee Department of Corrections (“TDOC”). He is a Muslim who is unable to exercise his religious beliefs at Trousdale Turner, while Christian inmates receive more favorable treatment, in violation of rights under the U.S. Constitution and federal statutes, including the Religious Land Use and Institutionalized Persons Act (“RLUIPA”). Plaintiff also fears for his safety due to severe understaffing at Trousdale.

JURISDICTION AND VENUE

2. This Court has jurisdiction over this action under 28 U.S.C. § 1331 because this action arises under the Constitution and laws of the United States.

3. This Court also has jurisdiction to grant declaratory relief under 28 U.S.C. §§ 2201 and 2202, and Fed. R. Civ. P. 57.

4. The Court has authority to grant injunctive relief under Fed. R. Civ. P. 65.

5. This Court has personal jurisdiction over each defendant. CoreCivic has a headquarters and principal place of business in Tennessee and operates Trousdale at issue in this litigation. Warden Washburn, Chaplain Shonebarger, Commissioner Parker, and Reverend Darnell (the “Individual Defendants”) work in Tennessee and, upon information and belief, permanently reside in Tennessee. TDOC is a department of the State of Tennessee and is responsible for the constitutional housing of state prisoners.

6. Venue is proper in this District under 28 U.S.C. § 1391(b)(1) because all Defendants reside in or otherwise do business in this District, and because a substantial part of the events giving rise to Plaintiffs’ claims occurred within this District.

PARTIES

7. **Boaz Pleasant Bey**: Plaintiff Boaz Pleasant-Bey is a prisoner who has been housed at Trousdale, located at 140 Macon Way, Hartsville, Tennessee from April 2018 to the present.

8. **CoreCivic**: Defendant CoreCivic is a Maryland corporation headquartered in Tennessee, with its principal place of business at 10 Burton Hills Boulevard, Nashville, Tennessee. It is a for-profit, publicly traded (NYSE:CXV) real estate investment trust that “specializes in owning, operating, and managing prisons and other correctional facilities,” and has referred to itself as the nation’s “largest owner of partnership correction and detention facilities and one of the largest prison operators in the United States.” Its website boasts that the corporation operates more than 60 detention facilities, jails, and prisons holding more than 90,000 beds. It operates Trousdale and other Tennessee facilities under the full authority of the State of Tennessee pursuant

to T.C.A. §§ 41-24-101 *et seq.* and/or 41-8-101 *et seq.* At all times relevant to Plaintiff's Complaint, CoreCivic was acting under color of state law. CoreCivic is the entity charged by the State of Tennessee with authority to maintain Trousdale and has a non-delegable duty to ensure that all inmates are protected by the Constitutions and laws of the United States and the State of Tennessee. CoreCivic is responsible for the implementation of policies, procedures, practices, and customs, as well as the acts and omissions, challenged by this action. At all relevant times, CoreCivic has operated Trousdale as instrumentalities of the State of the Tennessee in performing the TDOC's duty to house individuals serving state sentences during their terms of incarceration. At all relevant times, CoreCivic has received funding from the federal government, including but not limited to Medicare and/or Medicaid payments and payments for the housing of federal prisoners. CoreCivic is licensed to do business in Tennessee and may be served through its registered agent, CT Corporation System, 300 Montvue Rd. Knoxville, TN 37919-5546.

9. **Warden Washburn:** Defendant Warden Russell Washburn was, at all times relevant to this action, employed at Trousdale.

10. **Chaplain Shonebarger:** Defendant Chaplain Jon Shonebarger was, at all times relevant to this action, a Chaplain employed at Trousdale.

11. **Commissioner Parker:** Defendant Commissioner Tony Parker was, at all times relevant to this action, the Commissioner of the Tennessee Department of Corrections.

12. **Reverend Darnell:** Defendant Reverend B. Darnell was, at all times relevant to this action, the TDOC Director of Religious Services.

13. **Tennessee Department of Corrections:** The Tennessee Department of Corrections ("TDOC") is a department of the State of Tennessee that, in relevant part, is responsible for housing individuals serving state sentences of incarceration. To perform this

governmental function, TDOC contracts with CoreCivic to operate certain facilities, including Trousdale at all times relevant to Plaintiff's Complaint. In delegating these functions, the TDOC contractually entrusts CoreCivic to operate as an instrumentality of the State of Tennessee.

STATEMENT OF FACTS

A. Access to Khufain

14. The Plaintiff believes that the Prophet Muhammad wore Khufain [Prayer Socks] while he was making Salah [Prayer], and this is also a tradition that he must follow. Not being able to wear Khufain during Salah places a substantial burden upon the Plaintiff's religious exercise because he is not in compliance with the practices of the Sunnah of Prophet Muhammad.

15. The Prophet Muhammad wore Khufain during Salah and when he wasn't in Salah. The way Khufain works is that the person who makes Salah wipes his feet during Wudu [Ablution] and he puts on Khufain. He wears Khufain even when he breaks Wudu by using the bathroom or breaking wind. However, before every Salah, Wudu must be performed again. When wearing Khufain, he only needs to wipe over his Khufain one time with water when making ablution as long as he has whipped his bare feet within 24 hours of putting on the Khufain. Thus, the Prophet wore Khufain in and out of Salah. Clearly, Khufain is part of the Sunnah of Prophet Muhammad, but the Defendants are stubbornly denying the Plaintiff of this religious exercise which is essential to Salah, and they have not explained why they deny it. U.S. Const. Amend. 1; 42 U.S.C. § 2000cc-1 (a)-(b).

16. Defendants Parker, Darnell, Washburn and Shonebarger have all deprived the Plaintiff of his ability to purchase Khufain. The Plaintiff has submitted several requests concerning the Khufain, but those Defendants persisted in denying the Plaintiff the Khufain, which are part of the Sunnah of Prophet Muhammad, who believed in the convenience of Salah. The Plaintiff

believes that he must wear the Khufain socks while making Salah because the Khufain is part of the Sunnah of Prophet Muhammad and denial of the Khufain places a substantial burden upon his religious exercise because he is not fully in compliance with the Sunnah of Prophet Muhammad while making Salah. 42 U.S.C. § 2000cc-1 (a)-(b); U.S. Const. Amend. 1.

B. Wear Kifaya and Agal During Prayer

17. Defendants TDOC, CoreCivic, Parker, Darnell, Washburn, and Shonebarger have all placed a substantial burden upon the Plaintiff's religious exercise by totally banning Islamic attire worn in Salah designed to cover the arms and other body parts from materials that are in accordance with Islamic requirements for dress while in Salah. This substantial burden extends to them denying the Plaintiff a Kifiya [Towel-like Head-dress] and Agal [Designed to hold it in place] which was also worn by Prophet Muhammad and is part of the Sunnah that the Plaintiff follows. U. S. Const. Amend. 1; 42 U.S.C. § 2000cc-1 (a)-(b) Appendix 1-17.

C. Traditional Halal Foods During Ramadan and Id Feasts

18. The Plaintiff believes that eating is an act of worship in Islam once Bismillah [The Name of Allah] is said over the food. The Plaintiff believes that he must fast during the Holy Month of Ramadan, eat traditional Halal [Lawful] food during the Id Ul Fitr Feast at the completion of the Month of Ramadan, which is traditionally held from one to three days, and eat traditional Halal food during the Id Ul Adha [Feast of Sacrifice]. Those Id Celebrations have a Salah and Khutbah [Religious Sermon] that are traditionally held before the food is served. Also, while fasting during the Holy Month of Ramadan, the Plaintiff believes he must eat traditional Halal foods the entire month in order for the Fast to be in accordance with the Qur'an and Sunnah. Prophet Muhammad and his Companions all ate dates, drank whole milk, ate honey, Halal meats

[Lamb, Chicken, Beef, and Fish] with vegetables and natural fruits [not processed foods] both before and after he fasted every day during the Holy Month of Ramadan.

19. Defendants TDOC, CoreCivic, Darnell, Washburn, and Shonebarger have prevented Plaintiff from eating traditional Halal foods during Ramadan and the Id feasts in 2018 and 2019, in violation of RLUIPA.

D. Access to Prayer Oil

20. Defendants TDOC, CoreCivic, Parker, Darnell, Washburn and Shonebarger have forced the Plaintiff to purchase Islamic prayer oil from a Christian Vendor and a unislamic vendor. The Plaintiff's religious exercise of traditional Islamic Practices of purchasing Islamic Prayer Oil from an Islamic Vendor is being substantially burdened by the Defendants barring him from purchasing Islamic Prayer Oil from an Islamic Vendor, and purchasing Prayer Oil from Union Supply, a Christian Vendor, and from a unislamic vendor [Access]. U.S. Const. Amend. 1; 42 U.S.C. § 2000cc-1 (a)-(b). The Defendants have not given any compelling governmental interest for why they place such substantial burdens upon Plaintiff's religious exercise. In this case, the least restrictive means of furthering any compelling governmental interest would be to allow the Plaintiff to purchase Islamic Prayer Oil from Islamic Vendors.

E. Restriction on Donation of Islamic Religious Items

21. Defendants TDOC, CoreCivic, Parker, Darnell, Washburn and Shonebarger have all violated the Establishment Clause and Equal Protection Clause of the First and Fourteenth Amendments by showing special treatments to Christian inmates by allowing Kiros and Men of Valor to be able to enter TDOC and Core Civic America facilities to donate outside foods, hygiene products, and have religious meals brought into the prisons for Christmas and Easter Celebrations for all inmates [despite their religious preferences] every year, but deprive the Plaintiff of the

ability to have traditional Halal Foods, Islamic Prayer Oil and Halal hygiene products donated to TDOC, and TDOC Contracted Facilities. This behavior demonstrates that Christianity is preferred over Islam and that participants of the Islamic Faith have disadvantaged treatments. It also demonstrates that the Defendants have discriminatory intentions against the Islamic Faith by depriving them of traditional foods and religious items for their religious celebrations, while allowing Christians to receive traditional foods and religious items for their religious celebrations. Moreover, depriving the Plaintiff of the ability to have Halal Foods donated to TDOC and TDOC Contracted CCA Prisons places a substantial burden on his religious exercise.

22. 42 U.S.C. § 2000cc-1 (a)-(b); U.S. Const. Amend. 1 and 17; *Cutter v. Wilkinson*, 554 U.S. 709, 724-725 (2005) (Singling out a certain religion for "special treatment" violates the Establishment Clause of the First Amendment to the United States Constitution.); *Perez v. Frank*, 433 F. Supp. 2d 955, 996 (W.D. Wis. 2006) ("To the extent petitioner contends that the religious traditions of other inmates are being accommodated while Islamic traditions are not... states a claim under the Establishment Clause."); U.S. Const. Amend. 1; *Church of Lukumi Babalu Aye, Inc. v. Hialeah*, 508 U.S. 520, 532 (1993) (A law may not discriminate against "some or all religious beliefs."); *Davis v. Prison Health Services*, 679 F. 3d 433, 438 (6th Cir. 2012) ("The Equal Protection Clause of the Fourteenth Amendment protects against invidious discrimination among similarly situated individuals or implicating fundamental rights."); *Lindell v. Casperson*, 360 F. Supp. 2d 932, 958 (W.D. Wis. 2005) (Holding that "the denial of a privilege to adherents of one religion while granting it to others is discrimination on the basis of religion in violation of the Equal Protection Clause of the Constitution.").

F. Lack of Group Accommodations for Muslim Inmates

23. Defendants TDOC, CoreCivic, Washburn, Darnell and Shonebarger have all violated the Establishment Clause of the First Amendment to the United States Constitution by allowing the Men of Valor to have a Christian based program pod at Trousdale, but denying the Plaintiff's request for a Unit for Muslims to be able to practice their religion with a program designed to better themselves with the assistance of outside Muslim sponsors.

24. The Plaintiff submitted a program called Al Andalus to Chaplain Jon Shonebarger in 2018, and the Plaintiff has not received any response from the Rev. B. Darnell concerning the group accommodations request. Also concerning a violation of the Establishment Clause, the Plaintiff submitted a request to start a Qur'anic Arabic Studies Group in 2018 on the group accommodations request form, and Chaplain Jon Shonebarger has not provided any response from the Director of Religious Services, Rev. B. Darnell. Chaplain Shonebarger mentioned that he recommended that the class be denied by the religious activities committee despite the fact that there is a Hebrew/Greek Bible Study Group for Christians available at Trousdale. Clearly, this demonstrates that the Defendants show "special treatment" to Christian inmates, and unfavorable treatments to Muslim inmates concerning the same opportunities. U.S. Const. Amend. 1.

G. Qur'an Ban

25. Defendants CoreCivic and Washburn have printed a memorandum unfairly banning the Qur'an from entering Trousdale but allowing the Bible to be ordered from Union Supply. There is no purpose for this memorandum other than to give more favorable treatments and to promote Christianity while showing disfavoring beliefs towards Islam, the religion of the Plaintiff.

H. Cruel and Unusual Punishment

26. Plaintiff alleges that, based on the totality of conditions, practices, and incidents that have occurred at Trousdale, the conditions at Trousdale violate the Eighth Amendment and these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth Amendment.

27. Specifically, Plaintiff alleges that Tony Parker and CoreCivic violated and are continuing to violate the Eighth Amendment rights of prisoners housed at Trousdale by failing to protect them from prisoner-on-prisoner violence, prisoner-on-prisoner sexual abuse, and by failing to provide safe conditions. These violations are severe, systemic, and exacerbated by serious deficiencies in staffing and supervision; inadequate incident reporting; inability to control the flow of contraband into and within the prisons, including illegal drugs and weapons; ineffective prison management and training; and a high level of violence that is too common, cruel, of an unusual nature, and pervasive.

28. Since it began accepting state prisoners on January 4, 2016, Trousdale has been highly understaffed. In its November 2017 Performance Audit Report (“2017 Performance Audit Report”) covering the period from July 1, 2014 through August 31, 2017, the Tennessee Comptroller of the Treasury found that:

- Trousdale Turner Correctional Center, managed by CoreCivic, operated with fewer than approved correctional officer staff, did not have all staffing rosters, did not follow staffing pattern guidelines, and left critical posts unstaffed;
- Core Civic staffing reports for two Trousdale Turner Correctional Center contained numerous errors, so information about hires, terminations, and vacancies may not be reliable; and

- Trousdale Turner Correctional Center management's continued noncompliance with contract requirements and department policies challenges the department's ability to effectively monitor the private prison.¹

29. As a result of this understaffing, inmates at Trousdale experience a high level of violence and fear for their future safety. Plaintiff is personally aware of multiple instances of extreme violence. The shortage of staff issue is such a problem at Trousdale that the Plaintiff has witnessed groups of inmates stabbing each other in Echo Alpha Unit for about 20 minutes without any officers coming in the housing unit to stop the stabbings. During another incident, an inmate was stabbed 17 times by a domestic terrorist group while he was sitting in his cell. He went without medical attention and any assistance for about 15 minutes as he bled, limping to the medical unit for medical assistance. There were no officers in the pod at the time because of the shortage of staff issue. Several staff members have been brutally stabbed by domestic terrorist groups and inmates since Trousdale has been open. In early September 2019, a mental health worker was raped, sodomized, and brutally stabbed over 12 times for over 30 minutes without any officer interference by an inmate. Also, in September 2019, an inmate in Delta Unit was stabbed in his neck while in his cell by another inmate.

30. On June 10, 2019, the Human Rights Defense Center and No Exceptions Prison Collective reported that from 2014 through June 2019, there were twice as many murders in the four Tennessee prisons operated by CoreCivic than in the 10 prisons run by TDOC.² Also, the homicide rate in CoreCivic facilities was over four times higher than the rate for TDOC prisons.

¹ See Tennessee Comptroller of the Treasury's November 2017 Performance Audit Report, available at <https://comptroller.tn.gov/content/dam/cot/sa/advanced-search/2017/pa17275.pdf>.

² "CoreCivic Prisons in Tennessee Have Twice as Many Murders, Four Times the Homicide Rate as State-Run Facilities," Prison Legal News, Aug. 6, 2019, available at: <https://www.prisonlegalnews.org/news/2019/aug/6/corecivic-prisons-tennessee-have-twice-many-murders-four-times-homicide-rate-state-run-facilities/>.

This was despite the fact that during that time period, TDOC facilities held, on average, 70% of the state's prison population – including prisoners with higher security levels than in CoreCivic prisons.³

31. On June 15, 2019, Trousdale inmate Ernest Edward Hill, 42, was found unconscious by prison officials.⁴ Life-saving measures were attempted, but Hill was pronounced dead at the hospital.⁵ After an investigation by the Tennessee Bureau of Investigation, Hill's cellmate was indicted on a second-degree murder charge.⁶

32. On January 25, 2020, Trousdale inmate Frank Lundy was found injured at the entrance to the housing unit.⁷ Lundy was pronounced dead at the hospital.⁸ Reports indicate Lundy was stabbed in the neck, resulting in a fatal injury.⁹

³ *Id.*

⁴ Hineman, Brinley, "Murfreesboro man charged in death of prison cellmate at Trousdale Turner Correctional Facility," Feb. 20, 2020, available at: <https://www.dnj.com/story/news/2020/02/20/murfreesboro-man-jacob-kado-charged-death-prison-cell-mate-ernest-hill-trousdale-turner/4818354002/>.

⁵ *Id.*

⁶ *Id.*

⁷ Gregory, Chris, "Inmate killed in assault at Trousdale prison," The Lebanon Democrat, January 30, 2020, available at https://www.lebanondemocrat.com/hartsville/inmate-killed-in-assault-at-trousdale-prison/article_4808fd72-b736-5dba-8607-e510d899e1e2.html.

⁸ *Id.*

⁹ *Id.*

33. Former inmates and friends and families of inmates have complained of the extreme violence Trousdale.¹⁰ Trousdale employees have been assaulted.¹¹ There are reports of rampant gang activity and sexual assault at Trousdale.¹²

34. Trousdale staff refuse to properly document stabbings and other violent incidents. The 2020 Performance Audit found that health staff at Trousdale did not record any serious accidents or injuries in a state database during the 1.5-year audit period.¹³ The auditors wrote: "Given the nature of the correctional environment and when compared to other correctional facilities, it is unlikely that a facility would have no serious incidents to report."¹⁴

¹⁰ See e.g. "Prisons for profit: Concerns mount about Trousdale Turner Correctional Center, operator CoreCivic," NewsChannel5 Nashville, June 13, 2019, available at <https://www.newschannel5.com/longform/prisons-for-profit-concerns-mount-about-trousdale-turner-correctional-center-operator-corecivic>; Facebook Page, "Trousdale Turner—Close it Down," available at <https://www.facebook.com/hartsville.tn.prison/>.

¹¹ See e.g. Gregory, Chris, "Assault at Hartsville prison lands employee in hospital," The Lebanon Democrat, Mar. 26, 2020, available at https://www.lebanondemocrat.com/hartsville/assault-at-hartsville-prison-lands-employee-in-hospital/article_b7a35957-c316-5ce7-ba57-17a4076f72f4.html; Gregory, Chris, "Inmate indicted for assault on TTCC employee," The Lebanon Democrat, Jan. 22, 2020, available at https://www.lebanondemocrat.com/hartsville/inmate-indicted-for-assault-on-ttcc-employee/article_c24dd2de-14b4-5367-a5e2-5f58002f2d0e.html.

¹² See e.g. Hale, Steven, "Tennessee's Largest Prison Still Appears as Troubled as Ever," Nashville Scene, available at <https://www.nashvillescene.com/news/features/article/21047078/tennessees-largest-prison-still-appears-as-troubled-as-ever>; Kalodimos, Demetria, "Gang activity, security a concern at Trousdale Turner facility," WSMV News 4 Nashville, available at https://www.wsmv.com/news/gang-activity-security-a-concern-at-trousdale-turner-facility/article_df82a358-7073-552e-b5e4-9feb2e9cf8bc.html; Amons, Nancy, "Family questions inmate's death in Trousdale Co. prison," WSMV News 4 Nashville, available at https://www.wsmv.com/news/davidson_county/family-questions-inmates-death-in-trousdale-co-prison/article_d781fc30-3977-11ea-affd-cbade3eed916.html. "Inmate files suit against Trousdale prison run by CoreCivic" WKRN, Feb 22, 2019, available at <https://www.wkrn.com/news/inmate-files-suit-against-trousdale-prison-run-by-corecivic/1800562147/>.

¹³ *Id.* at 39.

¹⁴ *Id.*

35. The 2020 Performance Audit found numerous other reporting violations occurred at Trousdale. For example:¹⁵

At Trousdale Turner Correctional Center, we found the following:

- For 3 of 25 items (12%), facility staff did not enter the incident information into TOMIS within 8 hours of occurrence or discovery.
- For 7 of 25 items (28%), the body of the draft incident report did not match the information staff entered into TOMIS. Because Trousdale is a CoreCivic facility, we compared the CoreCivic 5-1a and 5-1c forms to TOMIS.
- For 24 of 25 items (96%), staff did not report the incident to the CCC within 30 minutes of occurrence or discovery.
- For 4 of 25 items (16%), staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 2 of 25 items (8%), staff could not locate the Staff Assault Incident Review Report.
- For 7 of 25 items (28%), staff did not submit a Use of Force report to the warden within 8 hours or by the end of shift.
- For 9 of 25 items (36%), staff did not enter all required information related to the incident into TOMIS; specifically, staff did not include lists of disciplinary infractions, names of all persons involved, and descriptions of homemade weapons.

36. Using a random sampling of Prison Rape Elimination Act (“PREA”) allegations, auditors found that Trousdale staff entered allegations into the PREA Allegation System ten days late, on average.¹⁶ These late-entered allegations had a high percentage of errors.¹⁷

37. Trousdale staff have demonstrated an inability to control the flow of contraband into and within Trousdale, including illegal drugs and weapons, increasing the frequency and risks of violent encounters. Employees have been caught smuggling contraband into the facility.¹⁸

¹⁵ *Id.* at 69.

¹⁶ *Id.* at 82.

¹⁷ *Id.*

¹⁸ *See e.g.* Gregory, Chris, “Trousdale Turner employee charged with smuggling contraband,” The Lebanon Democrat, April 23, 2020, available at:

Recently, an unauthorized individual was permitted to enter the facility and remain for hours before being discovered.¹⁹ Homemade weapons appear to be very easy for Trousdale prisoners to produce or procure. Many of the incidents already described demonstrate the widespread availability of such weapons.

38. Illegal drugs contribute to the ongoing violence and pose a substantial risk of future violence, yet Trousdale staff has routinely failed to conduct the required inmate drug screening.²⁰ In its January 2020 Performance Audit Report (“2020 Performance Audit Report”) covering the period from October 1, 2017 through July 31, 2019, the Tennessee Comptroller of the Treasury found that Trousdale did not conduct the minimally required random drug screenings of the inmate population.²¹ The report described an interview with the drug testing coordinator at Trousdale:²²

Based on our interview with the drug testing coordinator at Trousdale Turner Correctional Center, the coordinator informed us that he did not test the minimally required 2.5% of the inmate population for either March or April 2019. According to the drug testing coordinator, when he was given the responsibility for conducting the drug screenings in March 2019, he received on-the-job training from the former drug testing coordinator. He went on to state that he did not have access to TOMIS at that time and had to attend a critical incident response team class.

https://www.lebanondemocrat.com/hartsville/trousdale-turner-employee-charged-with-smuggling-contraband/article_6b865daf-fbc8-5a59-9a35-e84b61ace2e4.html.

¹⁹ Gregory, Chris, “CoreCivic investigating security breach at Hartsville prison,” The Lebanon Democrat, Jul. 30, 2020, available at:

https://www.lebanondemocrat.com/hartsville/corecivic-investigating-security-breach-at-hartsville-prison/article_ae6dd86e-3f6f-58e9-9d5f-ee68d8967e68.html.

²⁰ See Tennessee Comptroller of the Treasury’s January 2020 Performance Audit Report, available at <https://comptroller.tn.gov/content/dam/cot/sa/advanced-search/2020/pa19032.pdf>.

²¹ *Id* at 167.

²² *Id* at 168.

The auditors state, “By not performing the minimum number of monthly random drug screenings, facility management faces an increased risk that inmate alcohol or drug use could go undetected, creating an environment for increased violent behavior.”²³

39. Trousdale’s administration of prescription drugs poses similar problems. The 2020 Performance Audit Report found multiple issues surrounding Trousdale employees’ distribution of prescription medication.²⁴ The report notes the same problems in inmates’ medical records:

We determined that for all 13 medical files tested (100%), health services staff did not include key information about inmates’ medication on the medication administration record, including the start and stop date, dosage, order date, number of [keep on person] pills given, name of the prescribing doctor, and discontinue date.²⁵

40. Plaintiff has attempted to address issues by using Trousdale’s grievance process but has found that Trousdale regularly fails to follow its own policies and procedures.

41. Plaintiff is concerned for his safety and well-being. Without the proper staffing, his life is in great danger because there are not enough officers to monitor whether a medical emergency or violent assault occurs at Trousdale.

CAUSES OF ACTION

COUNT I

VIOLATION OF THE FIRST AMENDMENT TO THE UNITED STATES CONSTITUTION FREE EXERCISE CLAUSE (42 U.S.C. § 1983)

42. Plaintiff re-alleges and re-avers the preceding paragraphs, and the preceding are incorporated herein by reference.

43. Defendants Parker, Darnell, Washburn, and Shonebarger prevented Plaintiff from purchasing Khufain in violation of the Free Exercise Clause of the First Amendment.

²³ *Id.*

²⁴ *Id.* at 105.

²⁵ *Id.* at 118.

44. Defendants Parker, Darnell, CoreCivic, Washburn, and Shonebarger did not permit Plaintiff to wear Islamic attire during prayer, including a Kifaya and Agal, in violation of the Free Exercise Clause.

45. Defendants Parker, Darnell, CoreCivic, Washburn, and Shonebarger prevented Plaintiff from purchasing prayer oil from an Islamic vendor in violation of the Free Exercise Clause.

COUNT II

VIOLATION OF THE FIRST AMENDMENT TO THE UNITED STATES CONSTITUTION ESTABLISHMENT CLAUSE (42 U.S.C. § 1983)

46. Plaintiff re-alleges and re-avers the preceding paragraphs, and the preceding are incorporated herein by reference.

47. Defendants Parker, Darnell, CoreCivic, Washburn, and Shonebarger did not permit Plaintiff to receive donated Islamic religious items from Muslim organizations in violation of the Establishment Clause of the First Amendment.

48. Defendants CoreCivic, Washburn, Darnell, and Shonebarger prevented Plaintiff from participating in religious group accommodations equivalent to those for Christian inmates in violation of the Establishment Clause.

49. Defendants CoreCivic and Washburn prevented a Qur'an from entering the facility in violation of the Establishment Clause.

COUNT III

VIOLATION OF THE FOURTEENTH AMENDMENT TO THE UNITED STATES CONSTITUTION EQUAL PROTECTION CLAUSE (42 U.S.C. § 1983)

50. Plaintiff re-alleges and re-avers the preceding paragraphs, and the preceding are incorporated herein by reference.

51. Defendants Parker, Darnell, CoreCivic, Washburn, and Shonebarger did not permit Plaintiff to receive donated Islamic religious items from Muslim organizations in violation of the Equal Protection Clause of the Fourteenth Amendment.

COUNT IV

VIOLATION OF THE EIGHTH AND FOURTEENTH AMENDMENTS TO THE UNITED STATES CONSTITUTION

CRUEL AND UNUSUAL PUNISHMENT

(42 U.S.C. § 1983)

(Against Parker and CoreCivic for Injunctive Relief Only)

52. Plaintiff re-alleges and re-avers the preceding paragraphs, and the preceding are incorporated herein by reference.

53. Plaintiff alleges that, based on the totality of conditions, practices, and incidents that have occurred at Trowsdale, the conditions at Trowsdale violate the Eighth Amendment and these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth Amendment.

54. Plaintiff alleges that Defendants Tony Parker and CoreCivic violated and are continuing to violate the Eighth Amendment rights of prisoners housed at Trowsdale by failing to protect them from prisoner-on-prisoner violence, prisoner-on-prisoner sexual abuse, and by failing to provide safe conditions. These violations are severe, systemic, and exacerbated by serious deficiencies in staffing and supervision; inadequate incident reporting; inability to control the flow of contraband into and within the prisons, including illegal drugs and weapons; ineffective prison management and training; and a high level of violence that is too common, cruel, of an unusual nature, and pervasive.

55. Tony Parker and CoreCivic have failed to protect Trowsdale inmates, including Plaintiff, from a serious harm and a substantial risk of serious harm.

COUNT V

VIOLATION OF THE RELIGIOUS LAND USE AND INSTITUTIONALIZED PERSONS ACT ("RLUIPA") (42 U.S.C. § 2000cc-1(a))

56. Plaintiff re-alleges and re-avers the preceding paragraphs, and the preceding are incorporated herein by reference.

57. Defendants Parker, Darnell, Washburn, and Shonebarger prevented Plaintiff from purchasing Khufain in violation of RLUIPA.

58. Defendants TDOC, Parker, Darnell, CoreCivic, Washburn, and Shonebarger prevented Plaintiff from wearing Islamic attire during prayer, including a Kifaya and Agal in violation of RLUIPA.

59. Defendants TDOC, Parker, CoreCivic, Darnell, Washburn, and Shonebarger refused to allow Plaintiff to eat traditional Halal foods during Ramadan and the Id feasts in 2018 and 2019 in violation of RLUIPA.

60. Defendants TDOC Parker, Darnell, CoreCivic, Washburn, and Shonebarger prevented Plaintiff from purchasing prayer oil from an Islamic vendor in violation of RLUIPA.

RELIEF SOUGHT

Wherefore, Plaintiff requests that this District Court enter judgment as follows:

1. Damages in an amount to be determined at trial.
2. Punitive Damages.
3. Declaratory Judgment.
4. Temporary and permanent injunctive relief, as deemed necessary and appropriate by the Court.
5. Attorney's fees and costs pursuant to 42 U.S.C. 1988.

6. Any and all other relief the Court finds just and appropriate.

Dated: November 30, 2020

Respectfully submitted,

/s/ Tricia Herzfeld

Tricia Herzfeld (BPR #26014)

Branstetter, Stranch & Jennings, PLLC

223 Rosa L. Parks Ave.

Suite 200

Nashville, TN 37203

Ph: 615-254-8801

Fax: 615-255-5419

triciah@bsjfirm.com

Attorney for Plaintiff

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on November 30, 2020 a true and correct copy of the foregoing document was served by way of the Court's CM/ECF system upon the following:

Thomas J. Aumann
Tennessee Attorney General's Office
P O Box 20207
Nashville, TN 37202-0207
(615) 532-2551
Fax: (615) 532-2541
Email: thomas.aumann@ag.tn.gov

Erin Palmer Polly
Joseph F. Welborn , III
Terrence M. McKelvey
Butler Snow LLP (Nashville)
The Pinnacle at Symphony Place
150 Third Avenue South
Suite 1600
Nashville, TN 37201
(615) 651-6700
Email: Erin.Polly@butlersnow.com
Email: Joe.Welborn@butlersnow.com
Email: terrence.mckelvey@butlersnow.com

/s/ Tricia Herzfeld

Tricia Herzfeld

**UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION**

**NIKKI BOLLINGER GRAE, Individually)
and on Behalf of All Others Similarly)
Situating,)
)
Plaintiff,)
)
v.)
)
CORRECTIONS CORPORATION OF)
AMERICA, DAMON T. HININGER,)
DAVID M. GARFINKLE, TODD J.)
MULLENGER, and HARLEY G. LAPPIN,)
)
Defendants.)**

**Case No. 3:16-cv-2267
Judge Aleta A. Trauger**

MEMORANDUM

Amalgamated Bank, as Trustee for the LongView Collective Investment Fund, (“Amalgamated”) has filed a Motion for Reconsideration of the January 18, 2019 Order Denying Class Certification (Docket No. 148), to which CoreCivic, Inc. (“CoreCivic”) has filed a Response (Docket No. 160), and Amalgamated has filed a Reply (Docket No. 162). For the reasons set out herein, Amalgamated’s motion will be granted.

I. BACKGROUND¹

A. The Class Period and the Nature of Amalgamated’s Allegations

CoreCivic is a publicly traded real estate investment trust (“REIT”) that owns and operates private prisons and detention facilities. Amalgamated is the lead plaintiff in a putative class action against CoreCivic and four CoreCivic executives for securities fraud, based on the

¹ Because this matter is before the court only with regard to class certification, none of the factual assertions relevant solely to the merits of Amalgamated’s claims has yet been contested. Nevertheless, the scope and nature of the allegations are relevant to determining whether class certification is warranted. Accordingly, where the court is discussing only the scope and nature of the allegations, the facts cited will mostly be taken, unless otherwise indicated, from Amalgamated’s Amended Consolidated Complaint (Docket No. 57.) Where the court is discussing facts that go directly to whether Amalgamated has satisfied a condition of class certification, it will rely on evidence introduced into the record.

defendants' history of making allegedly false and/or misleading public statements about the quality of CoreCivic's services and its history of performance relative to the expectations of its government clients, including the Federal Bureau of Prisons ("BOP"). Amalgamated sought the certification of a class consisting of those investors allegedly defrauded by defendants' actions and omissions during a period beginning on February 27, 2012, and ending on August 17, 2016 ("Class Period").

The day after the close of the proposed Class Period, August 18, 2016, Deputy Attorney General Sally Q. Yates issued a memorandum to the BOP entitled "Reducing our Use of Private Prisons" ("Yates Memorandum"). (Docket No. 149-4.) The BOP is a subdivision of the U.S. Department of Justice ("DOJ"), *see Mauldin v. United States*, No. 3:07-0496, 2008 WL 821523, at *3 (M.D. Tenn. Mar. 27, 2008) (Haynes, J.), making the BOP's contracting decisions subject to DOJ supervision. The Yates Memorandum directed that, "as each [BOP private prison] contract reaches the end of its term, the Bureau should either decline to renew that contract or substantially reduce its scope in a manner consistent with law and the overall decline of the Bureau's inmate population." (Docket No. 149-4at 3.) DAG Yates explained that, while "[p]rivate prisons served an important role during a difficult period, . . . time ha[d] shown that they compare poorly to our own [BOP] facilities." (*Id.* at 2.) Private facilities, Yates wrote, "simply do not provide the same level of correctional services, programs, and resources; they do not save substantially on costs; and . . . they do not maintain the same level of safety and security." (*Id.*) Yates concluded that the BOP should "begin[] the process of reducing—and ultimately ending—our use of privately operated prisons." (*Id.* at 3.) In the wake of the Yates Memorandum, CoreCivic's stock price dropped precipitously. (*See* Docket No. 122-2 ¶ 73.)

During the Class Period, CoreCivic's BOP contracts had covered five facilities collectively housing approximately 8,000 inmates, accounting for a sizable amount of

CoreCivic's business. Accordingly, some decrease in the value of CoreCivic's stock in the wake of the Yates Memorandum was likely inevitable; after all, it would make very little sense for CoreCivic to be worth the same amount with or without the BOP's business. Amalgamated argues, however, that the severity of the drop did not need to be as great as it was. Rather, the steepness of the decline was, at least in part, attributable to the fact that CoreCivic and its executives had, for years, provided the public with an image of CoreCivic's contract performance that sharply diverged from the truth apparent behind the scenes. CoreCivic did not claim to be perfect, but it did publicly claim to be providing services that were, at least generally, in line with client expectations. Meanwhile, the feedback that CoreCivic was actually receiving from the BOP painted a different picture. The BOP routinely sent "Notices of Concern" and other forms of notification informing CoreCivic of shortcomings at specific facilities. Among the most commonly addressed issues were CoreCivic's chronically inadequate staffing and its failure to provide sufficient medical services to its inmates. As the Class Period progressed, warnings to CoreCivic that it was falling short of expectations piled up. At some point, DOJ leadership began to seriously question whether its continued reliance on private prison contractors, such as CoreCivic, should continue. The Yates Memorandum was the result.

Amalgamated seeks to represent a class of investors who bought and sold CoreCivic stock during the Class Period at prices that reflected the confidence that CoreCivic projected publicly, while, unbeknownst to investors, CoreCivic was routinely falling short of BOP expectations and putting the entities' relationship in jeopardy as a result. On December 17, 2017, the court denied a CoreCivic motion to dismiss, recognizing that Amalgamated had pled a viable theory of liability and met the exacting pleading standards of the Private Securities Litigation Reform Act ("PSLRA"), *see* 15 U.S.C. § 78u-4. (Docket Nos. 75–76.) On January 18, 2019, however, the court denied class certification on the ground that Amalgamated had failed to

establish shared questions of reliance among potential class members and, therefore, did not satisfy Rule 23(b)(3) of the Federal Rules of Civil Procedure. Amalgamated now seeks reconsideration of that decision, in light of new evidence unearthed during discovery as well as additional argument under the law.

B. Representative CoreCivic Statements

The court will not reiterate the full list of allegedly false and misleading statements that Amalgamated has cited, many of which can be found in the court's Memorandum of December 18, 2017, denying CoreCivic's Motion to Dismiss. (Docket No. 76 at 14–19.) Nevertheless, the precise nature of what CoreCivic claimed is relevant to Amalgamated's motion, because the crux of the parties' disagreement concerns whether particular events during the Class Period can be considered "corrective" of those misstatements. (*See* Docket No. 143 at 11–19.) Accordingly, the court will include a few representative statements here.

CoreCivic and its executives, as might be expected, typically portrayed its services in a positive light to shareholders. The statements at issue here, however, frequently went beyond generic puffery to claims that their services were of a high quality, specifically, in the eyes of their government clients. As the court observed in its December 18, 2017 Memorandum, CoreCivic's business model was marked by a heavy reliance on a few specifically identifiable clients. (Docket No. 76 at 28.) CoreCivic's viability and profits, therefore, were closely tied to those clients' perceptions of the value of CoreCivic's services. Recognizing as much, CoreCivic and its executives routinely boasted about meeting the expectations of its identifiable government clients.

For example, on March 30, 2016, CoreCivic CEO Damon T. Hininger wrote, in his annual letter to shareholders, "Every day we remain focused on providing high-quality, safe and secure facilities that meet the needs of our government partners. By consistently doing so, we

have experienced more than three decades of continued growth and contract retention rates in excess of 90 percent.” The letter boasted that CoreCivic’s “strong record of operational excellence” had “earned [CoreCivic] the confidence of our government partners.” (Docket No. 57 ¶ 35.) Similarly, numerous CoreCivic annual and quarterly reports throughout the Class Period claimed, in identical or slightly modified form:

We believe the outsourcing of prison management services to private operators allows governments to manage increasing inmate populations while simultaneously controlling correctional costs and improving correctional services.

We believe *our customers discover* that partnering with private operators to provide residential services to their inmates introduces competition to their prison system, resulting in *improvements to the quality and cost of corrections services throughout their correctional system.*

(*Id.* ¶ 126 (emphasis added).)

CoreCivic frequently claimed to be, at least generally, compliant with its government clients’ standards. Several annual reports included the following passage or slightly modified versions thereof:

We operate our facilities in accordance with both company and facility-specific policies and procedures. The policies and procedures reflect the high standards generated by a number of sources, including . . . federal, state, and local government guidelines, established correctional procedures, and company-wide policies and procedures that may exceed these guidelines.

(*Id.* ¶ 135.)

CoreCivic specifically tied this alleged high performance to an optimism that it would continue to receive government business in large volumes. Several annual and quarterly reports included the following claim:

We believe our renewal rate on existing contracts remains high as a result of a variety of reasons including, but not limited to, the constrained supply of available beds within the U.S. correctional system, our ownership of the majority of the beds we operate, and the quality of our operations.

(*Id.* ¶¶ 132–33.)

At a June 8, 2016 investor forum, Hininger characterized CoreCivic's business model as resilient in the face of political changes, due to the high level of quality CoreCivic provided:

One thing I'd point to when people ask us what's a Clinton White House look like for you all, what's a Trump White House look like for you all and their respective administrations, and I can't speak in absolutes and make definitive statements. But I would say that being around 30 years and being in operation in many, many states, and also doing work with the federal government going back to the 1980s, where you had Clinton White House, you had a Bush White House, you had Obama White House, we've done very, very well. *We have operationally made sure that we are providing high quality and standard and consistent services to our partners and being very flexible and innovative in the solutions. And with that, we've had some nice growth in our business under those three respective Presidents. We had a lot of growth under Clinton, we had a lot of growth under Bush, and we've had a lot of growth under President Obama. And so, with that, if we continue to do a good job on the quality, and with that, we can demonstrate savings . . . , then I think we'll be just fine.*

(*Id.* ¶ 168 (emphasis added).)

C. CoreCivic Contracts in Jeopardy

Meanwhile, however, there were reasons to believe that CoreCivic's relationship with the BOP was not fine. On January 9, 2015, the BOP had sent CoreCivic a "Cure Notice" regarding its Cibola County Correctional Center ("Cibola"). (*Id.* ¶ 79.) The BOP wrote:

[CoreCivic] is notified that the Government considers the failure to perform in the area of Health Services a condition that is endangering performance of the contract. . . . unless the conditions are cured by April 21, 2015 the Government may terminate this contract under the terms and conditions of [federal acquisition regulations.]

The Cibola County Correctional Center has **numerous and repetitive items of critical non-conformance in the area of Health Services**, specifically, Patient Care

(*Id.*) The Notice listed seven specific failures to perform, including the facility's mishandling of inmates with HIV or positive tuberculosis tests, failures to maintain accurate records of medication administrations, and an inadequate emergency response in the case of an inmate who eventually died. (*Id.*) The BOP's complaints about poor health services at Cibola were of a piece

with numerous Notices of Concern it had sent regarding other CoreCivic facilities, as detailed in the court's December 18, 2017 Memorandum. Those deficiencies were sometimes tied to inadequate medical staffing that was endemic of broader issues with staffing levels at CoreCivic facilities. (*See* Docket No. 76 at 5–12.)

Although the BOP did not immediately cancel its Cibola contract, issues with the health services at Cibola and other CoreCivic facilities continued. On October 22, 2015, one CoreCivic executive wrote, in an email² to Hininger, that “apparently we had a bad day today with BOP

² A number of internal CoreCivic communications relevant to Amalgamated's motions have been filed under seal pursuant to the parties' Revised Stipulation and Protective Order. (Docket No. 86.) That Order protected “Confidential Discovery Material,” defined pursuant to the following provision:

Any Producing Party may designate as confidential any Discovery Material that it believes in good faith contains: (i) trade secret or other confidential research, development, or commercial information; (ii) information the disclosure of which would, in the good faith judgment of the Producing Party, negatively impact the management of any corrections facility or be detrimental to the health and safety of inmates, corrections officers or the public; or (iii) “protected health information” (“PHI”) as defined in 45 C.F.R. §§ 160.103 and 164.501, which includes but is not limited to health information, including demographic information, relating to either (a) the past, present, or future physical or mental condition of an individual, (b) the provision of care to an individual, or (c) the payment for care provided to any individual, which identifies the individual or which reasonably could be expected to identify the individual (collectively, “Confidential Information”), in accordance with Rule 26(c) of the Federal Rules of Civil Procedure.

(Docket No. 86 ¶ 2.) The court has, so far, honored the parties' confidentiality claims in this case. Nevertheless, the court has now determined that it is necessary, in the interests of justice and transparency, to cite some covered communications and facts explicitly, without redaction, in the court's Memorandum. These limited disclosures are justified by the interests of the unnamed class members in evaluating and understanding the case, as well as the public interest in transparency related to underlying facts—which involve potential fraud by and on behalf of a company performing a public function and entrusted with the safety of individuals sentenced to incarceration by this country's courts. *See Rudd Equip. Co., Inc. v. John Deere Constr. & Forestry Co.*, 834 F.3d 589, 594 (6th Cir. 2016) (“[A] court must balance the litigants' privacy interests against the public's right of access, recognizing our judicial system's strong presumption in favor of openness.”). CoreCivic has argued that its internal responses to BOP scrutiny should be kept under seal because their disclosure could harm CoreCivic in the marketplace. (Docket No. 155 at 6.) The court, however, discerns no serious threat of unfair competition associated with disclosure of the relevant communications. None of the cited internal conversations reveal any confidential CoreCivic strategies, practices, or research and development. The conversations cited may be awkward or embarrassing for CoreCivic to see disclosed, but that, alone, is not enough to justify an unyielding seal in this case. The court concludes that, at least with regard to the limited facts cited in this Memorandum, the harms of maintaining the seal would be greater than any associated with relaxing it.

medical audit at Cibola.” He expressed concern that the issues at Cibola might have a negative impact on the possibility of renewal of the Cibola contract, as well as CoreCivic’s bid regarding a second facility, the Eden Detention Center. (Docket No. 149-26 at 2.) Another email exchange between CoreCivic executives expressed concern that “[t]his is going to kill us at both Cibola and Eden.” (Docket No. 149-27 at 3.)

In June 2016, the BOP was conducting a further review of Cibola’s medical services. As the review continued and the BOP remained silent about what its ultimate conclusions would be, CoreCivic executives apparently inferred that a negative outcome was forthcoming. “Silence is NOT GOLDEN!!!,” wrote one. “We’re dead,” replied another executive, whose duties specifically included relations with government partners. (Docket No. 149-31.) Other correspondence during the Class Period echoes similar concerns about the BOP’s assessment of CoreCivic’s services and the possibility of lost contracts as a result. (*See, e.g.*, Docket Nos. 149-9, -10, -24, -25, -27.)

On July 28, 2016, CoreCivic executives were forwarded an email chain, apparently through CoreCivic-affiliated lobbyists, discussing the fact that “BOP is making a round of phone calls to private prison companies ([CoreCivic and another company] so far) giving them notice that they are cancelling contracts effective October 2016.” The email beginning the thread characterized the BOP’s actions as a “realignment.” Although a cancellation or non-renewal of the Cibola contract had not yet been publicly announced, the emails made clear that CoreCivic was aware that the contract was going to be cancelled or not renewed. (Docket No. 149-32.)

The BOP’s non-renewal of CoreCivic’s Cibola contract became public knowledge in the early days of August 2016. The parties disagree, however, with regard to when the market should be assumed to have become aware of the non-renewal. Acknowledgment of the non-renewal first

appeared in local New Mexico news media as early as August 1 or 2. (Docket No. 135-1 ¶¶ 7–8.) Amalgamated suggests that the non-renewal should be treated as having been announced after the close of trading on August 3, 2016, when the non-renewal was included in CoreCivic’s second quarter 2016 earnings announcements. (Docket No. 120-1 ¶ 82.) The next day, August 4, 2016, the value of CoreCivic’s stock dropped significantly. (*Id.* ¶ 84.)

D. The OIG Report

On August 11, 2016, the DOJ’s Office of the Inspector General (“OIG”) published a report entitled “Review of the Federal Bureau of Prisons’ Monitoring of Contract Prisons” (“OIG Report”). (Docket No. 99-1.) The authors of the OIG Report explained that the OIG “initiated this review to examine how the BOP monitors [private prison] facilities” as well as to “assess[] whether contractor performance meets certain inmate safety and security requirements and analyze[] how contract prisons and similar BOP institutions compare with regard to inmate safety and security data.” (*Id.* at *i.*) The Report, which included examination of CoreCivic facilities and data, found that, “in most key areas, contract prisons incurred more safety and security incidents per capita than comparable BOP institutions.” (*Id.*) The OIG Report noted that, in “recent years, disturbances in several federal contract prisons resulted in extensive property damage, bodily injury, and the death of a Correctional Officer”—that death being the death of an officer killed during a riot at a CoreCivic facility. (*Id.* at 2.) The OIG Report observed that CoreCivic facilities experienced substantially higher rates, relative to BOP institutions, of a number of unwelcome occurrences, such as inmate fights, inmate-on-inmate assaults, and suicide attempts or self-mutilations. (*Id.* at 60–67.)

The OIG Report, however, had some express limitations. First, it was addressed to the BOP’s monitoring of contract prisons from FY 2011 through FY 2014, although it did include some field work that extended into early 2015. (*Id.* at 3.) The BOP’s 2014 fiscal year ended on

September 30, 2014. Accordingly, by the time the OIG Report was published, there had been nearly two more years of developments in the DOJ/BOP/CoreCivic relationship that were not covered by the Report.

The Report also elected to focus its data analysis on “eight key categories: (1) contraband, (2) reports of incidents, (3) lockdowns, (4) inmate discipline, (5) telephone monitoring, (6) selected grievances, (7) urinalysis drug testing, and (8) sexual misconduct.” (*Id.* at *ii.*) While those categories did capture a number of ways in which CoreCivic had underperformed relative to BOP prisons, none of the categories directly addressed the two issues that were arguably most pervasive in CoreCivic’s history of deficiencies—its chronic understaffing and the poor quality of its medical care. Staffing issues were mentioned in the Report but were not the subject of a systematic analysis. (*Id.* at 2–3.) Similarly, the Report did acknowledge the existence of problems related to medical care in contract facilities, but the Report’s authors specifically conceded that “the clinical adequacy of inmate medical care fell outside the scope of our review.” (*Id.* at 20.)

Internal CoreCivic correspondence confirms that knowledgeable CoreCivic employees considered the scope of the Report to have avoided, or at least downplayed, key issues about which they were concerned. CoreCivic received an advance version of the Report so that it would have an opportunity to respond or raise any objections. In an e-mail exchange between two CoreCivic executives about the report, one remarked—twice—that she was surprised that the Report had not, in her view, addressed CoreCivic’s staffing issues. (Docket No. 149-2.) The other CoreCivic executive observed that the criticisms in the Report “are all BOP directed”—meaning that the Report was chiefly focused on improving the BOP’s oversight practices, not merely finding fault with contractors. The executive who had noted the lack of content addressing staffing issues concluded that, after looking over the draft Report, her initial concern

about the Report “may [have been] a false alarm.” (*Id.*) In another e-mail exchange, a different CoreCivic executive wrote, “What I’m shocked over is they totally overlooked the consequences of our staff vacancies. They mentioned staffing at the end but could have been much more critical.” (Docket No. 149-3.)

The Report did not recommend that the BOP stop using contract prisons. Rather, it offered four recommendations, all of which contemplated, or at least did not foreclose, continuing to work with private prison contractors. First, the Report recommended that the BOP

1. Convene a working group of BOP subject matter experts to evaluate why contract prisons had more safety and security incidents per capita than BOP institutions in a number of key indicators, and identify appropriate action, if necessary.

(Docket No. 149-1 at 45.) The remaining three recommendations were made for the purpose of “improv[ing] monitoring and oversight of BOP contract prisons”:

2. Verify on a more frequent basis that inmates receive basic medical services such as initial medical exams and immunizations.
3. Ensure that correctional services observation steps address vital functions related to the contract, including periodic validation of actual Correctional Officer staffing levels based on the approved staffing plan.
4. Reevaluate the checklist and review it on a regular basis with input from subject matter experts to ensure that observation steps reflect the most important activities for contract compliance and that monitoring and documentation requirements and expectations are clear, including for observation steps requiring monitors to engage in trend analysis.

(*Id.*)

Appendix 9 to the Report consisted of response letters from the contractors under review, including CoreCivic. CoreCivic suggested that the allegedly higher incidences of undesirable events at contract prisons could be attributed to the fact that contract prisons tend to house a demographically different population than BOP prisons. In particular, CoreCivic noted that its

prisons housed a disproportionate number of foreign nationals, which, CoreCivic argued, posed unique security challenges. Ultimately, CoreCivic wrote:

We share the interests of the OIG and the BOP in ensuring contract prisons are operated safely and securely and in compliance with contract requirements. We are also committed to working in partnership with the BOP to address any recommendations in furtherance of these goals. . . . We look forward to further discussions with the BOP regarding the data and recommendations in the report and collaboration on any policy or operational changes.

(*Id.* at 70.)

As the court previously observed, the value of CoreCivic's stock does not appear to have immediately suffered in a statistically significant way from the release of the OIG Report. (See Docket No. 99-3 ¶ 58.) A week later, however, on August 18, 2016, the Yates Memorandum was released, leading to an immediate and substantial devaluation of the stock.

E. Amalgamated's Class Certification Motion

Amalgamated, which has been appointed lead plaintiff (Docket No. 52), filed a Motion to Certify Class (Docket No. 91), seeking certification of a class defined as follows:

All persons who purchased or otherwise acquired Corrections Corporation of America, Inc. ("CCA") [now "CoreCivic"] securities between February 27, 2012 and August 17, 2016, inclusive, and who were damaged thereby. Excluded from the Class are: (a) CCA, its parents, subsidiaries and any other entity owned or controlled by CCA; (b) Damon T. Hininger, Todd J. Mullenger, and Harley G. Lappin; (c) all other executive officers and directors of CCA or any of its parents, subsidiaries or other entities owned or controlled by CCA; (d) all immediate family members of the foregoing, including grandparents, parents, spouses, siblings, children, grandchildren and steprelations of similar degree; and (e) all predecessors and successors in interest or assigns of any of the foregoing.

(Docket No. 92 at 1.) CoreCivic opposed the motion. (Docket No. 98.) The principal disagreement between the parties centered around whether Amalgamated could establish that common questions of fact or law predominated among the various putative class members' claims. Specifically, Amalgamated sought to rely on a presumption of reliance under one or both

of two Supreme Court cases: *Basic Inc. v. Levinson*, 485 U.S. 224 (1988), which allows for a rebuttable presumption of reliance with regard to material public statements about a stock traded on an efficient market; and *Affiliated Ute Citizens v. United States*, 406 U.S. 128 (1972), which allows for a rebuttable presumption of reliance in cases primarily involving a failure to disclose.

The court concluded that Amalgamated could not rely on either presumption in order to show shared questions of reliance. The court held, first, that Amalgamated was entitled to the *Basic* presumption, but CoreCivic had successfully rebutted that presumption with evidence that CoreCivic's allegedly fraudulent statements had had no price impact, as permitted by *Halliburton Co. v. Erica P. John Fund, Inc.*, 573 U.S. 258, 283 (2014) ("*Halliburton II*"). (Docket No. 143 at 18–19.) The court concluded that Amalgamated was not entitled to the *Affiliated Ute* presumption because its allegations primarily involved statements, not failures to disclose. (*Id.* at 23–24.)

Amalgamated filed a Motion to Reconsider, in which it has (1) presented new evidence, received during discovery, that it argues is relevant to the court's class certification decision, (2) argued that the court's interpretation of *Halliburton II* was incorrect, and (3) advanced additional legal and factual arguments that it did not raise in its initial class certification motion but which bear on aspects of the court's reasoning in its earlier opinion, particularly with regard to the *Basic* presumption. (Docket No. 148.) CoreCivic opposes the motion. (Docket No. 160.)

II. LEGAL STANDARDS

A. Motion to Reconsider

While the Federal Rules of Civil Procedure fail to explicitly address motions to reconsider interlocutory orders, "[d]istrict courts have authority both under common law and Rule 54(b) to reconsider interlocutory orders and to reopen any part of a case before entry of final judgment." *Rodriguez v. Tenn. Laborers Health & Welfare Fund*, 89 F. App'x 949, 959

(6th Cir. 2004) (citing *Mallory v. Eyrich*, 922 F.2d 1273, 1282 (6th Cir. 1991)); see also *In re Life Investors Ins. Co. of Am.*, 589 F.3d 319, 326 n.6 (6th Cir. 2009) (“[A] district court may always reconsider and revise its interlocutory orders while it retains jurisdiction over the case.”) (citing *Rodriguez*, 89 F. App’x at 959; *Mallory*, 922 F.2d at 1282). Thus, district courts may “afford such relief from interlocutory orders as justice requires.” *Rodriguez*, 89 F. App’x at 959 (quoting *Citibank N.A. v. FDIC*, 857 F.Supp. 976, 981 (D.D.C.1994)) (internal brackets omitted). Courts traditionally will find justification for reconsidering interlocutory orders when there is (1) an intervening change of controlling law; (2) new evidence available; or (3) a need to correct clear error or prevent manifest injustice. *Louisville/Jefferson Cty. Metro Gov’t v. Hotels.com, L.P.*, 590 F.3d 381, 389 (6th Cir. 2009) (citing *Rodriguez*, 89 F. App’x at 959). This standard “vests significant discretion in district courts.” *Rodriguez*, 89 F. App’x at 959 n.7.

B. Motion for Class Certification

The principal purpose of class actions is to achieve efficiency and economy of litigation, both with respect to the parties and to the courts. *Gen. Tel. Co. v. Falcon*, 457 U.S. 147, 159 (1982). The Supreme Court has observed that, as an exception to the usual rule that litigation is conducted by and on behalf of individual named parties, “[c]lass relief is ‘peculiarly appropriate’ when the ‘issues involved are common to the class as a whole’ and when they ‘turn on questions of law applicable in the same manner to each member of the class.’” *Id.* at 155 (quoting *Califano v. Yamasaki*, 442 U.S. 682, 701 (1979)). The Court directs that, before certifying a class, district courts must conduct a “rigorous analysis” of the prerequisites of Rule 23 of the Federal Rules of Civil Procedure. *Id.* at 161. The Sixth Circuit has stated that district courts have broad discretion in deciding whether to certify a class but that courts must exercise that discretion within the framework of Rule 23. *Coleman v. Gen. Motors Acceptance Corp.*, 296 F.3d 443, 446 (6th Cir. 2002); *In re Am. Med. Sys., Inc.*, 75 F.3d 1069, 1079 (6th Cir. 1996).

Although a court considering class certification should not inquire into the merits of the underlying claim, a class action may not be certified merely on the basis of its designation as such in the pleadings. *See Eisen v. Carlisle & Jacquelin*, 417 U.S. 156, 178 (1974); *In re Am. Med. Sys.*, 75 F.3d at 1079. In evaluating whether class certification is appropriate, “it may be necessary for the court to probe behind the pleadings,” as the issues concerning whether it is appropriate to certify a class are often “enmeshed” within the legal and factual considerations raised by the litigation. *Falcon*, 457 U.S. at 160; *see also In re Am. Med. Sys.*, 75 F.3d at 1079; *Weathers v. Peters Realty Corp.*, 499 F.2d 1197, 1200 (6th Cir. 1974). Moreover, the party seeking class certification bears the burden of establishing that the prerequisites are met. *See Alkire v. Irving*, 330 F.3d 802, 820 (6th Cir. 2003); *Senter v. Gen. Motors Corp.*, 532 F.2d 511, 522 (6th Cir. 1976).

III. ANALYSIS³

A. Amalgamated’s Failure to Raise Arguments in Support of its Initial Motion

CoreCivic points out that many of the arguments that Amalgamated has raised in support of its Motion to Reconsider could have been raised in support of its initial class certification motion, but Amalgamated chose not to pursue those arguments at the time. While Amalgamated has supported some of its arguments with new evidence⁴ unearthed during discovery, CoreCivic is correct that most of the key points that Amalgamated now makes could have been raised based

³ This Memorandum’s analysis will focus on the issues raised in Amalgamated’s Motion to Reconsider and CoreCivic’s briefing in opposition to that motion. However, a number of other issues related to class certification were raised by the parties and addressed by the court in its earlier Memorandum. (Docket No. 143.) The court hereby incorporates the analysis of that Memorandum, except with regard to issues specifically addressed in this Memorandum.

⁴ CoreCivic disputes the contention that this evidence is truly “new,” pointing out that it was made available to Amalgamated before the completion of briefing on its initial motion. Regardless of whether one treats the evidence as newly discovered, however, it would not excuse a failure to raise arguments that could have been raised initially, as Amalgamated’s could have been. The specific timing of the relevant discovery, therefore, is not determinative in the court’s analysis.

only on the materials available at the time of the initial motion. Some of those arguments did appear, in some form, in Amalgamated's original briefing, but others did not. CoreCivic argues that, because Amalgamated has raised its new arguments belatedly, the court should not revisit its class certification decision. Amalgamated responds that "[a] district court's order denying or granting class status is inherently tentative," and the court, therefore, has "the discretion, even the obligation, 'to reassess [its] class ruling[] as the case develops.'" *In re Polyurethane Foam Antitrust Litig.*, No. 1:10 MD 2196, 2015 WL 4459636, at *1 (N.D. Ohio July 21, 2015) (quoting *Coopers & Lybrand v. Livesay*, 437 U.S. 463, 469 n. 11 (1978); *McNamara v. Felderhof*, 410 F.3d 277, 281 n. 8 (5th Cir. 2005)).

There are good reasons for requiring a party to raise all of its viable arguments in support of its initial motion, and those reasons do not simply go away when the issue at hand is class certification. Nevertheless, Amalgamated is correct that there are issues in the Rule 23 context that are relevant to the court's consideration of whether to give its earlier decision a second look. First is that, because Amalgamated is seeking to represent a class, the rights of parties other than it are at stake. Refusing to consider a meritorious argument simply because Amalgamated's counsel failed to raise it earlier risks punishing unnamed parties who had no role in the earlier litigation decisions. Second, the nature of Rule 23 itself carries a special risk of a premature, ultimately erroneous, ruling, because the Rule prizes resolving class certification questions early, even if relevant evidence and issues may arise later. A court is required to make a decision regarding class certification "[a]t an early practicable time after a person sues or is sued as a class representative." Fed. R. Civ. P. 23(c)(1)(A). Determining when that early practicable time should be, however, is not an exact science, particularly while the contours of a case are still taking shape. Accordingly, Rule 23 explicitly reserves to the court the power to "alter[] or amend[]" an order "grant[ing] or den[ying] class certification" at any time "before final

judgment.” Fed. R. Civ. P. 23(c)(1)(C); *see also Microsoft Corp. v. Baker*, 137 S. Ct. 1702, 1711 (2017) (observing that, after denying class certification, a district court can “later reverse course and certify the proposed class”).

Ultimately, “[i]t is within the sole discretion of the court to determine if a prior ruling should be reconsidered, and the Sixth Circuit has declined to impose any conditions or limitations upon a court’s power to review a prior ruling,” at least as long as the prior ruling was on an interlocutory matter and the case remains pending. *Grant v. Metro. Gov’t of Nashville & Davidson Cty., Tennessee*, No. 3-04-CV-00630, 2017 WL 1153927, at *2 (M.D. Tenn. Mar. 27, 2017) (Crenshaw, J.) (citing *Gillig v. Advanced Cardiovascular Sys., Inc.*, 67 F.3d 586, 590 (6th Cir. 1995)). While Amalgamated is admonished that both it and the court would have been better served by all viable arguments’ having been raised in support of the original motion, the court concludes that the harms of refusing to consider those arguments now would outweigh any benefits of treating the arguments as forfeited or waived. Moreover, while much of what Amalgamated now argues could have been raised before, aspects of its argument are significantly bolstered by evidence not previously available to the court. The court, accordingly, will consider the arguments that Amalgamated has raised on their own merits.

B. Application of *Halliburton II*

Amalgamated argues, first, that the court erred in its application of *Halliburton II*, particularly in light of two Supreme Court cases that preceded it, *Erica P. John Fund, Inc. v. Halliburton Co.*, 563 U.S. 804 (2011) (“*Halliburton I*”), and *Amgen Inc. v. Connecticut Retirement Plans and Trust Funds*, 568 U.S. 455 (2013). Specifically, Amalgamated argues that the court, in its Rule 23(b)(3) analysis, improperly considered certain evidence pursuant to *Halliburton II*, when consideration of that evidence should have been treated as barred by *Halliburton I* and *Amgen*.

1. The Role of the Basic Presumption under Rule 23(b)

A class action will be certified only if, after rigorous analysis, the court is satisfied that the prerequisites of Fed. R. Civ. P. 23(a) have been met and the action falls within one of the categories under Fed. R. Civ. P. 23(b). *Bridging Cmty. Inc. v. Top Flite Fin. Inc.*, 843 F.3d 1119, 1124 (6th Cir. 2016). Amalgamated sought to rely on Rule 23(b)(3), which allows for certification of a Rule 23(a)-compliant class if

the court finds that the questions of law or fact common to class members predominate over any questions affecting only individual members, and that a class action is superior to other available methods for fairly and efficiently adjudicating the controversy. The matters pertinent to these findings include:

- (A) the class members' interests in individually controlling the prosecution or defense of separate actions;
- (B) the extent and nature of any litigation concerning the controversy already begun by or against class members;
- (C) the desirability or undesirability of concentrating the litigation of the claims in the particular forum; and
- (D) the likely difficulties in managing a class action.

Fed. R. Civ. P. 23(b)(3). Although Amalgamated retained the initial burden of demonstrating compliance with the provisions of Rule 23(a) and Rule 23(b)(3), CoreCivic only specifically challenged its compliance in one respect: whether “questions of law or fact common to class members predominate over any questions affecting only individual members,” in particular with regard to the issue of reliance.

“Investors can recover damages in a private securities fraud action only if they prove that they relied on the defendant’s misrepresentation in deciding to buy or sell a company’s stock.” *Halliburton II*, 573 U.S. at 263. For example, in a conventional securities fraud case, an individual might show, via documentary or testimonial evidence, that he personally relied on a particular misrepresentation in making the decision to buy or sell at a specific price. *See Chelsea*

Assocs. v. Rapanos, 527 F.2d 1266, 1271 (6th Cir. 1975) (“In the usual fraud case or case brought for misrepresentation in violation of Rule 10b-5, proof of reliance upon the misstated or false fact is required.”) (citing *Schlick v. Penn-Dixie Cement Corp.*, 507 F.2d 374, 380 (2d Cir. 1974), *cert. denied*, 421 U.S. 976 (1975)). Although that approach may be adequate for traditional, single-plaintiff securities fraud cases, proving individual reliance in such a manner for each member of a class numbering in the hundreds or thousands would likely be prohibitively difficult. Accordingly, securities fraud class action plaintiffs often rely on *Basic* and/or *Affiliated Ute*, each of which allows a plaintiff to establish a “rebuttable presumption of reliance,” without the need for individual information about each plaintiff. *Stoneridge Inv. Partners, LLC v. Sci.-Atlanta*, 552 U.S. 148, 159 (2008). In the current motion, Amalgamated only disputes the court’s analysis under *Basic*.

The court, in its prior Memorandum, provided a detailed discussion of the theoretical underpinnings of the *Basic* presumption, which it will not repeat here. (Docket No. 143 at 7–9.) Put succinctly, *Basic* assumes that buyers and sellers of stock in an efficient market rely on the market as an intermediary for setting the stock’s price in light of all publicly available material information; accordingly, when one buys or sells the stock at the market price, one has, in effect, relied on all publicly available information, regardless of whether the buyer and/or seller was aware of that information personally. *See Basic*, 485 U.S. at 243–44. Fraud committed by artificially affecting a stock’s price through public information, as contemplated by *Basic*, is known as “fraud-on-the-market.”

In order to rely on the *Basic* presumption at the merits stage of a case, “a plaintiff must prove that: (1) the alleged misrepresentations were publicly known, (2) they were material, (3) the stock traded in an efficient market, and (4) the plaintiff traded the stock between when the misrepresentations were made and when the truth was revealed.” *Halliburton II*, 573 U.S. at

277–78 (citing *Basic*, 485 U.S., at 248 n.27). Then, once the plaintiff makes an initial showing that it is entitled to the *Basic* presumption, “a defendant may rebut it with ‘evidence that the asserted misrepresentation (or its correction) did not affect the market price of the defendant’s stock.’” *In re BancorpSouth, Inc.*, No. 17-0508, 2017 WL 4125647, at *1 (6th Cir. Sept. 18, 2017) (quoting *Halliburton II*, 573 U.S. at 279–80). The Supreme Court’s recognition of fraud-on-the-market in *Basic*, however, left open the question of which of those issues must be considered by the court at the class certification stage and which can be saved for the court’s consideration of the plaintiffs’ claims on the merits.

2. *Halliburton I*, *Amgen*, and *Halliburton II*

The Supreme Court has cautioned that “Rule 23 grants courts no license to engage in free-ranging merits inquiries at the certification stage.” *Amgen*, 568 U.S. at 466. While some questions may be relevant to both the merits and the class certification inquiry, a court may consider those questions “only to the extent . . . that they are relevant to determining whether the Rule 23 prerequisites for class certification are satisfied.” *Id.* (citing *Wal-Mart Stores, Inc. v. Dukes*, 564 U.S. 338, 352 n.6 (2011)). A plaintiff, then, is not required to show that its fraud-on-the-market claims will prevail in order to receive class certification. The plaintiff is, however, required to eliminate any obstacles to commonality or any other Rule 23 requirement, even if doing so requires the broaching of topics also relevant to the merits of the underlying claims.

Haliburton I. In *Halliburton I*, the plaintiff sought certification of its class under a fraud-on-the-market theory, but the district court denied certification on the ground that Fifth Circuit precedent required a plaintiff to establish loss causation in order to rely on the *Basic* presumption to satisfy Rule 23(b)(3). 563 U.S. at 808. The Fifth Circuit, consistently with its precedents, affirmed, but the Supreme Court reversed. *Id.* at 815. The Supreme Court conceded that a plaintiff seeking class certification via *Basic* must establish some threshold facts relevant to the

fraud-on-the-market presumption, namely “that the alleged misrepresentations were publicly known . . . , that the stock traded in an efficient market, and that the relevant transaction took place ‘between the time the misrepresentations were made and the time the truth was revealed.’” *Id.* at 811 (citing & quoting *Basic*, 485 U.S. at 241–47, 248 n.27; citing *Stoneridge*, 552 U.S. at 159). The Court held that requiring a plaintiff to show loss causation, however, improperly added an additional element with no relation to either the Rule 23(b)(3) commonality inquiry or *Basic* itself. “Loss causation,” the Court reasoned, “addresses a matter different from whether an investor relied on a misrepresentation, presumptively or otherwise, when buying or selling a stock.” *Id.* at 812. For example, a plaintiff might have relied on a misrepresentation relating to one matter when he bought a stock, and the stock’s later devaluation might have been the result of a wholly unrelated intervening event. In such a case, the plaintiff would be unable to show loss causation and its claim would fail on the merits. That issue, though, would have been wholly distinct from determining whether common issues of law or fact predominated with regard to reliance. Considering loss causation at the class certification stage, therefore, was error. *Id.* at 813.

In the alternative, the defendant argued that, even if the plaintiff should not have been required to prove loss causation as it is ordinarily understood, “loss causation,” in this context, “was merely ‘shorthand’” for “price impact”—the lack of which can be used to rebut the *Basic* presumption. *Id.* at 813–14. The Supreme Court rejected the defendant’s argument but did not offer an opinion on whether price impact might be properly raised at the Rule 23 stage in an appropriate case. Rather, the Supreme Court rejected the defendant’s “wishful interpretation of the Court of Appeals’ opinion” and “[took] the Court of Appeals at its word” that it was considering only the “familiar and distinct concept” of loss causation. *Id.* at 814–15.

Amgen. Two years later, in *Amgen*, a plaintiff sought to rely on the *Basic* presumption to satisfy Rule 23(b)(3), but the defendant argued that, in order to do so, a plaintiff must “prove[] materiality, [because] immaterial misrepresentations or omissions, by definition, would have no impact on [the] stock price in an efficient market.” 568 U.S. at 459 (emphasis removed). As the defendant pointed out, materiality, unlike the loss causation at issue in *Halliburton I*, is “an essential predicate of the fraud-on-the-market theory,” and, therefore, a failure to show materiality would result in a loss of the *Basic* presumption itself, not merely the failure of the plaintiff’s claim on some other ground. *Id.* at 467.

The Court agreed that materiality was a necessary element for establishing the fraud-on-the-market presumption on the merits but disagreed that it followed, from that premise, that a plaintiff must establish materiality at the Rule 23 stage. The Court, rather, grounded its analysis in the commonality inquiry, observing that, “[b]ecause materiality is judged according to an objective standard, the materiality of [the defendant’s] alleged misrepresentations and omissions is a question common to all members of the class.” *Id.* at 459. The class could, therefore, “prevail or fail in unison,” as contemplated by Rule 23(b)(3). *Id.* at 460. Whether a defendant must address a particular element of its case as part of the Rule 23(b)(3) inquiry, the Court explained, depends, not on whether the element is “essential” to the fraud-on-the-market presumption, but whether that element has any bearing on the question of if common questions of fact or law will predominate. *Id.* at 467–68.

The Court rejected the argument that, if the putative class failed to establish materiality, the result would be for the court to be left with numerous plaintiffs needing to establish reliance on an individual basis because they could not rely on the *Basic* presumption. Materiality can safely be saved for the merits stage, the Court explained, because materiality is not only a requirement for a fraud-on-the-market claim but also an “indispensable element[] of a Rule 10b–

5 claim.” *Id.* at 473. Accordingly, if a plaintiff class fails to show materiality and loses the *Basic* presumption, that will not lead to individual questions of reliance predominating in the case, because, reliance aside, all of the individual claims will fail on the merits due to the immateriality of the statements at issue. Even with the *Basic* presumption lost, common issues would predominate, albeit in defendant’s favor. *Id.*

The defendant argued, in the alternative, that the district court erred by refusing to consider rebuttal evidence “show[ing] that[,] in light of all the information available to the market,” the defendant’s alleged misrepresentations did not “significantly alter[] the total mix of information made available” to the public and, therefore, “could not be presumed to have altered the market price.” *Id.* at 480 (quoting *Basic*, 485 U.S. at 232; citation and other internal quotation marks omitted). The Court held that the district court did not err because that evidence “aimed to prove that the misrepresentations and omissions alleged . . . were immaterial.” *Id.* at 481 (citation omitted). Accordingly, the fact that the plaintiff was not required to establish materiality rendered the evidence inapposite. *Id.*

Halliburton II. The next year, the Halliburton litigation returned to the Supreme Court. As *Halliburton I* foreshadowed, the defendant had argued, on remand, that “the evidence it had earlier introduced to disprove loss causation also showed that none of its alleged misrepresentations had actually affected its stock price” and, therefore, the evidence, when presented on the issue of price impact, “rebutted *Basic*’s presumption that the members of the proposed class had relied on its alleged misrepresentations simply by buying or selling its stock at the market price.” *Halliburton II*, 573 U.S. at 265. The district court and the Fifth Circuit held that merely repackaging that evidence under the rubric of price impact did not permit the defendant to rely on it to defeat class certification. *Id.* at 266. The Supreme Court reversed, holding that, while a plaintiff is not required to establish price impact, as part of its initial

showing, in order to rely on the *Basic* presumption at the class certification stage, the defendant is entitled to present evidence of the *lack* of price impact to rebut the presumption. *Id.* at 279, 283.

The plaintiff argued that allowing the defendant to present price impact evidence at the class certification stage was inconsistent with the reasoning of *Amgen*, because *Amgen*'s analysis of materiality would apply with equal force to price impact. Price impact, like materiality, could be resolved on a class-wide basis. Moreover, a total lack of price impact would likely spell the end of plaintiffs' claims regardless of the issue of reliance, because it would be difficult, if not impossible, to show that the plaintiffs were harmed. The Supreme Court did not dispute the plaintiff's premise—conceding that it was “[f]air enough” to suggest that *Amgen*'s materiality analysis would apply, in largely the same manner, to price impact. The Court, nevertheless, concluded that price impact was ultimately distinguishable from materiality in one “crucial respect”—that, while materiality is a “discrete issue that can be resolved in isolation,” price impact is “*Basic*'s fundamental premise” and therefore “has everything to do with the issue of predominance.” *Id.* at 282–83 (internal citations, quotation marks, and brackets omitted). Accordingly, the Court held that, *Amgen*'s reasoning aside, a defendant could seek to rebut the *Basic* presumption with price impact analysis at the class certification stage. *Id.*

3. This Court's Interpretation of Halliburton II

Amalgamated and CoreCivic agreed that Amalgamated had established the elements necessary for initially invoking the *Basic* presumption at the class certification stage—that is, publicity, contemporaneousness, and market efficiency. CoreCivic argued, however, that it had successfully rebutted that presumption with evidence that none of the relevant statements had had any price impact, as permitted by *Halliburton II*. First, CoreCivic provided a Report, by economist Lucy P. Allen, evaluating the price impact of various events, including CoreCivic's

alleged misrepresentations, the publication of the OIG Report, and the publication of the Yates Memorandum. (Docket No. 99-3.) With regard to CoreCivic’s alleged misrepresentations, Allen found no evidence that any of the misrepresentations caused a statistically significant increase in the value of CoreCivic’s stock. (*Id.* at 12–14.) Similarly, she found no statistically significant decrease in the stock’s value in the immediate wake of the OIG Report’s release. (*Id.* at 33.) CoreCivic argued, therefore, that the evidence showed that its statements touting the quality of its services and client relationships did not contemporaneously inflate the price of its stock, and the revelation of CoreCivic’s shortcomings in the OIG Report did not result in a devaluation.

The court held that a lack of stock price increases correlated with CoreCivic’s statements did not necessarily establish a lack of price impact, because those statements might instead merely have perpetuated an already inflated valuation. In other words, Amalgamated could still argue for what is known as the “price maintenance” theory of price impact. *See Willis v. Big Lots, Inc.*, 242 F. Supp. 3d 634, 656–57 (S.D. Ohio 2017) (“[T]he price maintenance theory [is] the theory that a misrepresentation can have a price impact not only by raising a stock’s price but also by maintaining a stock’s already artificially inflated price”). Indeed, a price maintenance theory would be consistent with the facts presented, as CoreCivic concedes that it had made similar positive statements prior to the advent of the Class Period. (*See* Docket No. 160 at 4 (“The alleged false and misleading statements were made years before (and years after) the alleged class period”).)

The court was persuaded, however, by CoreCivic’s argument based on the OIG Report. Amalgamated argued that price impact was established by the decline in price following the release of the Yates Memorandum, via a “materialization of risk” theory.⁵ The court agreed that

⁵ “Materialization of risk” refers to a situation where a party’s fraud is revealed, not by an express disclosure of the truth, but by a fraudulently concealed risk’s coming to fruition. For example, a company

materialization of risk was, as a general matter, a viable theory of price impact, for reasons the court will not repeat here. (Docket No. 143 at 12–13.) As the court explained, however, the materialization of a risk can only be evidence of the price impact of an earlier false statement concealing the risk if the risk was not disclosed at some point between the statement and the materialization. If a previously concealed risk is disclosed before the risk comes to fruition, then the price adjustment attributable to the fraud should occur when the risk is revealed, not when the potential harm actually comes to pass. The price of the stock might still go down, again, when the risk materializes, but, because the risk was no longer concealed, that price decrease would not be attributable to the fraud. The court concluded that the OIG Report was an intervening event that revealed the risk that CoreCivic’s statements had allegedly concealed and that, therefore, the price drop after the Yates Memorandum did not negate the evidence showing a lack of price impact. (Docket No. 149 at 12–13.)

Amalgamated argues that, by considering the effect of the OIG Report, the court misapplied *Halliburton II*. Specifically, Amalgamated urges the court to adopt the following reading of *Halliburton II*, advanced by Judge James L. Dennis of the Fifth Circuit, in his concurrence to a *per curiam* order granting leave to appeal the district court’s post-*Halliburton II* certification of the plaintiff’s class in the Halliburton litigation:

I do not read *Halliburton II* to require that any evidence that is somehow related to price impact must be considered at the class certification stage. Instead, *Halliburton II* merely rejected our categorical holding below, prohibiting all direct evidence of lack of price impact to rebut the presumption of reliance at the class certification stage. The Court did not hold that issues that would otherwise be strictly merits issues under *Amgen* can be raised at the class certification stage merely because they bear on the issue of price impact. Indeed, materiality, too, is

might fraudulently conceal a product defect, but the defect might be revealed via product failures. Even without an express acknowledgment of the defect by the company, the materialization of the risk would serve as the equivalent of a corrective disclosure and precipitate a revaluation of its stock. The Sixth Circuit has recognized that materialization of risk is a viable theory of loss causation in a securities fraud case. See *Ohio Pub. Employees Ret. Sys. v. Fed. Home Loan Mortg. Corp.*, 830 F.3d 376, 388 (6th Cir. 2016).

directed at price impact. Yet *Halliburton II* made clear that courts should not consider defendants' evidence that their alleged misrepresentations were immaterial and thus had no price impact at the class certification stage. The Supreme Court in *Halliburton II* did not so much as hint that it intended to overrule *Amgen*.

Halliburton II, therefore, only allows defendants to introduce at the class certification stage evidence of lack of price impact that *Amgen* does not otherwise preclude

Erica P. John Fund, Inc. v. Halliburton Co., No. 15-90038, 2015 WL 10714013, at *2 (5th Cir. Nov. 4, 2015) (Dennis, J., concurring) (“2015 Judge Dennis Concurrence”).⁶ In other words, the 2015 Judge Dennis Concurrence suggests that *Halliburton II* only permits price impact evidence that would not be relevant to the issue of materiality, because evidence bearing on materiality would continue to be barred by *Amgen*. Because the OIG Report is relevant to materiality, Amalgamated argues, the court should not have considered it.

The court finds no error in its earlier conclusion that *Halliburton II* requires it to consider evidence of a lack of price impact, even if that evidence would also be evidence of immateriality. The conclusion that considering such evidence would be barred by *Amgen* conflates the question of which *issues* can be considered at the class certification stage with which *evidence* can be considered then—a conflation that *Halliburton II* necessarily must reject in order for it to be consistent with *Halliburton I*. The evidence at issue in *Halliburton II* was the same evidence that had been presented to dispute loss causation in *Halliburton I*. Moreover, it was being offered in support of the same general factual inference at issue in *Halliburton I*—that the allegedly fraudulent statements did not affect the price of Halliburton stock. Nevertheless, the Supreme Court allowed the defendant to present that evidence in *Halliburton II*, because it was being offered in relation to a different issue. Amalgamated has identified no convincing reason why the

⁶ Amalgamated refers to the 2015 Judge Dennis Concurrence as “*Halliburton III*” and attributes its analysis to “the Fifth Circuit.” (Docket No. 149 at 16.) Judge Dennis’s concurring opinion, however, was not joined by any other judges.

same rule would not apply with regard to evidence relevant to materiality. *Amgen* prevents a defendant from directly disputing materiality *qua* materiality at the Rule 23 stage, just as *Halliburton I* prevents it from disputing loss causation *qua* loss causation. It does not flow from either premise, however, that a court must exclude all evidence that might be relevant to those issues, if offered for another purpose.

Indeed, both *Amgen* and *Halliburton I* rejected certain arguments on the ground that the determinative issue, regarding whether to consider evidence at the class certification stage, is the purpose for which evidence is offered. The defendant in *Halliburton I* sought to reframe its loss causation evidence as price impact evidence, but the court rejected the maneuver because it “[ook] the Court of Appeals at its word” when that court stated that it was considering only loss causation. 563 U.S. at 815. Similarly, the defendant in *Amgen* sought to present evidence suggesting that its statements had not affected the mix of information available to investors, but the Court rejected that maneuver as well, because the evidence, as presented, “aimed to prove that the misrepresentations and omissions alleged . . . were immaterial.” 568 U.S. at 481. It was the aim, not the content of the evidence, that mattered.⁷

⁷ Amalgamated attempts to characterize this aspect of *Amgen*’s reasoning as involving the same issue here, because both cases involve allegations that the market was or became aware of the truth during the relevant class period. The situations, however, are different, as are both what is being contested and why it is being contested. The defendant in *Amgen* argued that, when it made the allegedly false statements or omissions, the truth was already available to investors from other sources:

For example, Connecticut Retirement’s complaint alleges that an Amgen executive misleadingly downplayed the significance of an upcoming Food and Drug Administration advisory committee meeting by incorrectly stating that the meeting would not focus on one of Amgen’s leading drugs. Amgen responded to this allegation by presenting public documents—including the committee’s meeting agenda, which was published in the Federal Register more than a month before the meeting—stating that safety concerns associated with Amgen’s drug would be discussed at the meeting.

568 U.S. at 481 (citations omitted). In other words, the defendant sought to argue that, based on the truth already being out, its statements would have been disregarded by a reasonable investor—a classic materiality argument. CoreCivic does not make such an argument with regard to the OIG Report, nor could it, because the OIG Report did not come out until nearly the end of the Class Period. Rather,

At the heart of this confusing area of the case law is the fact that all three concepts addressed—loss causation, materiality, and price impact—are, in essence, slightly different takes on the same fundamental question: Did a statement matter? As a result, evidence relevant to each issue is likely also to be relevant to the others. Evidence of price impact is relevant to materiality, because evidence that a statement affected a stock’s price confirms that a reasonable investor would have cared about the statement. Evidence of loss causation is relevant to price impact, because, if the plaintiff is to succeed, the price impact must be what caused the loss—the two become one and the same. And evidence of materiality is likely to be relevant to both price impact and loss causation, because, as the Court observed in *Halliburton II*, materiality, when used in the context of the *Basic* presumption, is itself merely a piece of indirect evidence offered to establish that a statement can be assumed to have affected a stock price. 573 U.S. at 278. Taking a piece of evidence and placing it in any of the three boxes, to the exclusion of the others, would be an artificial and logically questionable exercise.

The court pauses to note that, if this issue had come before it after *Amgen* but before *Halliburton II*, the court likely would have reached a different result. As the Supreme Court itself largely conceded, the reasoning applied to materiality in *Amgen* would seem to apply, with similar force, to price impact. Moreover, the ground given by the Supreme Court, in *Halliburton II*, for treating price impact differently—that price impact is an especially central concept to fraud-on-the-market—is difficult to reconcile with *Amgen*’s admonition that a Rule 23 commonality analysis is what should guide the court, not the necessity of the contested element. The court, if asked to interpret the law as it stood immediately after *Amgen*, likely would have held that price impact is an issue to be saved for the merits stage.

CoreCivic offers the OIG Report on the question of whether the Yates Memorandum was corrective, because the possibility of the Yates Memorandum’s being corrective is an obstacle to CoreCivic’s ability to demonstrate a lack of price impact.

Halliburton II, however, precludes the court from denying CoreCivic the opportunity to argue a lack of price impact at the class certification stage. Given that that issue is properly before the court, there is no reason to artificially limit the evidence on which CoreCivic can rely, merely because that evidence would also be relevant to a different issue that is reserved for the merits stage of litigation. To the contrary, the Court, in *Halliburton II*, made clear that a defendant can rely on “[a]ny showing that severs the link between the alleged misrepresentation and . . . the price received (or paid) by the plaintiff” to rebut the *Basic* presumption. 573 U.S. at 281 (quoting *Basic*, 485 U.S. at 248) (emphasis added). The court, therefore, finds no error in its earlier interpretation of *Halliburton II*.

4. Whether the OIG Report was Corrective

Amalgamated argues that, even if the court was permitted to consider the OIG Report in its price impact analysis, the court erred in concluding that the Report was sufficiently corrective to preclude relying on the price impact of the Yates Memorandum under a materialization of risk theory. The court’s previous analysis on this issue was as follows:

The Report discussed specific deficiencies at CoreCivic’s Eden Detention Center, which was one of the facilities closely examined in the OIG’s review. It included detailed statistics about various undesirable events at CoreCivic facilities, such as inmate-on-inmate assaults, suicide attempts, grievances, and lockdowns. The Report also made specific reference to private prisons’ issues with inadequate staffing, one of the deficiencies central to CoreCivic’s alleged quality control issues in this case. The Report, moreover, “caution[ed] against drawing the conclusion . . . that contract prisons are necessarily lower cost than BOP institutions on an overall basis.” In short, an investor who read the Report on the day of its publication, August 11, 2016, would have been well-apprised of the fact that there was evidence of significant quality issues with the BOP’s contract prisons, including, specifically, CoreCivic’s. . . .

Prior to the release of the Yates Memorandum, the truth, as alleged by Amalgamated, was this: 1) CoreCivic and other private prison operators had a history of major quality deficiencies, and the extent of the cost savings they offered was questionable. 2) There was ample reason for the DOJ to reconsider its relationship with private prison contractors, but CoreCivic defended its practices and hoped to continue doing business with the BOP. That is exactly the picture

one receives when one reads the OIG Report There was no concealed truth, then, left for the Yates Memorandum to disclose. All that the Memorandum revealed was the ensuing policy decision.

(Docket No. 143 at 16–17 (citations omitted).) Amalgamated now points to two issues with the OIG Report that, it argues, prevented the Report from precluding the later corrective effect of the Yates Memorandum. First, Amalgamated argues that the OIG Report ignored or gave short shrift to many of CoreCivic’s problems, particularly in the areas of staffing and medical care—and that even CoreCivic’s own executives internally conceded as much. Second, Amalgamated notes that, while the OIG Report was released shortly before the Yates Memorandum in 2016, it only covered FY 2011 through FY 2014. Accordingly, the picture painted by the Report did not capture the deterioration of the CoreCivic/BOP/DOJ relationship that occurred after the close of FY 2014, a deterioration embodied by the mounting concerns around the Cibola facility, the BOP’s ultimate non-renewal of the Cibola contract, and CoreCivic executives’ concerns that other contracts might be in jeopardy.

CoreCivic responds by arguing that Amalgamated’s reliance on internal CoreCivic communications is inappropriate, because non-public communications would have had no bearing on the market price of CoreCivic’s stock. CoreCivic argues that, if anything, those communications would be relevant to the merits of a fraud claim, but the merits are not currently before the court. (Docket No. 160 at 10–11.) CoreCivic’s argument, however, is merely another iteration of the same reasoning that CoreCivic correctly urged the court to reject with regard to evidence relevant to materiality. Amalgamated cannot, at this stage, use the internal CoreCivic communications to demonstrate, for example, that CoreCivic executives were acting knowingly when they made particular allegedly false statements. That issue would be irrelevant to class certification. Nevertheless, the internal communications are relevant insofar as they pertain to any of the matters currently contested.

Internal CoreCivic communications evaluating the OIG Report are relevant to the price impact inquiry because those communications demonstrate how individuals knowledgeable about the private prison industry reacted to the Report. The efficient market hypothesis assumes that the market will be able to assimilate publicly available information about a company with a level of insight and sophistication that accounts for the realities of the industry in which the company does business. Before Amalgamated identified the internal CoreCivic correspondence, the court was forced to read the OIG Report largely in isolation. Now, the court can see how people familiar with the private prison industry read the Report, and it appears that there is a strong case to be made that CoreCivic got off easy. That evidence is directly relevant to the issue of whether the OIG Report was corrective and, if so, to what degree.

Moreover, the correspondence regarding Cibola and the possibility of that and other contracts being in jeopardy is relevant because it demonstrates what being “corrective,” in this context, would have meant. The OIG Report, as the court already acknowledged, painted a picture of CoreCivic as a company that had often failed to meet government expectations. That picture, however, is far less severe than the reality apparent from the CoreCivic correspondence. While this reasoning unavoidably involves going far down the road toward considering issues relevant to the merits of Amalgamated’s claims, it was CoreCivic, in its attempt to demonstrate a lack of price impact, that made such an inquiry necessary. The court, accordingly, is entitled to consider evidence regarding how corrective the OIG Report really was.

CoreCivic’s boasts about the quality of its services and client relationships were mostly general in nature, and it was not necessary for the OIG Report to reveal every problem or shortcoming CoreCivic had had in order to qualify as corrective. Nevertheless, for the Report to sufficiently undercut the Yates Memorandum’s capacity to demonstrate price impact, the Report must have revealed at least enough to bridge the gap between CoreCivic’s representations and

the truth. Amalgamated has demonstrated that the OIG Report, due to limitations on its date range, subject matter, and methodology, failed to do so.⁸ The court, accordingly, erred in concluding that CoreCivic had rebutted the *Basic* presumption and, by doing so, shown that Amalgamated had failed to satisfy Rule 23(b)(3). To the contrary, as long as Amalgamated can rely on a fraud-on-the-market theory, it is clear that common questions of law and fact predominate over individual ones, and Rule 23(b)(3) is satisfied. The court will, accordingly, go on to considering whether the other requirements of class certification are met.

C. Other Requirements of Class Certification

While CoreCivic focused its opposition to class certification on the issue of common reliance, it is still ultimately Amalgamated's obligation, as the party seeking certification, to establish that it has met the requirements of Rule 23. *See Alkire*, 330 F.3d at 820; *Senter*, 532 F.2d at 522. "The class action is 'an exception to the usual rule that litigation is conducted by and on behalf of the individual named parties only.'" *Wal-Mart Stores*, 564 U.S. at 348 (quoting *Califanoi*, 442 U.S. at 700–01). "A class representative must be part of the class and possess the same interest and suffer the same injury as the class members." *Id.* (citation and internal quotation marks omitted). To be certified, a class must satisfy the prerequisites set forth in Rule 23(a) of the Federal Rules of Civil Procedure: that "(1) the class is so numerous that joinder of all members is impracticable; (2) there are questions of law or fact common to the class; (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class; and (4) the representative parties will fairly and adequately protect the interests of the class." Fed. R. Civ. P. 23(a); *Young v. Nationwide Mut. Ins. Co.*, 693 F.3d 532, 537 (6th Cir. 2012).

⁸ In its initial Memorandum, the court also considered and rejected Amalgamated's alternative argument that the non-renewal of the Cibola contract could be treated as a corrective event demonstrating price impact. (Docket No. 143 at 18.) Because CoreCivic has failed to rebut the *Basic* presumption regardless, that issue should have been left for the merits stage of litigation. The court, accordingly, withdraws its analysis on that point without passing judgment on whether such an argument will prevail at a later stage in the proceedings.

1. Numerosity

Rule 23(a)(1) requires that the class be so numerous that joinder of all members is impracticable. Although there is no strict numerical test, substantial numbers usually satisfy the numerosity requirement. *Gilbert v. Abercrombie & Fitch Co.*, No. 2:15-cv-2854, 2016 WL 4159682, at * 4 (S.D. Ohio Aug. 5, 2016) (citing *Daffin v. Ford Motor Co.*, 458 F.3d 549, 552 (6th Cir. 2006)). “There is no magic minimum number that will breathe life into a class.” *Russo v. CVS Pharmacy, Inc.*, 201 F.R.D. 291, 294 (D. Conn. 2001) (quoting *Jones v. CCH-LIS Legal Info. Servs.*, 1998 WL 671446, *1 (S.D.N.Y. Sept. 28, 1998)). A plaintiff must show some evidence of or reasonably estimate the number of class members, and, in assessing numerosity, the court may make common sense assumptions without the need for precise quantification of the class. *Id.* “[T]he exact number of class members need not be pleaded or proved” for a class to be certified, as long as the class representatives can show that joinder would be impracticable. *Golden v. City of Columbus*, 404 F.3d 950, 965–66 (6th Cir. 2005) (quoting *McGee v. E. Ohio Gas Co.*, 200 F.R.D. 382, 389 (S.D. Ohio 2001)).

Although Amalgamated has not identified the exact number of potential plaintiffs in this case, it has more than established numerosity. According to the report of Amalgamated’s expert, Professor Steven P. Feinstein, SEC filings show that “at least 783 major institutions owned [CoreCivic] stock during the Class Period.” (Docket No. 93-3 ¶ 61.) Over 110 million shares of CoreCivic’s common stock were traded on the New York Stock Exchange. (*Id.* ¶ 79.) Whatever the total number of plaintiffs, it is plain that they are too numerous for joinder to be practicable.

2. Commonality and Typicality

In order for the court to certify the class under Rule 23, the class members’ claims must depend upon a common contention of such a nature that it is capable of class-wide resolution. *In re Whirlpool Corp. Front-Loading Washer Prods. Liab. Litig.*, 722 F.3d 838, 852 (6th Cir.

2013). Variation in the ancillary details of the class members' cases is insufficient to defeat certification, as long as "[i]t is unlikely that differences in the factual background of each claim will affect the outcome of the legal issue." *Bacon v. Honda of Am. Mfg., Inc.*, 370 F.3d 565, 570 (6th Cir. 2004) (quoting *Califano*, 442 U.S. at 701).

Typicality is met if the class members' claims are fairly encompassed by the named plaintiffs' claims. This requirement ensures that the class representative's interests are aligned with the interests of the represented class members so that, by pursuing its own interests, the class representative also advocates the interests of the class members. *Whirlpool*, 722 F.3d at 852–53. Thus, a plaintiff's claim is typical if it arises from the same event or practice or course of conduct that gives rise to the claims of other class members and if his claims are based on the same legal theory. *In re Am. Med. Sys., Inc.*, 75 F.3d 1069, 1082 (6th Cir. 1996). Commonality and typicality tend to merge because both of them serve as guideposts for determining whether, under the particular circumstances, maintenance of a class action is economical, and whether the plaintiff's claims and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence. *Young*, 693 F.3d at 542.

The issues related to reliance that CoreCivic raised under Rule 23(b)(3) also bear on the issues of commonality and typicality, but, as the court now holds, CoreCivic's arguments in that regard are unavailing. Because Amalgamated has established that CoreCivic stock traded on an efficient market and the defendants' statements were public and made during the Class Period, and because CoreCivic has failed to rebut the *Basic* presumption by demonstrating a lack of price impact, Amalgamated is entitled to rely on the *Basic* presumption to establish commonality, and typicality, with regard to issues of reliance.

CoreCivic's expert also took issue with Amalgamated's model for using a single class-wide model for establishing individual plaintiffs' damages. Allen's methodological critique does

not, however, appear to undermine the conclusion that the plaintiffs' claims will ultimately hinge on shared issues of fact. Rather, Allen suggests that Amalgamated's proposed model fails to account for a "structural break" in the valuation of CoreCivic's stock associated with the February 7, 2013 conversion to the REIT form. (Docket No. 99-3 ¶¶ 96–99.) At most, however, this appears to create a generally applicable wrinkle with regard to all of the class members' damages based on the respective dates of the plaintiffs' transactions; it does not establish that damages will have to be determined on a wholly individual basis, without a shared methodology. Allen's observation regarding shared damages, therefore, does not defeat commonality or typicality. Nor does CoreCivic identify, or the court observe, any other obstacle. Because this is a fraud-on-the-market case, it hinges overwhelmingly on shared questions, and Amalgamated's claims are typical of those of the class.

3. Adequacy of Representation

Rule 23(a)(4) requires the court only to certify the class if "the representative parties will fairly and adequately protect the interests of the class." That requirement considers both general commonality of interests and whether the putative representative "will vigorously prosecute the interests of the class through qualified counsel." *Gonzales v. Cassidy*, 474 F.2d 67, 73 (6th Cir. 1973). As the court has already held, Amalgamated has established commonality. The court similarly sees no obstacle to class certification related to adequacy of representation. While Amalgamated should have raised some of its arguments sooner, it rectified any oversight, and its prosecution of this case has otherwise been vigorous, competent, and well-executed, as far as the court can tell. Because Amalgamated has satisfied the requirements of Rule 23, the court will certify its proposed class.⁹

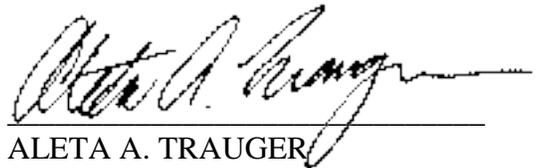
⁹ The court requested briefing on whether the court would be permitted to certify a class with a reduced Class Period, based on the possibility that the OIG Report may have been corrective with regard to some,

IV. CONCLUSION

For the foregoing reasons, Amalgamated's Motion for Reconsideration of the January 19, 2018 Order Denying Class Certification (Docket No. 148) will be granted.

An appropriate order will enter.

ENTER this 26th day of March 2019.



Aleta A. Trauger

ALETA A. TRAUGER
United States District Judge

but not all, portions of the Class Period. Because the court has concluded that the OIG Report included substantive deficiencies that undermined its ability to be corrective with regard to the entire Class Period, it is unnecessary to consider whether a shortened Class Period would be permissible. The court will certify the class with the originally requested scope.



PERFORMANCE AUDIT REPORT

Department of Correction

January 2020

Justin P. Wilson
Comptroller of the Treasury



DIVISION OF STATE AUDIT

DEBORAH V. LOVELESS, CPA, CGFM, CGMA
Director

State Agency Audits

KANDI B. THOMAS, CPA, CGFM, CFE, CGMA
Assistant Director

JENNIFER WHITSEL, CPA, CFE, CGMA
DENA W. WINNINGHAM, CGFM
Audit Managers

Melissa Boaz, CPA, CGFM, CFE, CGMA
Jaclyn Clute
Vincent Finamore, CFE
In-Charge Auditors

Mason Ball, CPA, CFE, CGFM
Chris Colvard
Michael Deloach, CPA, CGFM
Fonda Douglas
Heather Murray
De'Aundrea Pointer
Valeria Stadelman
Chas Taplin, CPA, CFE
Sarah Vandergriff
Jackson Wickham
David Wright, CFE
Staff Auditors

Amy Brack
Editor

Amanda Adams
Assistant Editor

Information Systems

DANIEL V. WILLIS, CPA, CISA, CGFM
Assistant Director

BRENT L. RUMBLEY, CPA, CISA, CFE
Information Systems Audit Manager

James Falbe, CISA
Sam Osborn, CISA
In-Charge Auditors

Andrew Bullard, CISA
Daniel Elkins
Malik M. Moughrabi
Timothy F. Powers II
Staff Auditors

Comptroller of the Treasury, Division of State Audit
Cordell Hull Building
425 Fifth Avenue North
Nashville, TN 37243
(615) 401-7897

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JUSTIN P. WILSON
Comptroller

January 6, 2020

The Honorable Randy McNally
Speaker of the Senate
The Honorable Cameron Sexton
Speaker of the House of Representatives
The Honorable Kerry Roberts, Chair
Senate Committee on Government Operations
The Honorable Martin Daniel, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, TN 37243
and
The Honorable Tony Parker, Commissioner
Department of Correction
320 Sixth Avenue North
Nashville, Tennessee, 37243

Ladies and Gentlemen:

We have conducted a performance audit of selected programs and activities of the Department of Correction for the period October 1, 2017, through July 31, 2019. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

Our audit disclosed certain findings, which are detailed in the Audit Conclusions section of this report. Management of the department has responded to the audit findings; we have included the responses following each finding. We will follow up the audit to examine the application of the procedures instituted because of the audit findings.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

A handwritten signature in black ink that reads "Deborah V. Loveless".

Deborah V. Loveless, CPA, Director
Division of State Audit

DVL/jw/dw
19/032



Division of State Audit

Department of Correction

Performance Audit
January 2020

Our mission is to make government work better.

AUDIT HIGHLIGHTS

The Department of Correction's Mission

To operate safe and secure prisons and provide effective community supervision in order to enhance public safety.

We have audited the Department of Correction for the period October 1, 2017, through July 31, 2019. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts. We conducted site visits at the following correctional facilities:

Scheduled Termination Date:

June 30, 2020

CoreCivic Facilities

Hardeman County Correctional Facility
Trousdale Turner Correctional Center
Whiteville Correctional Facility

State Facilities

Northeast Correctional Complex
Northwest Correctional Complex
Turney Center Industrial Complex

We divided our report into 11 sections:

- department leadership oversight;
- department's annual inspections of correctional facilities;
- public reporting of inmate deaths and other serious incidents;
- inmate sexual abuse and sexual harassment investigations;
- inmate medical and mental health services;
- correctional staffing and department turnover;
- inmate services and support;
- department's community supervision responsibilities;
- COMET implementation;
- public records management; and

- recidivism rates for the department’s educational and vocational programs.

We present a total of 18 findings, 13 observations, and 3 matters for legislative consideration. Our key conclusions below refer to each audit area and its overarching conclusions. The beginning of each section of the report lists the respective findings, observations, and other conclusions.

KEY CONCLUSIONS

Department Leadership Oversight

The Department of Correction’s leadership failed to provide adequate oversight activities of department and correctional facilities management in several areas relating to inmates, correctional staff, and the community, thereby affecting the department’s ability to meet its mission “to operate safe and secure prisons and provide effective community supervision in order to enhance public safety.”

As a result of our review of the department, we have determined that various areas of the department’s operations would benefit from increased oversight and the implementation of adequate internal controls. In order to ensure compliance with laws, regulations, and policies; provide safe and secure facilities; and reduce the risk to public safety, department management should develop a plan to improve areas throughout the organization, including

- quality reporting of information;
- correctional facilities staffing;
- inmate services, including medical and mental health services;
- parole and probation monitoring; and
- contracted services and other procurements.

Department management has a duty to provide a safe environment for staff at its facilities and inmates in its custody. Department management must also report complete and accurate information to decision makers. Department management must meet the medical and mental healthcare needs of individuals in custody and ensure that individuals on parole and probation are sufficiently monitored. Finally, management should provide sufficient oversight over contracted services and other procurements, ensuring that department staff comply with state laws and regulations and that vendors meet the department’s expectations. See **Finding 1** on page 11.

Department’s Annual Inspections of Correctional Facilities

Although the results of annual inspections provide management a basis to evaluate state and CoreCivic facility performance and to establish a basis to reward CoreCivic facilities, the department’s overall annual compliance percentage scores do not provide a clear measure of correctional facility performance.

Based on our review, we found that the Compliance Division's calculation of compliance percentages emphasizes the number of compliant items instead of the severity of critical findings. These scores do not differentiate between "critical" or "other" findings and do not stress mission-critical areas that may directly impact the safety and security of inmates, staff, and the general public. Management uses these scores to monitor performance at all correctional facilities and to reward CoreCivic's performance (although only at the Hardeman County facility currently). The Department of Correction's management has also used the overall scores to discuss facility inspection results during legislative hearings. See **Finding 2** on page 24.

Public Reporting of Inmate Deaths and Other Serious Incidents

Management did not ensure that state and CoreCivic facilities staff collected and reported complete, accurate, and valid information; as a result, their ability to provide reliable data is problematic.

Because state leadership and the public use the information provided by the Department of Correction to draw conclusions about how correctional facilities are operating, it is vital that management ensures that data on incidents, including deaths and other serious incidents, is valid and reliable.

Based on our review, management did not implement or enforce established internal controls to ensure state and CoreCivic correctional facilities staff collected and accurately reported incident information for

- inmate deaths (see **Finding 4** on page 43);
- inmate assaults, inmate violence, and correction officers' use of force (see **Finding 5** on page 46);
- inmate accidents and injuries (see **Finding 6** on page 50); and
- facility lockdowns (see **Observation 1** on page 54).

Because of these internal control deficiencies, management's ability to provide accurate and complete information to key decision makers is problematic, impacting both management's oversight of facility operations and its ability to provide a safe and secure correctional environment (see **Finding 3** on page 40 and **Finding 8** on page 57).

Inmate Sexual Abuse and Sexual Harassment Investigations

Department of Correction management has not ensured that state and CoreCivic correctional facility staff followed policies and procedures for investigating sexual abuse and harassment allegations and documented their results.

The failure to properly investigate and respond to allegations of sexual abuse and harassment can directly impact the safety and security of both inmates and staff at correctional facilities. During our review of investigations of sexual abuse and harassment occurring at correctional institutions, we identified the following deficiencies:

- at one state-managed facility, investigators misclassified investigative results as unfounded rather than unsubstantiated; in these cases, the investigators did not find sufficient evidence to substantiate the allegations; and
- at state- and CoreCivic-managed facilities, investigators did not record allegations timely, limiting department management's ability to effectively track and monitor the status of investigations.

Without accurate, complete, and timely investigation records, management cannot ensure that facility management, investigators, and staff take swift action to investigate and respond to allegations of sexual abuse and harassment. See **Finding 9** on page 82.

Inmate Medical and Mental Health Services

Because of issues at both state and CoreCivic facilities involving medical and mental health documentation; medical records and medication transfer; and medicine dispensing, Department of Correction management did not fully demonstrate that inmates received sufficient medical and mental health services when needed.

Pursuant to Section 41-1-408, *Tennessee Code Annotated*, the department has a responsibility to provide medical and mental health services to inmates under its custody. Based on our review of inmates' medical and mental health files, staff at the department and CoreCivic facilities did not maintain all required documentation, which prevents management from ensuring whether inmates received appropriate care (see **Finding 12** on page 100). Additionally, state correctional facilities staff did not ensure that inmate records and medications traveled with transferred inmates (see **Observation 5** on page 108). Based on our audit procedures, we also identified deficiencies with medicine distribution practices at CoreCivic facilities, placing both inmates and medical staff at risk (see **Observation 4** on page 103, **Observation 5** on page 108, and **Finding 13** on page 106).

Department of Correction management did not provide adequate oversight over medical and mental health contractors to ensure the contractors met required staffing levels, and management did not follow statewide procurement policies governing contract terms and amendments, increasing the risk that contractors may not be held accountable for performance that may adversely impact medical and mental health services for the inmate population.

The department's medical and mental health contractors, Centurion of Tennessee, LLC and Corizon Health, have been unable to consistently meet contractually required medical and mental health staffing levels, increasing the risk that inmates will not receive needed services (see **Finding 11** on page 98). Even though Centurion and Corizon have contract performance deficiencies, department management has established a value-added credit system (outside the scope of the contracts) in which the contractors are allowed to self-report areas and/or efforts that they believe deserve recognition. According to the department's Chief Financial Officer, the Chief Medical Officer reviews the contractor's reported information and may approve credits, which the contractor can use to offset any department-assessed liquidated damages. In the current system, contractors can fail to meet current contract requirements; receive credits for self-reported areas of good performance or efforts (including areas not currently required in the state's contract); and then use, or "net," the earned credits against assessed damages. Furthermore, we could not determine whether the contractors actually corrected the contract performance deficiencies, nor

did department management collect the majority of liquidated damages assessed. (See **Finding 10** on page 96.)

Correctional Staffing and Department Turnover

Management must continue efforts to ensure adequate staffing at state and CoreCivic correctional facilities in order to provide safe and secure facilities for inmates and staff.

Sufficient staffing of correctional officer positions is vital to achieving the mission of the Department of Correction; however, both state- and CoreCivic-managed facilities have experienced significant difficulties in hiring and retaining a sufficient number of correctional officers. Due to minimal staffing levels at both state and CoreCivic entities, management has increased overtime and temporarily closed noncritical posts to cover critical posts and duties. At the facilities we visited, we found that, on average, they operated with fewer than the approved number of correctional officers while noncritical posts, such as transportation and recreation, were consistently under-staffed or closed. Low staffing levels coupled with frequent overtime impacts management's ability to provide safe and secure facilities, especially in emergencies. See **Observation 6** on page 130 and **Observation 7** on page 133.

The department should continue its efforts to remedy the deficiencies on CoreCivic's staffing reports as noted in the prior audit.

Despite management's stated corrective action after the November 2017 performance audit and efforts to accurately track staffing positions on a monthly basis, CoreCivic facilities' monthly staffing reports contained the same errors noted in the prior audit, so department management cannot effectively track whether CoreCivic is meeting its contractually required staffing levels. See **Finding 14** on page 135.

Inmate Services and Support

Management did not ensure that state and CoreCivic facilities performed mandatory procedures designed to protect and serve inmates.

Staff at both the state-run and CoreCivic facilities did not conduct screenings to determine if inmates posed a risk of being a sexual abuser or victim within the policy-required timeframes (see **Finding 15** on page 160). Furthermore, Trousedale Turner Correctional Center did not conduct the minimally required number of random inmate drug screenings, while Whiteville Correctional Facility, Turney Center Industrial Complex, and Northwest Correctional Complex did not consistently and accurately record the results of these screenings. Without consistent application and documentation of these drug screenings, management cannot reasonably ensure facilities have taken sufficient measures to control drug use and its detrimental effects on facilities' safety and security (see **Observation 10** on page 167).

Management did not ensure inmates are aware of, and have access to, information and services the Department of Correction provides.

In compliance with law and policy, state and CoreCivic facilities are required to provide access to various programs and services for inmates. As dictated by department policy, facilities must provide inmates with an orientation program within three days of their arrival; these orientation programs provide information on rules of conduct; disciplinary procedures; reporting grievances

and allegations of sexual abuse or assault; access to medical and mental health services; clothing; and family visitation. Management did not ensure facilities performed inmate orientations within the three-day timeframe that policy requires (see **Finding 16** on page 163). As a result of our review, we also determined that

- two state-managed facilities impeded inmates' access to forms and healthcare instructions (see **Observation 8** on page 165); and
- state and CoreCivic correctional staff did not properly maintain class and job documentation, such as an inmate's documented understanding of job duties and pay rates (see **Observation 9** on page 166).

Department's Community Supervision Responsibilities

Although we saw improvement, the Department of Correction has still not ensured the adequate monitoring of individuals placed on parole or probation.

Offenders placed on parole or probation have been found guilty of crimes, and probation and parole officers are charged with ensuring that offenders comply with the conditions of their release in order to keep the community safe. The department's Community Supervision unit is responsible for monitoring approximately 40,000¹ individuals placed on parole or probation statewide. As noted in the previous three audits,² supervisors and management have not fulfilled their oversight responsibilities of the state's probation and parole officers and have not ensured these officers fulfilled their monitoring responsibilities (see **Finding 17** on page 179 and **Observation 11** on page 182). Additionally, as a result of our review, we determined that probation and parole officers and state and local law enforcement agencies do not have a single comprehensive resource to look up arrests made throughout the state, which would constitute parole or probation violations. As detailed in the **Matter for Legislative Consideration** on page 175, such a system would help officers determine if an offender had any recent arrests or open arrest warrants.

COMET Implementation

After signing a \$15.3 million contract, spending 3 years on development, and facing unforeseen obstacles, the department's vendor has been unable to implement the new COMET system, and as of September 2019, there is no official "go-live" date.

The department currently uses the Tennessee Offender Management Information System (TOMIS) as its primary offender management system. This system is outdated, costly to maintain, and requires significant manual processes and outside applications to sufficiently compile and track inmate data. The department's new offender management system, Correctional Offender Management Electronic Tracking (COMET), should streamline department operations, but its implementation is 18 months behind schedule with no official start date as of September 2019 (see **Observation 12** on page 188). We provide further information on management's production and distribution of quality information in our **Public Reporting of Inmate Deaths and Other Serious Incidents** section.

¹ We calculated a six-month average using monthly department supervisory reports we reviewed during the audit.

² We reported this finding in the 2012 performance audit of the Board of Probation and Parole. In 2012, the Department of Correction became responsible for community supervision; we followed up on this finding in the department's 2014 performance audit follow-up and in its 2017 performance audit.

Public Records Management

Department of Correction management did not ensure that both department and CoreCivic staff complied with public records regulations, resulting in lost records as well as potential evidence.

Public records provide evidence of government operations and hold government officials accountable for their actions. For the department and its CoreCivic contractor, such records are also vital to review the effective operation of correctional facilities and community oversight and may even serve as potential evidence in investigations. Based on our review, we determined the following:

- At four of six correctional facilities, state and CoreCivic management did not properly retain, maintain, and destroy public records.
- At three of six correctional facilities, state and CoreCivic staff disposed of large volumes of files without submitting the state-required certificates of destruction.
- One state correctional facility did not maintain security footage for the department-established minimum of 90 days, sometimes overwriting footage within 2 weeks of recording.

For more information, see **Finding 18** on page 195. Additionally, staff at one state facility did not follow the department's procedure for restoring public records after a minor flood destroyed some Fire and Safety records in spring 2019 (see **Observation 13** on page 198).

Recidivism Rates for the Department's Educational and Vocational Programs

The Department of Correction has not reported recidivism rates for inmates who participated in educational and vocational programs, as required by statute, but has provided other information to the General Assembly.

Section 41-21-238 et seq., *Tennessee Code Annotated*, requires the Commissioner of Education, with the assistance of the Commissioner of Correction, the Board of Regents,³ and the University of Tennessee System, to develop a plan to increase educational and vocational opportunities for inmates. The Commissioner of Correction is required to monitor and document the plan's effectiveness, which includes calculating recidivism rates of inmate participants in these programs. Although the department routinely presents other measures of educational and vocational programs' success to the General Assembly, the department does not currently report program-specific recidivism rates. We have included a **Matter for Legislative Consideration** on page 203 concerning the requirement to report these recidivism rates.

³ The General Assembly may also wish to amend Section 41-21-238 et seq., to include the six locally governed institutions, which are no longer part of the Tennessee Board of Regents.

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INTRODUCTION

AUDIT AUTHORITY

This performance audit of the Department of Correction was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-241, the department is scheduled to terminate June 30, 2020. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the agency and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the department should be continued, restructured, or terminated.

BACKGROUND

The Department of Correction was established in 1923 under Section 4-3-601, *Tennessee Code Annotated*, to operate the state's correctional system. As such, the department's mission is to "operate safe and secure prisons and provide effective community supervision in order to enhance public safety."

The department ensures housing for 21,669 inmates⁴ at 14 correctional facilities (see **Table 1**). The state owns and operates 10 facilities that house approximately 14,000 inmates, while CoreCivic, the state's private prison contractor, operates 4 facilities and provides housing for the remaining 7,700 inmates. See **Exhibit 1** on page 3 for a map with the list and locations of the state's and CoreCivic's correctional facilities.



All CoreCivic facilities and 7 of the state facilities provide housing exclusively to male inmates; the Tennessee Prison for Women and the Women's Therapeutic Residential Center (located at the West Tennessee State Penitentiary site) exclusively house female inmates; and the Bledsoe County Correctional Complex houses both male and female inmates.

A map of the state's correctional facilities is on page 3.

The department's Community Supervision unit supervises approximately 77,000 offenders on probation, on parole, or in a community correction program. **Table 1** illustrates the population of inmates and offenders under the department's jurisdiction as of August 2019.

⁴ In this report, we will use the term "inmates" to describe individuals housed in a correctional facility; the term "offenders" will refer to individuals who are in the department's custody but reside in the community.

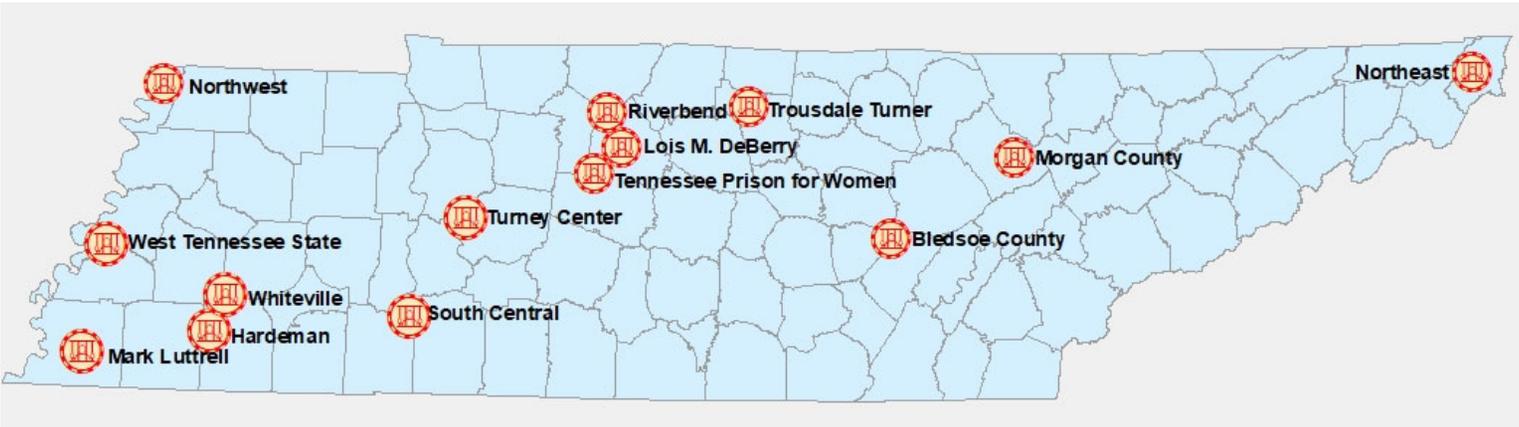
Table 1
Number of Inmates/Offenders Under Department of Correction Oversight
as of August 2019

Type of Oversight	Number of Inmates/Offenders
Felons Incarcerated in Correctional Facilities	21,669
Probation and Community Corrections ⁵	66,589
Parole	10,621
Total Population	98,879

Source: Department of Correction's Tennessee Felon Population Update, August 2019.

⁵ For sentenced offenders, Community Corrections programs allow nonviolent felony offenders to participate in community-based alternatives to incarceration. The department contracts with local governments and private agencies to develop services and resources to reduce the chances that the offender will continue criminal behavior.

Exhibit 1
Department of Correction
Map of State Correctional Facilities



State-Run Facilities

Correctional Facility Name	Shortened Facility Name	Correctional Facility Name	Shortened Facility Name
Bledsoe County Correctional Complex	Bledsoe County	Northwest Correctional Complex	Northwest
Lois M. DeBerry Special Needs Facility	Lois M. DeBerry	Riverbend Maximum Security Institution	Riverbend
Mark Luttrell Transition Center	Mark Luttrell	Tennessee Prison for Women	Prison for Women
Morgan County Correctional Complex	Morgan County	Turney Center Industrial Complex	Turney Center
Northeast Correctional Complex	Northeast	West Tennessee State Penitentiary	West Tennessee State

CoreCivic Facilities

Correctional Facility Name	Shortened Facility Name	Correctional Facility Name	Shortened Facility Name
Hardeman County Correctional Facility	Hardeman	Trousdale Turner Correctional Center	Trousdale Turner
South Central Correctional Facility	South Central	Whiteville Correctional Facility	Whiteville

Department's Organizational Structure

The Department of Correction is organized into nine offices, whose division heads report directly to the Commissioner.

The Chief of Staff is responsible for carrying out the Commissioner's strategic vision for the department. He represents the Commissioner on various committees and acts as a liaison with other state departments.

The department's organizational chart is on page 7.

The Office of Administration and General Counsel oversees

- legal services,
- human resources,
- offender administration, and
- policy development.

This office also oversees the department's information systems through its partnership with the Department of Finance and Administration's Strategic Technology Solutions.

Operational Support is responsible for overall support to facilities, community supervision offices, and the central office. This responsibility includes facilities planning and construction; facilities management and maintenance; mission support; and staff development and training. Under the leadership of the Assistant Commissioner, the Tennessee Correction Academy provides pre-service, in-service, and specialized training schools to department staff.

The Office of the Chief Financial Officer (CFO) manages and oversees the department's annual budget and helps department management with budget management, cost benefit analysis, forecasting needs, and securing new funding to support the department's short- and long-term goals. In addition, the CFO is responsible for the department's accounting, procurement, contract administration, payments to local jails to offset costs relating to state inmate housing and care, and food services.

The Office of the Assistant Commissioner of Prisons oversees the operations of the correctional facilities. The Assistant Commissioner is responsible for

- the Local Jails Resources Office,
- statewide correctional facility transportation,
- inmate classification, and
- inmate disciplinary issues and grievances.

Reporting directly to the Assistant Commissioner of Prisons are four Correctional Administrators, who oversee the day-to-day operations of facilities within their respective regions and supervise the facility wardens and four contract monitors at the CoreCivic facilities.

The Community Supervision unit oversees approximately 77,000 offenders within the felony probation and parole operations and community corrections programming. The Assistant Commissioner is responsible for providing an accountability and support structure to help offenders achieve success in the community.

The Office of Rehabilitative Services is a team of professional educators, licensed medical and behavioral health care providers, and administrators who enhance public safety by providing essential, evidence-based services that prepare justice-involved individuals to lead healthy, independent, and successful lives.

The Chief Interdiction Officer is responsible for identifying, intercepting, restricting, and prosecuting people, including department staff, who provide contraband to the department's correctional facilities.

The department's Executive Operations include the following groups:

- The *Office of Investigations and Compliance* is the department's investigative arm. It investigates a wide range of matters that affect inmate safety, such as homicides.
- The *Compliance Section* is responsible for performing internal fiscal audits; annual inspections of correctional facilities and probation and parole districts;⁶ program and fiscal reviews; and contract monitoring.
- The *Decision Support: Research and Planning Division* is responsible for the department's reporting functions, including preparing the department's Annual Report, Statistical Abstract, and all other publicly reported data.



Executive Operations also houses the Communications and Public Relations office; the Legislative Liaison; and Customer-Focused Government.

Other Background Information

American Correctional Association Accreditation

The American Correctional Association (ACA) is a national professional organization and accrediting body for the correctional industry. The ACA sets the standards and practices for

⁶ The department has 13 districts that serve probation and parole offenders statewide.

correctional facilities to “ensure staff and inmate safety and security, enhance staff morale, improve records maintenance and data management capabilities; assist in protecting the agency against litigation; and improve the function of the facility or agency at all levels.” ACA’s roles include developing and monitoring ACA standards and developing an accreditation process. As of August 14, 2019, all 14 of the department’s state-run and CoreCivic correctional facilities are ACA-accredited.

State’s Recidivism Rates

The department uses the federal Bureau of Justice’s definition of recidivism, which is defined as counting the criminal acts that result in an individual’s rearrest, reconviction, or return to a correctional facility⁷ with or without a new sentence for a period of three years. The department’s Decision Support: Research and Planning Division calculates annual recidivism rates for inmates housed in Tennessee correctional facilities and jails and posts the rates to openmaps.tn.gov.⁸ In May 2018, the department published the 2017 recidivism rates for inmates who were released from custody in 2014. See **Appendix K-3** on page 209 for the most recent recidivism data on OpenMaps.

Recidivism Calculation Formula

To calculate recidivism rates, the department extracts from its Tennessee Offender Management Information System (TOMIS) data that shows all inmates released from custody in a given year. The extract also lists

$$\text{RECIDIVISM RATE} = \frac{\text{INMATES WHO RETURN TO PRISON OR JAIL WITHIN THREE YEARS}}{\text{INMATES RELEASED IN A GIVEN BASE YEAR}}$$

- which of these inmates returned to custody for reasons such as violating probation or parole conditions or committing new charges with or without a new sentence; and
- whether the inmates returned to custody within one, two, or three years of their release date.

Because the county’s courts and jails might not enter inmate-related information timely, the department requests that Strategic Technology Solutions (STS)⁹ run new data extracts every quarter to capture any new information. Based on the data, the Research and Planning Division calculates the recidivism rate by applying the rate formula.

Revenues and Expenditures

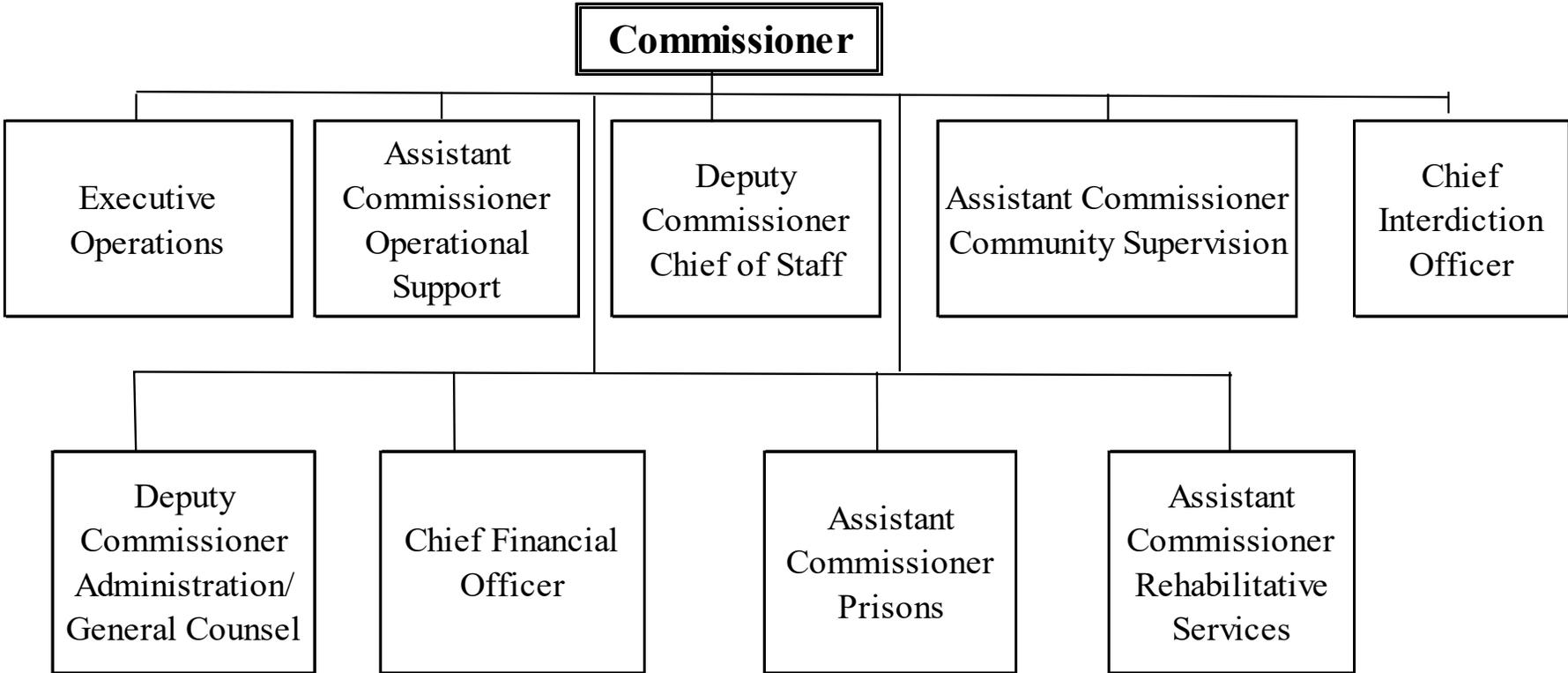
For information relating to the department’s financial information for fiscal years 2018 through 2019, see **Appendix K-2** on page 207.

⁷ Rearrests, even if charges are dropped, can be included in recidivism rates.

⁸ Created under former Governor Bill Haslam’s administration, OpenMaps is a web portal that contains interactive data visualizations that showcase key, in-demand metrics from all corners of Tennessee state government.

⁹ The Department of Correction has a partnership agreement with STS to provide information technology support and project management services to the department.

Department of Correction
Organizational Chart
February 2019



Source: Department of Correction management.

AUDIT SCOPE

We have audited the Department of Correction for the period October 1, 2017, through July 31, 2019. Our audit scope included a review of internal controls and compliance with laws, regulations, policies, procedures, and provisions of contracts. We conducted site visits at the following correctional facilities:

CoreCivic Facilities

Hardeman County Correctional Facility
Trousdale Turner Correctional Center
Whiteville Correctional Facility

State Facilities

Northeast Correctional Complex
Northwest Correctional Complex
Turney Center Industrial Complex

We examined the following areas during the site visits or at the department level:

- department leadership oversight;
- department's annual inspections of correctional facilities;
- public reporting of inmate deaths and other serious incidents;
- inmate sexual abuse and sexual harassment investigations;
- inmate medical and mental health services;
- correctional staffing and department turnover;
- inmate services and support;
- department's community supervision responsibilities;
- COMET implementation;
- public records management; and
- recidivism rates for the department's educational and vocational programs.

Department management is responsible for establishing and maintaining effective internal control and for complying with applicable laws, regulations, policies, procedures, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient appropriate audit evidence to support the conclusions in our report. Although our sample results provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections to the original populations. We present more detailed information about our methodologies in the individual sections of this report.

We conducted our audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

PRIOR AUDIT FINDINGS

REPORT OF ACTIONS TAKEN ON PRIOR AUDIT FINDINGS

Section 8-4-109(c), *Tennessee Code Annotated*, requires that each state department, agency, or institution report to the Comptroller of the Treasury the action taken to implement the recommendations in the prior audit report. The prior performance audit report was dated November 2017 and contained five findings. The department filed its report with the Comptroller of the Treasury on June 28, 2018. We conducted a follow-up of the prior audit findings as part of the current audit.

REPEATED AUDIT FINDINGS

The prior audit report contained findings stating that

- two CoreCivic-managed correctional facilities operated with fewer than approved correctional staff, did not have all staffing rosters, did not follow staffing pattern guidelines, and left critical posts unstaffed;
- CoreCivic staffing reports at Trousdale Turner Correctional Center and Hardeman County Correctional Facility contained numerous errors;
- Trousdale Turner Correctional Center management's noncompliance with contractual requirements and department policies relating to inmate services challenged the department's ability to effectively monitor the correctional facility;
- probation and parole officers did not always meet supervision requirements; and
- probation and parole supervisors did not always meet oversight requirements.

The current audit disclosed the following results of our follow-up work.

Repeated as a Partial Finding

- CoreCivic staffing reports still contain numerous errors.

Repeated Condition in a New Finding

- Although the department implemented tools to improve probation and parole supervisors' performance, the supervisors were still not consistently performing all their required duties; we also found that the department did not track whether District Directors and Correctional Administrators performed their required quarterly case file reviews.

Repeated as Observations

- Although department management took steps to address staffing matters at CoreCivic- and state-managed correctional facilities, all of Tennessee's facilities are operating with minimal staff.
- Although CoreCivic corrected the issues involving inmates' access to grievance forms and access to healthcare information at Trousdale Turner Correctional Center, we found these issues at state-managed facilities.
- Although department management initiated corrective action to address the problems with probation and parole officers' supervision of offenders, the parole officers did not meet supervision requirements in one area.

AUDIT CONCLUSIONS

DEPARTMENT LEADERSHIP OVERSIGHT

CHAPTER CONCLUSION

Finding 1 – The department’s leadership failed to provide adequate oversight activities of department and correctional facilities management in several areas relating to inmates, correctional staff, and the community, thereby affecting the department’s ability to meet its mission (page 11)

DEPARTMENT LEADERSHIP OVERSIGHT

Background

In order to meet its mission “to operate safe and secure prisons and provide effective community supervision in order to enhance public safety,” the Department of Correction is responsible for approximately 98,000 individuals who are either incarcerated in state correctional facilities or under a type of community supervision. For the department’s incarcerated population, the department is required to ensure that it provides each inmate under its care safe and secure accommodations and services, such as medical and mental health care, education, and job training, so that the inmates become successful within the correctional environment and in the community upon release.

Audit Results

Audit Objective: Did department leadership provide oversight and establish and implement controls to ensure the central office and the correctional facilities achieved the department’s mission through effective and efficient operations and compliance with federal and state law and department policies and procedures?

Conclusion: We found that department leadership did not enforce established controls or did not implement controls to ensure the department and correctional facilities operated effectively and efficiently and complied with laws and department policies and procedures. See **Finding 1**.

Finding 1 – The department’s leadership failed to provide adequate oversight activities of department and correctional facilities management in several areas relating to inmates, correctional staff, and the community, thereby affecting the department’s ability to meet its mission

As a result of our review, we determined that the Department of Correction’s leadership failed to provide adequate oversight by establishing, implementing, enforcing key controls governing the department’s and the correctional facilities processes. Providing clear oversight and enforcing or establishing needed controls is not only one of management’s primary responsibility, but it is key to successfully fulfilling the department’s mission to operate and maintain safe and secure prisons; provide effective community supervision; and adequately track and report facility performance and inmate statistics. We identified the following areas of concern.

Department’s Annual Inspections of Correctional Facilities

The department performs annual inspections of its correctional facilities to assess the facilities’ operations and compliance with American Correctional Association prison operation standards, department policies and procedures, and contractual agreements. The department’s calculation of a facility’s inspection compliance score does not place more weight on critical inspection findings over other findings. Without a more transparent process and without a

weighted score methodology, state decision makers cannot effectively assess the severity of issues at a given facility based solely on the compliance score. For more information, see **Finding 2**.

Public Reporting of Inmate Deaths and Other Serious Incidents

During our work related to the department's reporting of inmate deaths and serious incidents (including accidents, injuries, and lockdowns) that occurred in the state's correctional facilities during our audit period, we found multiple instances where correctional staff did not enter death and incident data in the Tennessee Offender Management Information System (TOMIS), the department's official record, as required by department policy. The department uses this data to report important inmate-related safety statistics to the members of the General Assembly, inmates' families, and the community. The deficiencies we noted, beginning with **Finding 3**, question the accuracy and completeness of the department's publicly reported information.

Inmate Sexual Abuse and Sexual Harassment Investigations

According to the department's policy relating to sexual abuse and sexual harassment, the department is to provide a "safe, humane, and appropriately secure environment, free from threat of sexual abuse and sexual harassment for all inmates." Although department management has provided inmates with ways to report allegations of sexual abuse and sexual harassment, it is imperative that correctional investigators in charge of investigating these serious allegations follow department policy relating to logging and documenting the investigative process, as well as properly concluding on the investigation based on the evidence collected. We present additional details in **Finding 9**.

Inmates' Medical and Mental Health Services

Pursuant to Section 41-1-408, *Tennessee Code Annotated*, the department is to provide medical and mental health services to inmates under its care, and it does so by contracting with Centurion of Tennessee, LLC for primary medical services and with Corizon Health for mental health services. For these two contractors, management implemented an informal "value-added credit system" outside the scope of the current vendor contracts; the department gives credits to the vendors for different circumstances and allows the vendors to use the credits to offset assessed liquidated damages resulting from noncompliance with contract requirements. See **Finding 10** and **Finding 11** for more information.

Correctional Staffing and Department Turnover

While CoreCivic and state correctional facilities ensured that staff covered critical posts, both the CoreCivic and state facilities are experiencing difficulties with hiring a sufficient number of correctional officers. In response to the staff shortage, the CoreCivic and state facilities have temporarily closed noncritical posts and required officers to work significant overtime to ensure staff covered critical posts, which places both staff and inmates at risk due to officer fatigue. Overall, we found that all correctional facilities were operating with minimal staff. For more information, see **Observations 6 and 7**.

Furthermore, despite management's stated corrective action in the November 2017 performance audit report, we still found that CoreCivic facilities' monthly staffing reports contained the same errors noted in the prior audit, which means that department management still cannot effectively track whether CoreCivic is meeting its required staffing levels. The details are in **Finding 14**.

Inmate Services and Support

While the department has a policy in place to perform random monthly inmate drug screenings at all correctional facilities, staff at four correctional facilities either did not enter inmate drug screening results in TOMIS or entered inaccurate results; did not perform the minimally required number of drug screens each month; or, for those inmates who tested positive for alcohol and drugs, the facility staff did not hold the inmates' disciplinary hearings timely. For more information, see **Observation 10**.

Department's Community Supervision Responsibilities

The Community Supervision unit ensures that parole and probation officers monitor both types of offenders to ensure that the offenders comply with the conditions of their release so that the public is protected. Parole and probation officers use TOMIS to document monitoring efforts to ensure compliance with supervision requirements. The officers' supervisors are also responsible for ensuring that the officers have appropriately monitored the offenders in compliance with policy. The department's probation and parole supervisors continue to have issues relating to their oversight responsibilities. See **Finding 17** for additional details.

COMET¹⁰ Implementation

The department currently uses a 25-year-old system as its official record of all matters concerning inmates and offenders in its care. Although the department signed a contract with Abilis Solutions, Inc. in February 2016 to develop a new offender management system called COMET, the project is approximately 18 months behind schedule. The department estimates that COMET may go live by December 2020. Additional information can be found in **Observation 13**.

U.S. Government Accountability Office (GAO)

GAO's *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards for federal entities and serves as best practices for nonfederal entities. The Green Book assigns governing bodies responsibilities for an organization's control environment, including making strategic decisions. In Principle 12, "Implement Control Activities," the Green Book states that "Management should implement internal control through policies." Per paragraphs 12.02 and 12.03,

¹⁰ COMET stands for Correctional Offender Management Electronic Tracking.

- Management documents in policies the internal control responsibilities of the organization.
- Management documents in policies for each unit its responsibility for an operational process's objectives and related risks, and control activity design, implementation, and operating effectiveness. Each unit, with guidance from management, determines the policies necessary to operate the process based on the objectives and related risks for the operational process. Each unit also documents policies in the appropriate level of detail to allow management to effectively monitor the control activity.

Furthermore, per paragraph 12.05,

Management periodically reviews policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks. If there is a significant change in an entity's process, management reviews this process in a timely manner after the change to determine that the control activities are designed and implemented appropriately. Changes may occur in personnel, operational processes, or information technology.

Finally, as presented in Principle 16 of the Green Book, "Perform Monitoring Activities," to ensure that internal controls are properly designed and operating effectively, "Management should establish and operate monitoring activities to monitor the internal control system and evaluate the results."

Management's Annual Risk Assessment Process

Pursuant to Section 9-18-102, *Tennessee Code Annotated*,

- (a) Each agency of state government and institution of higher education along with each county, municipal, and metropolitan government shall establish and maintain internal controls, which shall provide reasonable assurance that:
 - (1) Obligations and costs are in compliance with applicable law;
 - (2) Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation; and
 - (3) Revenues and expenditures are properly recorded and accounted for to permit the preparation of accurate and reliable financial and statistical reports and to maintain accountability over the assets.
- (b) To document compliance with the requirements set forth in subsection (a), each agency of state government and institution of higher education shall annually perform a management assessment of risk. The internal controls discussed in subsection (a) should be incorporated into this assessment. The objectives of the annual risk assessment are to provide reasonable assurance of the following:
 - (1) Accountability for meeting program objectives;

- (2) Promoting operational efficiency and effectiveness;
- (3) Improving reliability of financial statements;
- (4) Strengthening compliance with laws, regulations, rules, and contracts and grant agreements; and
- (5) Reducing the risk of financial or other asset losses due to fraud, waste and abuse.

Effect of Lack of Oversight

The department's leadership must provide strong oversight to guide department and correctional facility management in the administration of their duties and responsibilities. Without such oversight, the leadership may not promptly identify issues and address key concerns and cannot effectively manage the strategic direction of the department.

Recommendation

The Commissioner and top management should perform critical oversight responsibilities to ensure that all levels of department and correctional staff perform their responsibilities in accordance with federal and state law and department policies and procedures, and within a control environment as outlined by the Green Book. This may include revising current policies; training and re-training staff on the department's policies; and performing additional monitoring to ensure staff are following laws and policies.

Top management should also assess all risks in the department's documented risk assessment, including the risks noted in this report. In addition, top management should adequately document and approve the risk assessment and the mitigating controls. They should implement effective controls to ensure compliance with policies, procedures, and other instructions; assign employees to be responsible for ongoing monitoring of the risks and any mitigating controls; and take action if deficiencies occur.

Management's Comment

Concur in part.

The Tennessee Department of Correction (TDOC) has demonstrated an unwavering commitment to continual improvements in the process of administering prisons and supervising offenders in the community.

Well established and highly developed internal controls, policies, and processes are in place to protect the public and ensure the safe operations of prisons and the delivery of effective community supervision in Tennessee.

TDOC has a long history of emphasizing internal controls, and they are integrated into our operational processes on a daily basis as evidenced by their inclusion in *every* policy written and *every* process implemented.

TDOC is a nationally recognized correctional industry leader having been accredited for more than thirty years. The agency voluntarily operates under the American Correctional Association (ACA), a private, non-profit accrediting body for the corrections industry that was founded in 1870 and has a significant place in the history of prison reform in the United States.

TDOC was the first state system to receive the prestigious ACA Golden Eagle Award, which represents the highest commitment to excellence in correctional operations and dedication to enhancing public safety and the well-being of incarcerated individuals. The award is based upon achieving accreditation in every area of operation. Currently every facility, all of community supervision, the Tennessee Training Academy, and central office headquarters have all achieved and maintained ACA accreditation.

In addition to ACA accreditation, TDOC maintains Prison Rape Elimination Act (PREA) certification at all of our facilities. Each facility is reviewed and evaluated by an independent Department of Justice (DOJ) Certified PREA Auditor. The DOJ on-site audits occur at each facility and include review of operations, conducting interviews with staff and inmates, observing practices, examining policies, and evaluating compliance documentation to determine if the facility should be issued PREA certification.

As a result of the Department of Justice certified PREA auditing process, TDOC has been recognized by ACA as one of only six state correctional systems that have earned the Lucy Webb Hayes Award which signifies that TDOC has achieved both department-wide ACA accreditation and DOJ PREA certification.

While our policies, practices, and processes have been rigorously evaluated by an outside independent correctional accrediting organization and found to meet or exceed all nationally recognized standards of practice, it is nonetheless important to give thoughtful consideration and provide swift action in the areas identified by the Comptroller's Office performance report.

The Comptroller's Office auditors have provided, and we acknowledge, that opportunities exist to improve and further enhance performance in ways that are in keeping with the United States Government Accountability Office's Green Book published in 2016.

Historically, correctional administration is by its very nature *compliance to expectation* business. As such, TDOC already has an established control environment as defined by the five principals in the Green Book.



TDOC holds ethics as the critical foundation to correctional pursuits and demonstrates its commitment to ethics through our Honor the Oath Program. The Oath requires all employees to adhere to a code of conduct that includes following policies and exhibiting due diligence in the performance of duties or face disciplinary processes as well as prosecution should the infraction rise to that level.

Under the guidance of the Commissioner and executive leadership, oversight of internal controls is assigned to the Compliance Division. The Compliance Division is comprised primarily of individuals with more than ten years of service to the State of Tennessee, and each represent a significant depth of knowledge regarding our processes to include Community Supervision, Community Corrections, Fiscal, and PREA and Institutional Compliance.

The Compliance Division is tasked with a variety of functions that contribute to the internal controls of the department to include conducting annual inspections of all of our facilities, correctional academy, and community supervision. During these annual inspections, a thorough review of all facility and district operations is conducted in accordance with the hierarchical organized structure of responsibility and associated policies.

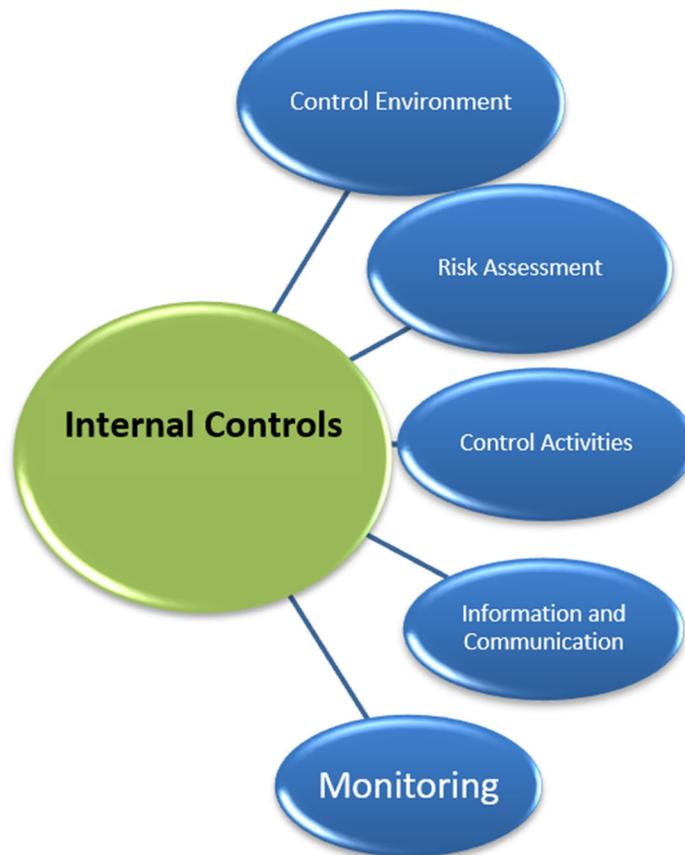
Internal audits of all of TDOC operations are also conducted annually to include all ten TDOC facilities, the Tennessee Correctional Academy, and the central office. This includes reviewing employment hiring, training, and retention. These annual inspections are heavily relied upon because they are a good report card in determining the current status of internal controls throughout the department.

The Contract Monitoring Division oversees the internal controls for the privately managed facilities with an on-site monitor at each facility. Additional oversight is provided quarterly in the contract areas of food service, health services, and behavioral health services by subject matter

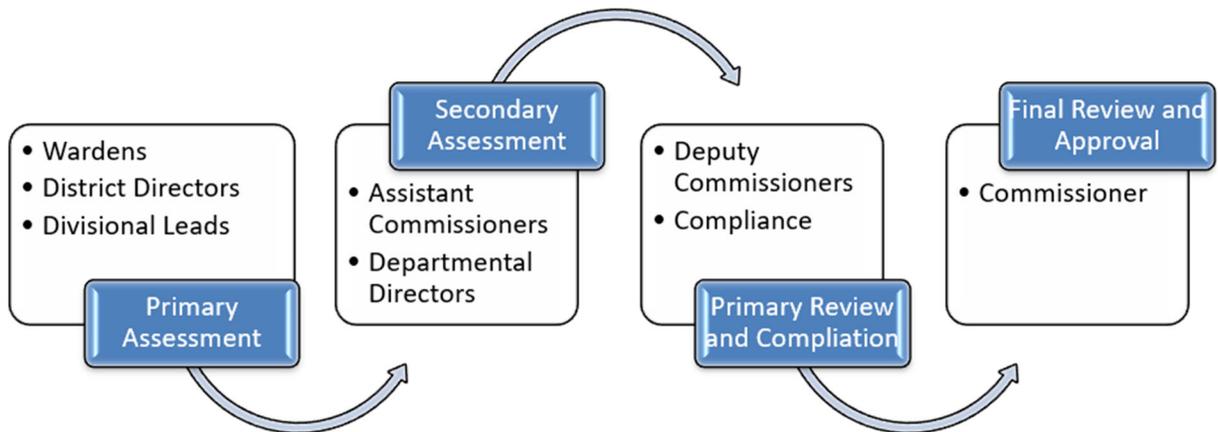
experts employed by TDOC's central office. Also, fiscal and program reviews are conducted of all Community Corrections contracts.

All compliance findings require a Plan of Corrective Action (POCA) from the area or division where the compliance issue was found. Follow-up reviews are conducted to determine the effectiveness of the POCA. All results are reported to Executive Staff through written reports as well as a presentation either during an executive briefing or during the Annual Commissioner's Tour.

Accountability for findings is primarily administered by facility or divisional staff where the noncompliance occurred, but the Commissioner and Executive Staff are engaged in the process. Although TDOC currently operates in a control environment as defined by the Green Book, there are four additional components of internal controls.



In order to accomplish the component of risk assessment, a comprehensive risk assessment is conducted annually of our operations in accordance with the Financial Integrity Act (T.C.A. 9-18-102). In 2018 TDOC's Enterprise Risk Management (ERM) process identified 248 departmental risks in 31 different service areas. The departmental process takes approximately five months to complete and requires all managers to evaluate their area of responsibility to determine areas of risk.



Each Warden, District Director, and Divisional Lead is tasked with reviewing their area to determine risks as well as a control to minimize each risk. The identification of 248 risks in 2018 required 248 controls to be implemented or maintained. Once identified, each division submits their assessment to the Executive Leadership to include Deputy and Assistant Commissioners for review.

A comprehensive submission is made by each division to the Director of Compliance and included in the report that details the risk and control implemented to include the potential impact as well as the likelihood of occurrence. The Compliance Division evaluates and compiles the submission for the Commissioner to review and approve.

Once approved, the required forms are submitted to F&A [the Department of Finance and Administration] and the Comptroller by December 31 of each year. The ERM process ensures that the department has accountability for meeting objectives; promotes operational efficiency and effectiveness; improves the reliability of financial statements; strengthens compliance with laws regulations, rules, contracts and grant agreements; as well as reduces the risk of financial or other asset loss due to fraud, waste and abuse.

The process helps to guide internal control activities in the department and helps to focus internal audit and compliance activities. Control activities are built into policies and procedures and evaluated for effectiveness at least annually. Evaluation of progress towards achievement of objectives is a continuous process and multiple layers exist in the review of information.

Information is communicated as accurately and as clearly as possible to internal and external stakeholders. When compliance issues are noted by the internal control process, monitoring of the deficiency is established, plans are made for how the issue will be resolved, and a subsequent evaluation of the effectiveness of the corrective action is performed. All deficiencies noted, including those identified in this report, are monitored by TDOC to ensure resolution.

In summary, TDOC has an extensive internal control process in place that includes the essential components identified by the United States Government Accountability Office's Green

Book. Nonetheless formal leadership training for TDOC management in Green Book implementation will be provided.

Going forward TDOC is committed to further strengthening existing internal controls and oversight processes by taking the decisive step of hiring a senior executive official who will be responsible for inspecting conformance to standards and contract administration and will report directly to the Commissioner.

DEPARTMENT'S ANNUAL INSPECTIONS OF CORRECTIONAL FACILITIES

CHAPTER CONCLUSION

Finding 2 – The department's overall annual compliance percentage scores do not provide a clear measure of correctional facility performance (page 24)

DEPARTMENT’S ANNUAL INSPECTIONS OF CORRECTIONAL FACILITIES

General Background

The American Correctional Association (ACA) publishes correctional operational standards designed to enhance correctional practices for the benefit of inmates, staff, administrators, and the public. The ACA serves as the primary accrediting association for correctional facilities in Tennessee and the nation. ACA requires accredited facilities to be inspected every three years by the ACA and to perform annual departmental self-reviews. This requirement includes both state-run and CoreCivic facilities in Tennessee. Teams of experienced Department of Correction employees, including central office employees and correctional facilities subject matter experts, evaluate compliance levels at each facility.¹¹ The department refers to these self-reviews of compliance as annual inspections.

Inspection Tools

The department’s Compliance Division develops the annual inspection tools, which incorporate ACA’s operational standards, department policies and procedures, and contractual agreements. The Compliance Division ensures that the inspection tool includes, but is not limited to, compliance categories for security; safety and physical plant; facility administration; inmate education and jobs; medical and behavioral health; and food services. The annual inspection tools identify each compliance item subject to inspection and classify each compliance item as either “critical” or “other.” Management updates the inspection tools annually.



The department has a separate inspection tool designed specifically for inspections at the CoreCivic-managed facilities. This inspection tool is tailored to the language in each facility’s contract. According to department management, they developed a different tool for CoreCivic inspections to avoid duplicating work that the department’s CoreCivic contract monitors perform monthly.¹²

During the annual inspections, the department’s team of inspectors use observations, discussions, and sampling to evaluate the appearance, physical condition, and overall operation of each correctional facility to determine whether the facility has achieved compliance with each of the compliance items evaluated. According to department policy, the inspectors determine that an inspection item on the inspection tool is compliant if the facility met the requirement at least 95% of the time during the inspection period.

Upon completing the inspection, inspectors finalize the report, which includes information on a facility’s totals for compliance and noncompliance. The department classifies findings as either “critical” or “other” in its annual inspection reports. The department defines a critical inspection finding as

¹¹ According to the department, CoreCivic personnel do occasionally participate as inspectors of department-managed facilities, but only under the supervision of department personnel, and they do not serve as subject matter experts.

¹² Contract monitors are department employees who are assigned to monitor contract compliance at the CoreCivic-managed facilities monthly.

mission critical to the safety and security of the operational unit, general public, and inmates/offenders.

Examples of critical findings that the department identified during the fiscal year 2019 annual inspection cycle include, but are not limited to, the following:

- security staff did not follow tier management¹³ protocols, which are designed to help staff supervise inmates or perform or document counts of inmates, in accordance with policy;
- staff did not properly inventory keys, tools, equipment, kitchen utensils, or sharp medical instruments;
- facility management did not ensure security gates, sprinkler systems, heating and cooling systems, and plumbing systems operated properly; and
- correctional staff did not perform mental health monitoring checks timely.

Examples of other findings that the department identified during the fiscal year 2019 annual inspection cycle include, but are not limited to, the following:

- staff did not check and record dishwasher temperatures;
- kitchen and laundry water heaters leaked;
- showers were not in good and clean operating order; and
- staff did not properly document medication administration records, filed items in the wrong sections of inmate medical files, and did not sign laboratory reports.

Upon receiving inspection findings, correctional facility administrators must develop corrective action plans for all areas of noncompliance; critical findings require expedited corrective action plans.¹⁴ Inspectors also perform a follow-up review for all critical inspection findings within 30 days of the annual inspection to determine if critical findings were resolved. The inspectors also perform follow-up inspections 90 days after the initial inspection to determine whether correctional facility administrators effectively implemented corrective actions for all other findings; however, the inspectors do not score the follow-up inspections.

Management internally circulate the results of the facilities' annual inspection reports, which includes the inspector's calculation of the facility's overall compliance percentage score. According to management, the department also provides the results to legislators upon request. Based on our review of past legislative hearings, we found that department leadership quotes overall compliance percentages during legislative hearings as indicators of correctional facility

¹³ Tier management is a supervision method that allows one half—or tier—of a medium or higher custody level group of inmates out of their cells into the pod or unit for leisure activities.

¹⁴ Department Policy 103.07, "Annual Inspection and Compliance Reviews for Facilities," requires the facilities to develop corrective actions plans for critical inspection findings within seven working days and to document the plan on the Critical Response Form.

performance. In September 2019, the department executed a new contract for the operation of the Hardeman County Correctional Facility, which included language describing that the facility’s overall compliance scores were a key performance indicator to measure safety and security of the correctional facility. The contract further provides that if the facility scores 98% or above, the department will apply a credit of \$113,481.77 toward any outstanding liquidated damages. In other words, the correctional facility has an incentive to achieve a high overall compliance score to gain monetary credit to apply against any future liquidated damages assessed for noncompliance or unmet performance measures.

For the following fiscal years, the inspectors used the applicable tool and reviewed a total number of compliance items during the annual inspections:

- fiscal year 2017 – 645 items reviewed for both department and CoreCivic facilities;
- fiscal year 2018 – 685¹⁵ items reviewed for department facilities and 578 for CoreCivic facilities; and
- fiscal year 2019 – 695¹⁶ items reviewed for department facilities and 595 for CoreCivic facilities.

Inspection Scoring

To determine the overall compliance percentage, the department uses the following formula:

$$\frac{\text{Compliant Items}}{\text{Compliant Items} + \text{Noncompliant Items}} = \text{Overall Compliance Percentage}$$

For example, inspectors reviewed **596** items at Northwest Correctional Complex in 2019 and found that the facility was compliant on **557** items and noncompliant on **39**. The inspector calculated the overall compliance score based on the above formula: **557** divided by **596** results in an overall score of **93.46%**. In the example, this calculated score alone does not reflect that of the **39** areas of noncompliance, **11** of the **39** noncompliant items were classified as critical findings. **Figure 1** summarizes the annual inspection results and details of the critical inspection findings for fiscal year 2019 at Northwest Correctional Complex.

Figure 1
Example of Northwest Inspection Results From 2019 Compliance Review¹⁷

Critical	Finding	Total Findings	Overall Compliance Percentage
11	28	39	93.46%

¹⁵ For fiscal year 2018, the department reviewed 613 items at Mark Luttrell Transition Center.

¹⁶ For fiscal year 2019, the department reviewed 680 items at Mark Luttrell Transition Center.

¹⁷ We obtained this exhibit from Northwest’s 2019 Compliance Review. The “critical” column represents critical findings; the “finding” column represents other findings.

Audit Results

Audit Objective: Do the department’s annual inspections provide clear and useful results (overall compliance percentage scores) for decision makers and management?

Conclusion: Based on our observation and review of the department’s annual inspection process and inspection results, the department’s inspections did identify noncompliance that required correctional facilities to submit corrective action plans and take action to resolve noncompliance; however, we found that the department’s calculation of an overall compliance score is potentially misleading. Specifically, we found that the methodology to calculate the score does not consider the severity of the noncompliance by differentiating between critical findings of noncompliance and other findings. See **Finding 2**.

Finding 2 – The department’s overall annual compliance percentage scores do not provide a clear measure of correctional facility performance

To achieve our objective, we observed the annual inspections performed at Whiteville Correctional Facility (Whiteville) and Northwest Correctional Complex (Northwest) to obtain an understanding of the inspection process, and we examined the Department of Correction’s inspection tools. We also reviewed the department’s annual inspection reports for all correctional facilities (state-run and CoreCivic-managed) from fiscal years 2017, 2018, and 2019, and analyzed the scoring process.

See the full methodology in Appendix A-1 on page 29.

Based on our observations of the annual inspection process at Whiteville and Northwest and on our review of the department’s annual inspection policies, inspection tools, and inspection reports, we found that the Compliance Division’s calculation of compliance percentages emphasizes the number of compliant items instead of the severity of critical findings. A compliance score in the 90s could be construed as an indicator of high performance, when in reality, the facility may have multiple findings that are mission critical to the safety and security of the operational unit, general public, and inmates. **Table 2** shows the overall compliance percentages for each correctional facility for fiscal years 2017, 2018, and 2019.

Table 2
Overall Compliance Percentages by State and CoreCivic Facility
Fiscal Years 2017 Through 2019

Correctional Facility	FY 2017	FY 2018	FY 2019
Bledsoe County Correctional Complex	99.70%	99.69%	99.08%
Lois M. DeBerry Special Needs Facility	97.51%	95.10%	94.09%
Mark Luttrell Transition Center	N/A*	96.20%	97.99%
Morgan County Correctional Complex	99.40%	98.48%	99.53%
Northeast Correctional Complex	99.50%	99.60%	99.32%
Northwest Correctional Complex	97.80%	95.98%	93.46%
Riverbend Maximum Security Institution	99.50%	97.12%	97.76%

Correctional Facility	FY 2017	FY 2018	FY 2019
Tennessee Prison for Women	95.00%	95.20%	96.50%
Turney Center Industrial Complex	96.00%	98.70%	95.95%
West Tennessee State Penitentiary	97.20%	98.08%	96.57%
Hardeman County Correctional Facility†	97.50%	95.07%	98.06%
South Central Correctional Facility†	97.00%	95.40%	92.10%
Trousdale Turner Correctional Center†	85.00%	96.90%	94.96%
Whiteville Correctional Facility†	95.80%	94.57%	94.28%

*Mark Luttrell Transition Center was not inspected in fiscal year 2017 because the facility had just opened.

†Operated by CoreCivic.

Source: Auditors compiled this table from the department's annual inspection reports.

Table 3 shows the actual number of findings by type for fiscal years 2017, 2018, and 2019; **Table 4** shows the number of findings by type and the compliance scores for all state and CoreCivic facilities for fiscal year 2019.

Table 3
Inspection Findings by Type and by Facility
Fiscal Years 2017 Through 2019

Correctional Facility	FY 2017		FY 2018		FY 2019	
	Critical Findings	Other Findings	Critical Findings	Other Findings	Critical Findings	Other Findings
Bledsoe County	0	2	0	2	1	5
Lois M. DeBerry	4	12	6	24	10	24
Mark Luttrell	N/A*	N/A*	6	14	2	9
Morgan County	0	3	1	8	1	2
Northeast	0	3	0	3	4	0
Northwest	0	14	5	20	11	28
Riverbend	0	4	3	14	6	8
Prison for Women	2	23	5	24	5	17
Turney Center	0	10	4	4	10	14
West Tennessee State	0	15	1	12	4	18
Hardeman County†	0	15	7	15	3	7
South Central†	0	20	2	23	15	28
Trousdale Turner†	4	62	1	14	7	19
Whiteville†	0	21	9	17	7	22

*Mark Luttrell Transition Center was not inspected in fiscal year 2017 because it had just opened.

†Operated by CoreCivic.

Source: Auditors compiled this table from the department's annual inspection reports.

Table 4
Fiscal Year 2019 Inspection Results – Findings and Scores Combined
State and CoreCivic Facilities

Correctional Facility	Total Findings	Other Findings	Critical Findings	Overall Score
State Facilities				
Morgan County	3	2	1	99.53%
Northeast	4	0	4	99.32%
Bledsoe County	6	5	1	99.08%
Mark Luttrell	11	9	2	97.99%
Riverbend	14	8	6	97.76%
West Tennessee State	22	18	4	96.57%
Prison for Women	22	17	5	96.50%
Turney Center	24	14	10	95.95%
Lois M. DeBerry	34	24	10	94.09%
Northwest	39	28	11	93.46%
CoreCivic				
Hardeman	10	7	3	98.06%
Trousdale Turner	26	19	7	94.96%
Whiteville	29	22	7	94.28%
South Central	43	28	15	92.10%

The U.S. Government Accountability Office’s *Standards for Internal Control in the Federal Government* (Green Book) sets internal control standards for federal entities and serves as best practices for nonfederal entities. The Green Book assigns governing bodies responsibilities for an organization’s control environment, including making strategic decisions. In Principle 13, “Use Quality Information,” the Green Book states that “Management should use quality information to achieve the entity’s objectives.” Per Paragraph 13.05,

Management processes the obtained data into quality information that supports the internal control system. This involves processing data into information and then evaluating the processed information so that it is quality information. Quality information meets the identified information requirements when relevant data from reliable sources are used. Quality information is appropriate, current, complete, accurate, accessible, and provided on a timely basis. Management considers these characteristics as well as the information processing objectives in evaluating processed information and makes revisions when necessary so that the information is quality information.

In Principle 15, “Communicate Externally,” the Green Book states that “Management should externally communicate the necessary quality information to achieve the entity’s objectives.” Per Paragraph 15.03,

Management communicates quality information externally through reporting lines so that external parties can help the entity achieve its objectives and address related risks. Management includes in these communications information relating to the entity's events and activities that impact the internal control system.

Based on our review of legislative hearings and discussions with management and inspection staff, we found that department leadership quotes overall compliance scores when testifying about correctional facilities' performance before key officials. We found, however, that the department's methodology to calculate the overall compliance score

- does not adequately capture the severity of noncompliance ("critical" versus "other" findings); and
- is skewed given the high number of items evaluated and deemed compliant, which is far greater than the number of critical items reviewed.

The department's new contract with CoreCivic for the Hardeman County Correctional Facility includes a performance measure tied to the facility's annual inspection score that allows CoreCivic to earn a value-added credit. Therefore, it is important that the department's calculation of the overall compliance percentages properly and clearly reflects the findings that are mission critical to the safety and security of the operational unit, general public, and inmates, thereby providing the public with an accurate picture of a correctional facility's performance.

Recommendation

The Commissioner should create a weighted scoring methodology for annual inspection findings that emphasizes critical findings over other findings. Alternatively, the Commissioner could drop the overall compliance percentages and focus on evaluating and reporting the nature of the findings, with an appropriate focus on critical findings that require immediate action.

Management's Comment

Concur.

The agency's extensive annual inspection process currently utilizes 27 inspection instruments to review 713 items. The 713 items contain a total of 196 items that are labeled critical for TDOC institutions. There are 637 items for CoreCivic institutions with 144 items that are labeled critical.

TDOC welcomes recommendations for additional ways to improve our internal assessment and control process, and the two alternatives suggested by this audit have been considered: a weighted scoring system and a separate score system.

In constructing a weighted scoring system, the scoring should allow as much credit for those items found compliant as would be deducted for the same items found to be noncompliant. Also the value placed on critical items should be more than the value placed on noncritical items.

Using a five-point value for critical items and a one-point value for noncritical items is an example of a weighted scoring system that places more emphasis on critical than noncritical items.

Using this weighted scoring system, each TDOC facility has the opportunity to earn a maximum of 1,497 points (196 critical items x 5 + 517 noncritical items) and each CoreCivic facility has the opportunity to earn 1213 points (144 critical items x 5 + 493 noncritical items). Not all items apply to every institution, so the institution’s possible points would be adjusted accordingly as this varies from institution to institution. Here are the scores applying this method for the current audit cycle.

Facility ¹⁸	Original Percentage	Weighted Percentage
NECX	94.53%	93.57%
DSNF	93.72%	94.93%
WTSP/WTRC	93.25%	94.98%
TCIX	95.55%	95.73%
TTCC	86.00%	87.28%

Alternatively, the unweighted scores were calculated for each category, critical and noncritical item, and the results are shown below.

Facility	Old Method Score	CRITICAL Finding Score	NONCRITICAL Finding Score
NECX	94.53%	92.70%	95.21%
DSNF	93.57%	96.13%	92.56%
WTSP/WTRC	93.25%	96.59%	92.02%
TCIX	95.55%	95.90%	95.43%
TTCC	86.00%	88.70%	85.21%

While only modest differences exist between the old method of scoring and either of the recommended scoring systems, both recommended scoring systems will be used going forward to ensure the highest degree of specificity and clarity in reporting critical and noncritical item scores.

¹⁸ The facility abbreviations stand for

- NECX – Northeast Correctional Complex;
- DSNF – Lois M. DeBerry Special Needs Facility;
- WTSP/WTRC – West Tennessee State Penitentiary/Women’s Therapeutic Residential Center;
- TCIX – Turney Center Industrial Complex; and
- TTCC – Trousdale Turner Correctional Center.

Appendix A

Department's Annual Inspections of Correctional Facilities

Appendix A-1

Methodologies to Achieve Objective

To achieve our objective, we interviewed the department's Director of Compliance, reviewed the department's policy regarding annual inspections, and observed the annual inspections performed at Whiteville Correctional Facility and Northwest Correctional Complex to obtain an understanding of the inspection process. We obtained and reviewed the department's inspection tools, we reviewed the American Correctional Association (ACA) standards, and we interviewed an ACA accreditation specialist to determine the ACA's expectations relating to the inspection process. We also reviewed the department's annual inspection reports from fiscal years 2017, 2018, and 2019 and analyzed the scoring process.

PUBLIC REPORTING OF INMATE DEATHS AND OTHER SERIOUS INCIDENTS

CHAPTER CONCLUSIONS

Finding 3 – The department’s ability to provide accurate and complete information relating to deaths and other serious incidents is problematic (page 40)

Finding 4 – The department did not accurately record inmates’ causes of death in the Tennessee Offender Management Information System, which impacted the accuracy of the death information in the Statistical Abstract (page 43)

Finding 5 – Department management did not ensure state and CoreCivic facility staff followed incident reporting policies, entered incident information accurately into TOMIS, and maintained supporting documentation for incidents as required (page 46)

Finding 6 – The department did not ensure that state and CoreCivic correctional facility and health services staff entered all serious accidents, injuries, and illnesses in TOMIS in accordance with department policy (page 50)

Observation 1 – Department policy does not formally define partial or total institutional lockdowns; therefore, correctional facility staff may not report them consistently in TOMIS (page 54)

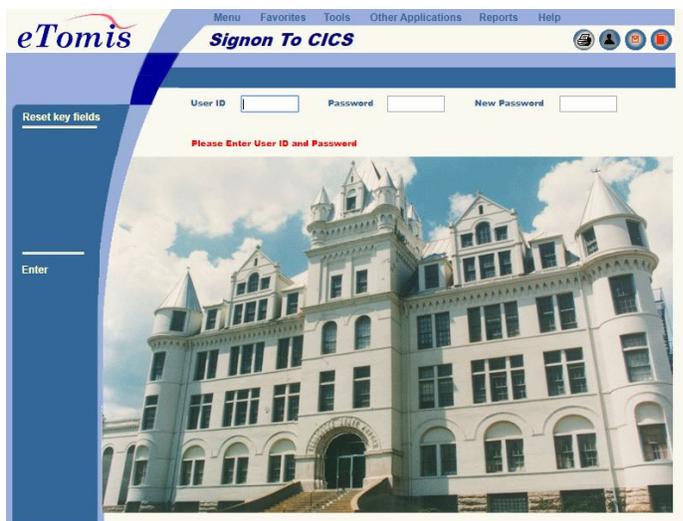
Finding 7 – The Department of Correction and the Department of Finance and Administration’s Strategic Technology Solutions did not implement effective internal controls in two areas, increasing the risk of errors or data loss (page 56)

Observation 2 – The Department of Correction and the Department of Finance and Administration’s Strategic Technology Solutions did not provide adequate internal controls in two areas; however, the areas noted do not pose a critical risk to the state (page 56)

Finding 8 – The department published inaccurate and incomplete inmate incident data in its fiscal year 2018 Statistical Abstract (page 57)

PUBLIC REPORTING OF INMATE DEATHS AND OTHER SERIOUS INCIDENTS

General Background



The Department of Correction uses the Tennessee Offender Management Information System (TOMIS) to track information on all aspects of an inmate's incarceration from initial intake through release. One important function of TOMIS is to track significant events, or incidents, that occur within correctional facilities and concern the safety and security of the facility, community, staff, and inmates. The department requires security staff at correctional facilities to enter all incidents into TOMIS and to perform two levels of review to ensure accuracy:

- first by the shift captain, and
- second by the warden or his/her designee.

If either party identifies any reporting errors, the warden/designee must put in a request to the department's central office information systems support group to modify or delete the incident.

Department management uses TOMIS to collect incident information to identify safety and security concerns at correctional facilities, evaluate current practices, identify needs for future training, and develop corrective action plans. Each October, the department's Decision Support: Research and Planning Division publishes a Statistical Abstract, which includes a summary of incidents correctional facility staff have entered into TOMIS during the previous fiscal year. The department also reports certain types of incidents, like inmate deaths, to the federal government annually. Because the public and key government decision makers use this information to draw conclusions about how correctional facilities are operating, it is vital that management ensure the incident data in the abstract is valid and reliable. We focused our audit work on the internal controls over data collection and reporting of serious incidents, including inmate deaths; accidents and injuries; and facility lockdowns.

General Incident Classification and Reporting

Pursuant to the department's Policy 103.02, "Incident Reporting," correctional incidents are significant events that occur within correctional facilities and are defined within one of three classes: A, B, or C. Types of incidents include, but are not limited to,

- inmates in possession of weapons;

- inmate assaults on staff or other inmates;
- correctional officers' use of force to restrain inmates, such as pepper spray, handcuffs and leg irons, medical restraints (arm and leg restraints to protect from self-harm), deadly weapons, and bean bag rounds;¹⁹
- deaths;
- discovery of contraband;
- injuries;
- lockdowns; and
- inmate defiance.

Department Policies Governing Incidents

When incidents occur in a correctional facility, correctional staff at both state and CoreCivic facilities are required to follow several department policies, including reporting to the department's Central Communication Center (CCC), which is a unit within the department's central office that is responsible for receiving and disseminating critical incident information. In addition, correctional staff may have to initiate disciplinary action against the inmate(s) involved and may have to use force in response to certain events. See **Appendix B-1** on page 60 for a list of the department's policies governing serious incidents.

CoreCivic facilities follow the department's policies, but CoreCivic staff also use two additional forms, the 5-1a Incident Report and the 5-1c Incident Statement, to record first-hand accounts of incidents and to summarize all events surrounding an incident. CoreCivic staff may also record first-hand accounts of incidents using departmental forms, such as the witness statements found in the Use of Force packets and the disciplinary forms that record disciplinary actions taken against an inmate as the result of an incident.

The department does not consider CoreCivic's 5-1a and 5-1c forms part of its official record. Staff at the state facilities do not use a standard form to record initial incidents, so the first-

¹⁹ Bean bag rounds are small fabric pillows filled with lead that an officer fires from a shotgun to briefly immobilize an inmate without causing long-term injury.

Types of Incident Classifications

- **Class A** incidents involve life-threatening matters and breaches of security that are likely to cause serious operational problems, imminent threat to the control and order of the correctional facility, and/or risk to the community. Examples include escapes and attempted escapes, deaths, assaults, hostage situations, total institutional lockdowns, rapes, certain uses of force, and various weapons.
- **Class B** incidents are less serious incidents involving injuries to staff and/or inmates that cause the disruption of the normal facility operation or that pose a possible risk to the health or general safety of the general public. Examples include bomb threats, drug confiscation, illnesses, partial institutional lockdowns, natural disasters, tobacco possession, and cell phone possession.
- **Class C** incidents are the least serious; they pose no threat to the local community or to the facility's safe and secure operation. Examples include defiance, positive drug screens, fighting, possession of intoxicants such as alcohol, sexual harassment and misconduct, and abuse of telephone privileges.

Source: Tennessee Department of Correction Policy 103.02.

hand accounts of incidents consist of documents from the Use of Force packets if the incident involved a use of force.

Inmate Death, Accident, and Injury Reporting by Facility Health Services Staff

Because accidents, injuries, illnesses, and deaths occur in correctional facilities, the department has established policies and procedures that instruct correctional facility health services staff on the process to provide and document immediate medical attention given to inmates, employees, and visitors who sustain injuries or suffer medical emergencies at the facilities, as well as procedures to follow when a death occurs at a correctional facility.

The department enacted Policy 113.53, “Accident/Injury Reporting,” to establish accident and injury reporting procedures and to facilitate the monitoring of accidents and injuries for quality improvement and risk management purposes.

This policy defines two kinds of injuries:

- **injuries of greater degree or severity** – a wound or other damage to the body that requires intervention beyond first aid (such as a deep laceration, fracture, or concussion), especially if the inmate or staff must be taken to an off-site health services provider; and
- **minor self-limiting injuries** – a wound or other damage to the body that will heal on its own or can be treated with first aid (such as a bruise, abrasion, bump, or laceration that does not require stitches).

Both departmental and CoreCivic health services staff are required to document all injuries with a greater degree of severity, occupational injuries, injuries associated with institutional violence, and deaths that occur within the facilities on a paper Accident/Incident/Traumatic Injury Report and then key the information into the department’s offender management system, Tennessee Offender Management Information System (TOMIS), under the Accidents screen.²⁰ Staff document minor self-limiting injuries on progress notes²¹ in the inmates medical file; these are not required to be documented in TOMIS.

The Accident/Incident/Traumatic Injury Reports allow facility health services staff to document important information, such as

- the location, date, and time of the accident, injury, or death;
- the type of injury or incident (work-related, sports, violence, use of force, or other);
- the weapon, property, equipment, or machinery involved;
- patient and witness statements of the event;

²⁰ TOMIS has multiple screens where users can input data. The screens that deal with health data, like the Accidents screen, are used by health services staff only.

²¹ Health services staff use progress notes to document their interactions with inmates, observations of medical conditions, and treatment provided. These forms go in the inmate’s health file and are not in TOMIS.

- the patient assessment and plan of treatment (also called SOAP)²² and/or the referral to an outside hospital;
- the date and time of treatment; and
- whether the inmate died.

In most cases, if health services staff make an entry in TOMIS on the Accidents screen for a serious injury, inmate hospitalization, work-related injury, injury associated with violence, or death, the facility's security staff should enter a corresponding entry on a separate TOMIS Incidents screen. The Accidents screen contains the medical assessments of the injury or a description of the circumstances of death, and the Incidents screen contains the narrative of the incident (such as an assault, fight, pending investigation, work-related injury, inmate hospitalization, or manner of death) that corresponds to the injury and lists the parties involved.

While the department includes the information for **injuries of greater degree or severity** in its annual Statistical Abstract, management extracts this information from the TOMIS Incidents screen, which correctional officers enter data for, rather than from the Accidents screens used by facility health services staff.

Additional Procedures for Inmate Deaths

In addition to the **injuries of greater degree or severity** reporting requirements (for both facility health services and security staff), in the event of an inmate's death, the correctional facility security staff enter the death as an incident in TOMIS and select a cause of death based on the death incident type. Furthermore, correctional facility health services and department central office staff are required to follow additional policies involving inmate deaths. See **Appendix B-1** on page 60 for detailed descriptions of each policy.

TOMIS Inmate Death Incident Type

- Accident
- Execution - electric chair
- Execution - lethal injection
- Homicide
- Natural
- Suicide

Source: Tennessee Department of Correction Policy 103.02.

The facility health administrator places the Accident/Incident/Traumatic Injury Report (if applicable), the Problem Oriented Progress Report,²³ the Mortality and Morbidity Summary Report, and the original inmate death certificate in the inmate's health record. For documented Accident/Incident/Traumatic Injury Reports, health services staff also record the inmate's death on the TOMIS Accidents screen to document the inmate's death. The health services staff should

²² SOAP is an acronym medical staff use to document a patient's medical assessments, and, according to department policy, this assessment is confidential. SOAP stands for

- Subjective – patient-reported complaints, history, and symptoms;
- Objective – exam and diagnostic tests;
- Assessment – diagnostic impression, rule-outs; and
- Plan – treatment plan, interventions, and follow-up.

²³ Problem Oriented Progress Reports are documents that medical personnel use to track an inmate's medical condition. They are a record of medical problems.

enter information contained in the Accident/Incident/Traumatic Injury Report that documents how the inmate was found; the treatment provided by the facility medical staff; and whether the inmate was transported to a local emergency room, hospital, or county medical examiner or coroner. The death certificate documents the medical examiner's official cause of death.

The department's Mortality and Morbidity Review Committee reviews all data related to an inmate's death and illness for quality assurance purposes. The committee also identifies risk factors related to inmate morbidity and mortality and recommends and implements strategies to reduce risk factors, such as disease management, and improve the health of the inmate. The committee members include the department's Chief Medical Director, the department's Associate Medical Director, Centurion and Corizon's²⁴ Chief Medical Officer/Medical Directors, and the facility's health services administrators. The Death in Custody Coordinator reports inmate death statistics to the U.S. Department of Justice's Bureau of Justice Statistics for publication.

The department's Chief Medical Officer stated that department policy requires designated health services staff at facilities (both CoreCivic and state-managed) to enter death information into the Online Sentinel Event Log (OSEL)²⁵ within six hours of the medical event. This web-based log is separate from TOMIS because it contains confidential health information.

When security staff enter inmate death information into TOMIS, the system limits the available death incident codes. Staff can only enter an inmate's death as Natural, Accident, Suicide, or Homicide (excluding the codes for an execution).²⁶ Because security staff must report incidents into TOMIS within eight hours of the event, staff initially enter the cause and time of death based on their initial observation. When the Death in Custody Coordinator sends the inmate's certified death certificate to the correctional facility, she sends it to health services staff for filing in the inmate's medical record. The department's Chief Medical Officer stated that if the official cause of death is different than what the security staff originally entered in TOMIS, the security staff should update the entry in TOMIS. In order for security staff to update the entry, health services staff have to communicate the inmate's official cause of death to security staff because only the facility's security staff can update the inmate's cause of death on the TOMIS Incidents screen.

For inmate deaths from October 1, 2017, to May 30, 2019, security staff at the correctional facilities classified 150 of the 171 total death incidents (88%) as Natural in TOMIS based on the results of the initial observation when the death was discovered. See **Table 5**.

²⁴ Centurion and Corizon are the department's medical and mental health vendors. CoreCivic provides its own medical and mental health care.

²⁵ According to the department's Policy 111.54, the department uses OSEL to report clinical decisions requiring mediation from the central office or significant events that impact daily operations of health and behavioral health care services within the facility. These entries would include things like medical emergencies; serious illnesses and injuries; infirmary and hospital admissions; suicide attempts; deaths; and missing medical records.

²⁶ The warden (or his/her designee) at the Riverbend Maximum Security Institution enters execution information into the TOMIS Incidents screen.

Table 5
Classification of Inmate Deaths in the TOMIS Incidents Screen
October 1, 2017, Through May 30, 2019

Classification of Inmate Death	Number of Deaths	Percentage
Natural Death	150	88%
Homicide	4	2%
Accident	1	1%
Suicide	12	7%
Execution – Lethal Injection	2	1%
Execution – Electric Chair	2	1%
Total Inmate Deaths	171	100%

Source: TOMIS.

Lockdown Incident Reporting

According to the Merriam-Webster dictionary, the word lockdown describes a situation where people are temporarily prevented from entering or leaving an area or building (such as a school) during a threat of danger. In a correctional setting, the term lockdown refers to the confinement of inmates to their cells for a temporary period for security purposes. Department staff described lockdowns as an appropriate security measure correctional officers use to control the movements of inmates in response to a variety of situations, such as a major fight or infection control.

The department’s Policy 103.02, “Incident Reporting,” outlines these procedures and identifies two types of lockdowns that must be reported in TOMIS and to the CCC:

- a partial institutional lockdown, and
- a total institutional lockdown.

The department also publicly reports the number of partial and total lockdowns annually within the incident summary table in its Statistical Abstract.

Facility Incident Reviews and TOMIS Modifications

At the facility level, the responding correctional officer completes a draft incident report when the incident occurs, and the shift commander subsequently reviews the report before staff enter the incident into TOMIS. Once entered into TOMIS, the warden/superintendent reviews each incident in TOMIS for clarity and accuracy to ensure the information reflects the actual events reported on the incident report.

According to the department’s Policy 103.02 and 502.01, when a correctional facility has to change or delete an incident already entered into TOMIS, the warden/superintendent/designee will submit an Incident/Disciplinary Modification or Deletion Request form to the Assistant Commissioner of Prisons or the Deputy Commissioner of Operations. When the facility emails

the change request to the central office, the department's Prison Operations Team reviews the request for propriety and changes the incident in TOMIS as requested.

According to department management, central office staff do not perform any TOMIS reviews of recorded incidents, beyond the reviews conducted at the facility level, to check for accuracy, consistency, and compliance.

Department's Annual Report and Statistical Abstract

Each October, as required by Section 4-4-114, *Tennessee Code Annotated*, the department publishes an Annual Report that describes the department's organization and budget; outlines major initiatives and achievements; and provides basic demographics of incarcerated and supervised offenders. The department's Decision Support: Research and Planning Division (Research and Planning) also publishes a companion report, called the Statistical Abstract, which provides a deep dive into the various statistics that the department tracks. The most recent abstract available during our audit period was for fiscal year 2018; it is organized into the following categories:

- **Department Statistics** – budget, personnel, vacancy, and turnover;
- **Prison Statistics** – inmate population capacity at each facility, felon characteristics, local jail population, admissions and releases, sentence length and time served, and prison incidents;
- **Community Supervision Statistics** – population characteristics, admissions and releases, and supervision standards; and
- **Offender Accountability, Programs and Services** – community service, jobs, rehabilitative services, educational programs, drug screens, inmate health services, and behavioral health services.

Research and Planning obtains most of the information reported in the abstract from TOMIS. Strategic Technology Solutions is responsible for extracting information from TOMIS, like correctional facilities' incident data, by automatically generating and sending a Monthly Comprehensive Incident Summary report to Research and Planning and key department management personnel, who use this information to monitor the type and frequency of incidents in the correctional facilities. Research and Planning then compiles all these monthly incident reports for a given fiscal year into one table for inclusion in the annual Statistical Abstract. We examined the correctional facilities' reporting of incidents, including inmate deaths, and how the department reports incident data in the annual Statistical Abstract.

Appendix B-5 on page 65 shows the prison incident summary table included in the department's fiscal year 2018 Statistical Abstract. The table summarizes incident data entered into TOMIS by facility operations personnel on felony arrests (of staff, inmates, and visitors); arson; assaults; deaths; disturbances; drugs; escapes; fires; injuries; illnesses; rapes; strikes; uses of force; weapons; lockdowns; and other miscellaneous incidents.

Audit Results

- 1. Audit Objective:** Did department management establish internal control processes to ensure the department's critical information and incident data is reliable and that management and staff met reporting requirements?

Conclusion: Based on our work related to inmate deaths; other serious incidents, including accidents and injuries; and lockdowns, we found that, although the department has policies governing data and reporting in TOMIS, the department and correctional facility management did not ensure staff followed all data entry policies and did not adequately review incident data to ensure the accuracy and completeness of the data.

As a result, department management cannot rely on TOMIS, the official system of record, to capture, track, and provide data to report critical department and correctional facility statistics for internal and external users. See **Finding 3**.

- 2. Audit Objective:** Did staff update the causes of inmate deaths in TOMIS once they learned the official cause of death based on the inmates' certified death certificates?

Conclusion: We found that, after reviewing death certificates relating to 38 inmate deaths, the department did not accurately classify 8 inmate deaths (21%) in TOMIS, which resulted in inaccurate reporting of death information. See **Finding 4**.

- 3. Audit Objective:** Did deceased inmates' paper health files contain the required documentation to support and document their deaths?

Conclusion: Based on our review of paper inmate health files relating to 38 inmate deaths, we found at least 14 inmate health files (37%) did not contain all required documents, such as Accident/Incident/Traumatic Injury Reports, Problem Oriented Progress Reports, Morbidity and Mortality Summaries, and certified death certificates. See **Finding 4**.

- 4. Audit Objective:** Did the correctional facilities staff appropriately document and enter Class A (the most serious) incidents into TOMIS?

Conclusion: Based on our audit testwork, state and CoreCivic correctional facilities staff did not appropriately maintain original documentation of Class A incidents, nor did they consistently enter the incidents into TOMIS. See **Finding 5**.

- 5. Audit Objective:** Did department management and staff ensure that, when required by departmental policy, health services staff entered required accidents, illnesses, and traumatic injuries on the Accidents screen and that security staff entered the precipitating incident on the Incidents screen in TOMIS?

Conclusion: Based on our review of serious accident/injury reporting practices, we found that at two CoreCivic facilities (Whiteville Correctional Facility and Trousdale Turner Correctional Center), the health services staff had not entered any serious accidents or injuries on the Accidents screen in TOMIS during our audit period. We found the lack of reporting questionable given the nature of the correctional environment.

We also found that state health services staff had not always entered serious injuries and illnesses into TOMIS in accordance with department policy at Hardeman County Correctional Facility, Northeast Correctional Complex, Northwest Correctional Complex, and Turney Center Industrial Complex.

We also compared the entries health services staff made on the Accidents screen to entries security staff made on the Incidents screen for the same event and found instances where security staff at both state and CoreCivic facilities failed to make the appropriate entry on the Incidents screen. This data is important because management uses the entries from the Incidents screen for security purposes and as the basis for publicly reporting the incident data in the department's annual Statistical Abstract. Management did not ensure that both health services and correctional staff entered accurate and complete information. See **Finding 6**.

6. Audit Objective: Did correctional staff consistently report partial and total lockdowns in TOMIS in accordance with department policy?

Conclusion: Based on our audit work, although department policy identifies the types of lockdowns, we found that management has not defined partial lockdowns in the department policy, resulting in inconsistent lockdown reporting by correctional staff. See **Observation 1**.

7. Audit Objective: Did the department and Strategic Technology Solutions (STS) follow state information systems security policies regarding information systems controls?

Conclusion: We determined that the department and STS did not provide adequate internal controls in two specific areas. See **Finding 7**. In addition, we found minor issues in two areas. See **Observation 2**.

8. Audit Objective: Did the department's Statistical Abstract provide accurate information regarding correctional facility incidents to the public and members of the General Assembly?

Conclusion: Based on our review of incident data that the department included in its fiscal year 2018 Statistical Abstract, we found that department management did not ensure the incident information reported to the public was accurate and transparent. See **Finding 8**.

Finding 3 – The department’s ability to provide accurate and complete information relating to deaths and other serious incidents is problematic

Based on our audit work related to deaths and other serious incidents, we found that Department of Correction and correctional facility management did not always ensure staff followed all policies related to entering and reviewing incident information in the Tennessee Offender Management Information System (TOMIS), the department’s official system of record. We noted several instances where information related to incidents was incorrect, incomplete, or not entered at all. As a result, information reported to the public, including families of inmates and decision makers, may be incorrect. In addition, department management needs accurate information on incidents to assess the safety and security conditions for staff and inmates.

Inmate Deaths

For eight inmate deaths that were classified as natural deaths in TOMIS, we found that five inmates actually died due to drug overdoses, two due to homicides, and one due to suicide. We also found that inmate health files did not contain all required department documentation that describe the events involving the death, including certified death certificates. See **Finding 4**.

Serious Incidents

We found that correctional facility staff did not appropriately maintain original documentation of Class A incidents, which are the most serious type of incidents that occur in correctional facilities, nor did they consistently enter the incidents into TOMIS in accordance with policy. See **Finding 5**.

Accident and Injury Reporting

Based on our review of serious accident/injury reporting practices, we found that at two CoreCivic facilities (Whiteville Correctional Facility and Trousdale Turner Correctional Center), the health services staff had not entered any serious accidents or injuries on the Accidents screen in TOMIS during our audit period—approximately one and a half years. Given the nature of the correctional environment and when compared to other correctional facilities, it is unlikely that a facility would have no serious incidents to report.

We found that health services staff had not entered serious injuries and illnesses into TOMIS in accordance with department policy at Hardeman County Correctional Facility, Northeast Correctional Complex, Northwest Correctional Complex, and Turney Center Industrial Complex.

We also found instances at both state and CoreCivic facilities where correctional staff did not make the appropriate accident/injury entries on the TOMIS Incidents screen. Department management extracts information correctional facility staff enter on the Incidents screen in TOMIS as the basis for the statistics and information in the department’s annual Statistical Abstract. See **Finding 6**.

Lockdown Reporting

Although department policy identifies the types of lockdowns, we found that management has not defined partial lockdowns in its department policy, resulting in inconsistent reporting of this security measure by correctional staff in the department's Statistical Abstract. See **Observation 1**.

Statistical Abstract

The department uses information from TOMIS as the basis for its annual Statistical Abstract, which is available to the public on the department's website. The Statistical Abstract contains information on incidents such as assaults, injuries, rapes, lockdowns, and deaths, all of which comes from data the correctional staff entered into TOMIS. We also found that the department

- included inactive incident codes that showed zero incidents occurring in its abstract for fiscal years 2017 and 2018;
- did not report the incident summary table by facility in fiscal year 2017, making comparisons between facilities impossible; and
- did not include a label in the incident summary tables to explain that the tables excluded some correctional facility incidents.

These deficiencies impact management's ability to adequately track and report critical information and incident data used to assess conditions in its correctional facilities. See **Finding 8**.

Information Systems

We determined that the department and Strategic Technology Solutions did not provide adequate internal controls in two specific areas. See **Finding 7**. In addition, we found minor issues in two areas. See **Observation 2**.

Overall Effect and Criteria

The department relies on the information entered into TOMIS to provide a snapshot of how its correctional facilities are operating. If that information is not entered correctly, department management cannot rely on TOMIS to report critical department and correctional facility statistics to internal and external users.

The U.S. Government Accountability Office's *Standards for Internal Control in the Federal Government* (Green Book) provides internal control standards for federal entities and serves as best practices for state and other nonfederal entities. In Principle 13, "Use Quality Information," the Green Book dictates that management of an entity "should use quality information to achieve that entity's objectives." According to the Green Book, to obtain and use

quality information, management must identify information requirements, obtain relevant data from reliable sources, and then process data into quality information.

Management first identifies the necessary information requirements for achieving objectives and addressing risks while also considering “the expectations of both internal and external users.” Management then “evaluates both internal and external sources of data for reliability,” assessing whether the sources “provide data that are reasonably free from error and bias and faithfully represent what they purport to represent.” Paragraph 13.05 of the Green Book adds

Quality information is appropriate, current, complete, accurate, accessible, and provided on a timely basis. Management considers these characteristics as well as the information processing objectives in evaluating processed information and makes revisions when necessary so that the information is quality information. Management uses the quality information to make informed decisions and evaluate the entity’s performance in achieving key objectives and addressing risks.

Recommendation

Department management should ensure that staff receive proper training on entering information into TOMIS and should stress the importance that the public and decision makers place on the data that comes from TOMIS. Management should also review its policies to ensure they align with current practices.

Management’s Comment

Concur in part.

All deaths in custody have been reported in accordance with statutory requirements.

It is true that some associated documents for a few of the deaths were received at a later time and had not yet been entered into TOMIS when the audit was performed.

Nonetheless, department management stands by the process of properly reporting and documenting the deaths in custody but remains committed to finding opportunities, such as the adoption of an electronic medical records system, to further improve the process.

As it relates to serious incidents, department management notes that the vast majority of incidents in the testwork were correctly entered and that the audit expectation for maintaining documentation, in the form of incident drafts, is not required by policy. However, we will implement policy changes to ensure the most accurate and transparent process is in place.

Finding 4 – The department did not accurately record inmates’ causes of death in the Tennessee Offender Management Information System, which impacted the accuracy of the death information in the Statistical Abstract

We obtained a list of 171 inmate deaths from October 1, 2017, through May 30, 2019, to determine the accuracy of inmate deaths recorded in the Tennessee Offender Management Information System (TOMIS). We compared this list to narrative information health services staff entered in the Online Sentinel Event Log (OSEL) to identify any natural deaths that could be misclassified. As a result of this comparison, we identified 38 inmate deaths with questionable causes and compared the causes of deaths in TOMIS to the inmates’ certified death certificates.

See the full methodology in Appendix B-10 on page 74.

Conflicts Between Cause of Death in TOMIS and the Death Certificate

Based on our testwork, we determined that the Department of Correction did not update TOMIS with the official cause of death for 8 of the 38 inmates tested (21%) who died in custody. See **Table 6**.

**Table 6
Results of Testwork – Inmate Cause of Death Comparison**

Inmate Location	Information by Source and Listed Cause of Death		
	TOMIS Incidents Screen	TOMIS Dead Offender Screen ²⁷	Department of Health’s Issued Death Certificate
Northwest	Natural	Natural	Accident <i>Overdose of fentanyl and synthetic opioid</i>
Northwest	Natural	Natural	Accident <i>Overdose of fentanyl and methamphetamine</i>
Lois M. DeBerry	Natural	Natural	Accident <i>Complications from falling off top bunkbed</i>
Turney Center	Natural	Drug Related	Accident <i>Overdose of fentanyl and methamphetamine</i>
Turney Center	Natural	Natural	Accident <i>Fentanyl overdose</i>
Morgan County	Natural	Natural	(Issued) ²⁸
Riverbend	Natural	Suicide	Suicide <i>Bled out after reopening previously self-inflicted wound</i>
Lois M. DeBerry	Natural	Natural	Homicide <i>Complications from serious assault</i>

²⁷ The Dead Offender screen is an administrative screen in TOMIS where correctional officers log the date, location, and type of death to remove inmates from the population count of the correctional facility.

²⁸ Although the department did not update this inmate’s cause of death in TOMIS, we cannot disclose the cause because the department is currently investigating the circumstances surrounding this inmate’s death.

The Chief Medical Officer stated that although the TOMIS Incidents screen records events that occur at the facility to ensure the facility's safety and security, the Incidents screen is not intended to capture/record the official cause of death for an inmate who dies in custody. While we understood the Chief Medical Officer's point, we found that the department's Research and Planning Division uses the TOMIS Incidents screen data to report inmate deaths by cause in the department's Statistical Abstract. The department's Death in Custody Coordinator ultimately receives the inmate death certificates and is better suited to provide accurate statistics related to inmates' causes of death.

To determine whether the department accurately reported inmate deaths to the U.S. Department of Justice's Bureau of Justice Statistics, we also compared the 38 inmate deaths we tested to the Bureau of Justice Statistics' reports and found that the Death in Custody Coordinator accurately reported the cause of death for these 38 inmates to the bureau.²⁹ We also found that the federal report contained more useful and accurate inmate death information than the department's required annual Statistical Abstract.

According to discussion with the Death in Custody Coordinator, we learned that she relies on various sources of information, including the official death certificate,³⁰ rather than death information in TOMIS for federal reporting purposes.

Missing Inmate Health File Documents

Based on our testwork, we also determined that the department did not maintain the required supporting documentation relating to inmate deaths in the inmates' paper health files. Specifically, we found that 14 of 38 deceased inmate health files (37%) did not contain the documents listed in **Appendix B-1** on page 60 as required by department policy. According to the Chief Medical Officer, the facility health administrator is responsible for placing the documents in the inmates' health files.

Additionally, according to department policy, staff should maintain an inmate's death certificate in the inmate's health file. From our initial file review, we found that management had not ensured that staff placed 21 of 38 (55%) death certificates in the health files. When we brought the missing documents to management's attention and asked them to follow up on the missing death certificates, the Death in Custody Coordinator provided the 21 death certificates.³¹ Given our testwork results, management lacked an adequate control process to ensure inmates' health records had all the required documentation. See **Table 7** for the list of documents missing from the initial file review that the department subsequently provided. See **Appendix B-6** on page 68 for testwork details.

²⁹ The Death in Custody Coordinator enters the information into the Bureau of Justice Statistics' online database after she receives the official inmate death certificate indicating the cause of death.

³⁰ Other sources include inmate death information provided by the Central Communication Center notifications, information entered in OSEL, death notices from the Lois M. DeBerry Special Needs Facility (which provides various medical and mental health services to inmates with complex medical issues), death notices from the Assistant Commissioner for Prisons, and death notices from Victim Services Coordinators.

³¹ For these 21 death certificates, the inmates passed away between November 8, 2017, and May 12, 2019.

Table 7
Results of Testwork – Missing Documentation From Deceased Inmates Health File Review

Required Death-Related Documentation	# of Files Missing From Initial File Review	# of Files Provided After Follow-up Request	# of Total Missing Documents*
Accident/Incident/Traumatic Injury Reports	12	2	10
Problem Oriented Progress Reports	4	4	-
Mortality and Morbidity Summaries	23	9	14
Death Certificates	21	21	-

*We have reported for each missing document type even though the error may represent the same inmate file that required multiple documents given the nature of the incident.

To determine whether management maintained accurate death information in TOMIS, we also performed testwork to review both TOMIS Accidents and Incidents screens. Based on our testwork, we found that the health services staff also did not enter 15 of 38 inmate deaths (39%) on the TOMIS Accidents screen as required by Policy 113.53, “Accident/Injury Reporting.” Based on discussions with the Chief Medical Officer, he could not explain why the death certificates were not in the inmate health records when management provided us the files or why health services staff did not enter the death information in the TOMIS Accidents screen. We also found that correctional staff did not update the TOMIS Incidents screens for 8 of 38 inmate deaths (21%) once the official death certificates became available.

The department prepares the Statistical Abstract based on the TOMIS Incidents screen. Therefore, it is imperative that management ensure that correctional staff timely and accurately update TOMIS for the inmate’s official cause of death when the death certificate becomes available (since the cause of death is not known when staff must initially report the incident into TOMIS).

Recommendation

The Commissioner should immediately review the department’s death reporting procedures to ensure all inmate deaths are fully and accurately documented in all sources. In addition, the Commissioner should work to improve death reporting communication among relevant parties, including health services and correctional facility staff, to ensure the department reports accurate death statistics.

Given the current efforts for COMET (the new offender management system) implementation, the Commissioner should ensure COMET is designed to provide staff with the appropriate codes to use when classifying inmate deaths for initial death reporting while awaiting final certified death certificates. The department should consider adding a pending death incident status to force facility staff to update the official cause of death once it is received.

Management’s Comment

Concur.

As noted by the auditors, this Department's Death in Custody Report, required by the U.S. Department of Justice, is 100% accurate.

As a result of information provided during this audit and our own continuous review, department management is creating procedures to ensure all inmate deaths are fully and accurately documented in all sources.

We are implementing a Pending Death Investigation code in TOMIS for staff to select until the official death certificate is received. Once received, the official manner of death will be updated in our offender management system. Likewise, additional cause of death information will be placed in a narrative screen associated with the death incident. This will allow the department to maintain the manner of death and cause of death on the same narrative screen. (A matter for clarification, TOMIS incident reporting related to deaths in custody identifies the manner of death not the cause of death as also mentioned in this audit.)

We are also examining current policy requirements concerning inmate and health records associated with those inmates who die in custody. Previously, these files were maintained at each facility. We are examining the feasibility of creating a centralized records storage repository for all inmate files that are considered "Death in Custody." This will allow a copy of the death certificate to be sent to a central location for inclusion in the inmate health record. At the same time the copy of the death certificate is sent for inclusion in the health record, a copy will be forwarded to Operations to be used to update the TOMIS incident. The department will update policy to reflect newly established/revised procedures.

Finding 5 – Department management did not ensure state and CoreCivic facility staff followed incident reporting policies, entered incident information accurately into TOMIS, and maintained supporting documentation for incidents as required

From a total population of 2,271 serious (Class A) incidents recorded in the Tennessee Offender Management Information System (TOMIS) from October 1, 2017, through May 30, 2019, at the 6 facilities we visited, we tested a total random sample of 156 serious incidents to determine whether correctional staff entered the incidents into TOMIS in accordance with Department of Correction policy.

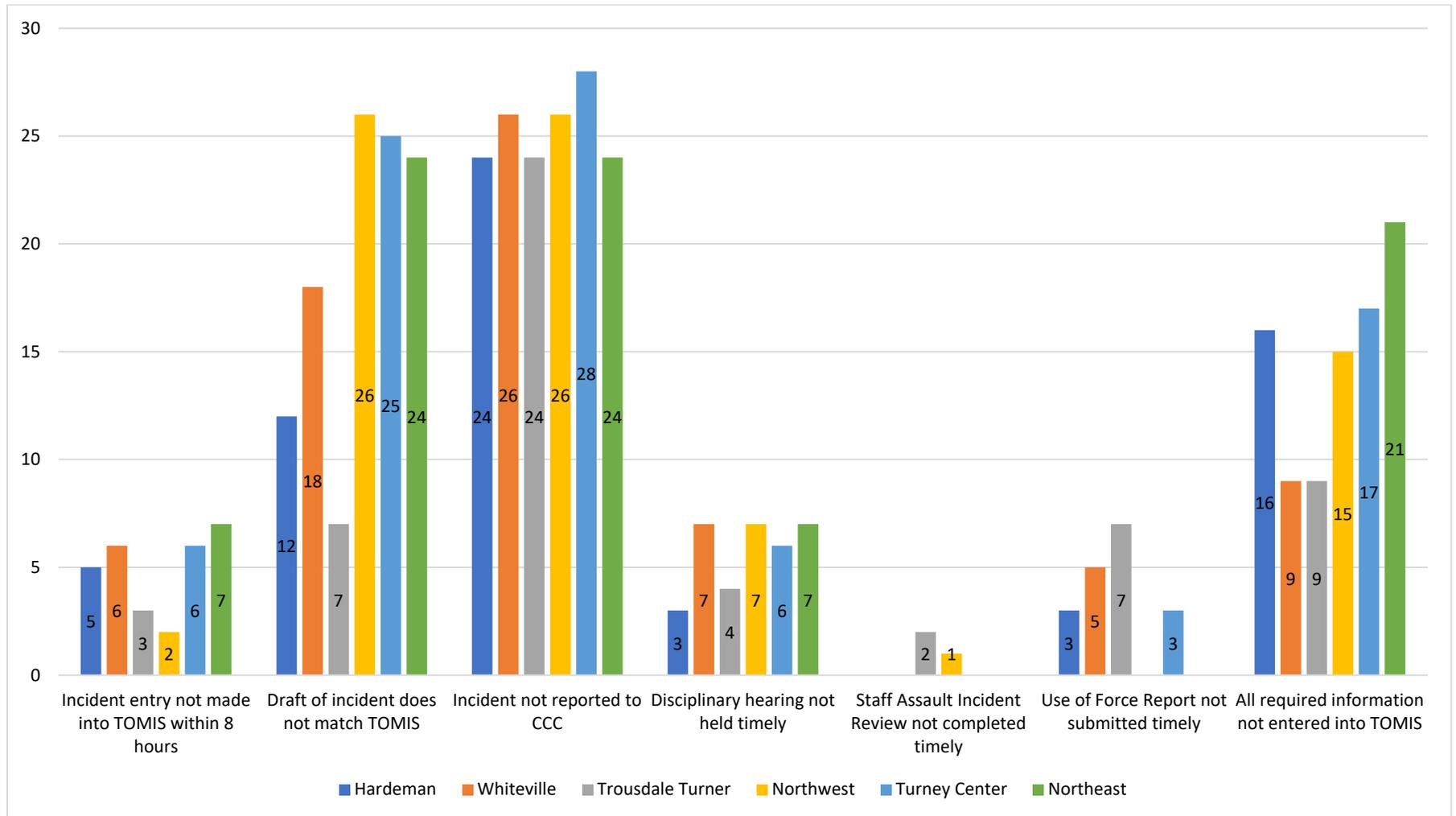
For the full methodology, including the breakdown of the population and sample sizes for each correctional facility we visited, see Appendix B-10 on page 74.

Based on our review, we found that staff at the correctional facilities did not enter incidents into TOMIS as required by department policy. In addition, we found that the department did not maintain the original documentation to support incident entries into TOMIS. By policy, CoreCivic is required to use department-approved forms and record complete incident information into TOMIS; however, CoreCivic correctional staff did not always do so. We performed testwork during site visits at six correctional facilities (three state-managed and three CoreCivic-operated facilities), where we found numerous instances of noncompliance, including the following:

- correctional staff involved in use of force incidents did not always submit the required documents to the warden in accordance with policy;
- wardens did not submit required documents pertaining to assaults on facility staff to the Assistant Commissioner of Prisons and the Director of the Office of Investigations and Compliance in accordance with policy;
- correctional staff did not ensure that supporting documentation (such as 5-1a and 5-1c forms and witness statements) for incidents matched the incident information entered into TOMIS;
- the department does not require correctional facility staff to preserve supporting documentation of incident information (such as draft incident reports) entered into TOMIS—in some cases, even though management did not require facilities to keep the draft incident reports, management did provide these reports to us for our review if they still had them;
- correctional staff did not enter all required information related to incidents into TOMIS;
- correctional staff could not locate supporting documentation that we requested for our audit;
- correctional staff did not hold disciplinary hearings within the required timeframe;
- correctional staff did not use the incident report form or used the form incorrectly, while staff at other facilities were not aware that the form existed; and
- correctional staff did not always report incidents to the Central Communication Center within the required timeframe.

See **Chart 1** for a summary of our testwork results. The details of noncompliance for incident reporting is located on **Appendix B-7** on page 68.

Chart 1
Number of Errors by Type of Noncompliance and by Correctional Facility
For the Period October 1, 2017, to April 12, 2019



Source: Summary of audit testwork results.

We noted that the majority of incidents in our testwork were the result of homemade weapons. According to department staff, due to the high number of homemade weapons they find, it is not always feasible to report the incident to the Central Communication Center within 30 minutes as required by policy.

Based on discussions with department staff, they believe correctional facility staff were not adequately trained to enter incidents into TOMIS. In addition, they stated that some department policies related to incidents may require updates to better reflect actual practice.

Correctional facility staff use TOMIS, the department's system of record, to collect and report incident-related information to management, state decision makers, and the public. Management uses TOMIS to maintain records of incidents to support any disciplinary action against inmates. Failure to accurately and consistently include incident information in TOMIS as required by policy can result in underreporting information to the public, management, and other stakeholders. In addition, without transparent and accurate reporting, management increases the risk that correctional staff may not have taken appropriate actions to respond to incidents, including proper disciplinary action. Furthermore, by not maintaining original documentation to support the entries in TOMIS, the department has no means of determining whether staff accurately described the events and individuals involved.

Recommendation

Department management should ensure that correctional facility staff are properly trained and understand the importance of following all policies and procedures for completing department-required incident forms, preserving original incident documentation, and accurately entering incidents in TOMIS. If management determines the current policy does not reflect actual practice, management should review department policies and consider appropriate changes.

Management's Comment

Concur.

Department management agrees that TOMIS incident entries could be improved.

Several factors have contributed to the shortcomings outlined in the finding. Staffing, training, and TOMIS access, to name a few, have an integral role in the timely, complete, and accurate entry of incidents, as well as fulfilling requirements related to supporting documentation.

The agency has been vigorously recruiting and working to retain our valuable workforce. We experience multiple benefits from maintaining institutional knowledge in our workforce, not only by having staff who are capable of producing relevant and accurate work products, but also by passing on that knowledge.

Similarly, effective training and delivery is paramount in ensuring our staff has the requisite ability to properly perform in the area of incident entry, thereby reducing the need to delete or modify erroneous incident entries.

Lastly, appropriate access is vital in protecting the integrity of incident entries in TOMIS. By limiting access to properly trained personnel, we can reduce errors and greatly increase the accuracy and completeness of the incident information.

Although there currently is no policy requirement to maintain a copy of “draft” incident information, we will implement policy changes to ensure the most accurate and transparent process is in place. The modifications made will be based on best practices and accepted industry standards. Reviews will also be made of the incident and timeline requirements for reporting to the Central Communication Center. It is important for incident information to be delivered to the appropriate leadership in a timely and accurate manner. It is also recognized that rushing the process could result in the delivery of incomplete or inaccurate information.

Finding 6 – The department did not ensure that state and CoreCivic correctional facility and health services staff entered all serious accidents, injuries, and illnesses in TOMIS in accordance with department policy

For the full methodology, including the breakdown of the population and sample sizes for each correctional facility we visited, see Appendix B-10 on page 74.

From a total population of 1,514 accident/injury entries that health services staff entered into the TOMIS Accidents screen from October 1, 2017, through April 12, 2019, we examined a total nonstatistical, random sample of 100 entries at 4³² of the 6 facilities we visited and compared the information in TOMIS to the original

documentation to determine if the TOMIS entries complied with Department of Correction policy.

No Accident/Incident/Traumatic Injury Entries at Trousdale Turner and Whiteville

From our review of accidents, illnesses, and traumatic injuries in TOMIS, we found that health services staff at two CoreCivic facilities, Whiteville Correctional Facility and Trousdale Turner Correctional Center, did not enter any serious accidents, injuries, or illnesses in the TOMIS Accidents screen for the period October 1, 2017, to April 12, 2019. As a result, we were unable to perform our testwork to meet our audit objectives at these facilities.



Because we believed that, given the correctional environment, both facilities would have experienced qualifying accidents, illnesses, and traumatic injuries, we discussed this issue with the health services staff at Trousdale Turner and Whiteville. We found that health services staff completed the paper Accident/Incident/Traumatic Injury Reports but did not key the reports into TOMIS as required

³² The four facilities are Hardeman County Correctional Facility, Northeast Correctional Complex, Northwest Correctional Complex, and Turney Center Industrial Complex.

by policy. Management and staff at both facilities stated they were unaware of the requirement to enter accidents, illnesses, and traumatic injuries into TOMIS. According to the Assistant Wardens of Treatment at both facilities, key health services positions experienced turnover and new staff were not properly trained in departmental policy or TOMIS reporting. We also informed department management of our concerns, and the department promptly provided training to Trousdale and Whiteville’s health services staff and told us that they would work backwards to enter the Accident/Incident/Traumatic Injury Reports completed from October 1, 2017, to April 12, 2019, into TOMIS.

Testwork Results From Four Correctional Facilities

For facilities we could test, we randomly selected a nonstatistical sample of 25 accidents or injuries from each facility based on a list of all serious accidents, illnesses, and injuries entered in TOMIS under the Accidents screen from October 1, 2017, to April 12, 2019. Our sample included accidents, illnesses, and traumatic injuries from Hardeman County Correctional Facility, a CoreCivic facility, and three state-managed facilities (Northeast Correctional Complex, Northwest Correctional Complex, and Turney Center Industrial Complex) to meet our audit objective of determining whether health services staff properly entered accidents, illnesses, and traumatic injuries into TOMIS in accordance with departmental policies.

Confidential Health Information Entered on the Accidents Screen

The department’s policy on accident/injury reporting requires that “Health Services staff shall ensure that entries onto TOMIS [Accidents screen] do not contain confidential health information (e.g., SOAP documentation,³³ vital signs, diseases, illnesses, or health intervention).” Based on our testwork at Hardeman, Northeast, Northwest, and Turney Center, we found that health services staff at all four facilities entered confidential health information in TOMIS. According to department management, they believe this noncompliance is the result of lost institutional knowledge resulting from turnover and from a lack of training. See **Table 8** for a summary of our results.

Table 8
Results of Testwork – TOMIS Entries Contained Inappropriate Confidential Health Information From October 1, 2017, to April 12, 2019

Correctional Facility	Number of Errors/Total Sample = (Error Percentage)
Northeast Correctional Complex	16/25 (64%)
Northwest Correctional Complex	19/25 (76%)
Turney Center Industrial Complex	16/25 (64%)
Hardeman County Correctional Complex*	22/25 (88%)

*Operated by CoreCivic.

³³ See footnote 23 on page 34.

Other Data Entry Errors

During our review, we also found that health services staff made data entry errors at two correctional facilities (see **Table 9**). These entry errors included the following:

- the date, time, or location of the accident or injury listed on the Accident/Incident/Traumatic Injury Report did not match the information entered in TOMIS;
- health services staff made duplicate entries for the same event; and/or
- the Accidents screen entry was blank, meaning staff created an entry but failed to enter the details of the injury.

Department management stated these mistakes were due to human data entry errors.

Table 9
Data Entry Errors
October 1, 2017, to April 12, 2019

Correctional Facility	Number of Errors/Total Sample = Error Percentage
Northeast Correctional Complex	7/25 (28%)
Hardeman County Correctional Facility*	17/25 (68%)

*Operated by CoreCivic.

Additionally, based on our request for data, we found that health services staff at Turney Center could not locate three of the original Accident/Incident/Traumatic Injury Reports in the inmates' medical files. The facility was able to produce duplicates of two forms but could not locate the originals or any duplicate of one form. According to the department's Policy 113.53, "Accident/Injury Reporting," staff are required to place original forms in the inmates' medical files.

Results of Other Audit Work

During our primary testwork to determine whether health services staff entered accidents, illnesses, and traumatic injuries into the TOMIS Accidents screen, we also noticed that not all accidents or injuries involving inmates had a corresponding incident entry on the TOMIS Incidents screen. We found that facility health services staff may not have entered minor bumps, scrapes, bruises, or handcuff checks³⁴ into the Accidents screen because the injuries did not rise to the level of an injury of greater degree of severity. In other situations, facility security staff did not enter incidents on the Incidents screen when they should have. See **Table 10** for instances where facility security staff did not enter required incidents in TOMIS.

³⁴ When an inmate is placed in handcuffs for an extended period of time in response to an incident, medical staff routinely check to make sure the cuffs are not so tight that they are cutting off circulation. We found that health services staff at Northwest use the Accident/Incident/Traumatic Injury Report form and Accidents screen to document such cuff checks even though they are not required to do so by policy.

Table 10
Types of Accidents, Illnesses, and Injuries Entries With No Corresponding Incident Entry in TOMIS

Incident Type	Northeast	Northwest	Turney Center	Hardeman*	Total
Use of Force (Chemical, Physical, or Security Restraints)	1	0	0	1	2
Assault and/or Fight†	2	4	0	1	7
Serious Hospitalization	2	2	2	0	6
Accidental Injury/Illness	4	2	2	0	8
Work-related Injury	4	0	4	3	11
Self-inflicted Injury	0	1	0	0	1
Total	13	9	8	5	35

*Operated by CoreCivic.

†For these items, there was not an incident for an assault/fight or a pending investigation entry for instances where it was unclear whether an assault/fight occurred.

Reporting Expectations Not Communicated or Not Followed

We asked the department’s Assistant Commissioner of Prisons to discuss his incident reporting expectations related to accidents, injuries, and illnesses, which we exhibit in **Appendix B-8** on page 72. Based on our discussion, the correctional facilities are not meeting the Assistant Commissioner’s expectations for reporting workplace injuries, serious hospitalizations, self-inflicted injuries, and pending investigations when institutional violence may have been involved. Additionally, management at the correctional facility level agreed that there were some isolated use of force incidents that, although they should have been, were not reported.

When security staff do not enter all required incidents related to accidents, illness, and traumatic injuries into TOMIS in accordance with policy, it lessens the department’s ability to use the information to identify safety and security concerns at correctional facilities. Additionally, if the facilities are underreporting incidents, it could undermine the accuracy and usefulness of incident data provided to the public and members of the General Assembly.

Recommendation

The department should ensure that health services staff and security staff at correctional facilities are adequately trained on accident, injury, and incident reporting policies and that staff consistently and accurately enter such information into TOMIS so that the department can make informed decisions for corrective action and quality improvement of the state’s correctional system.

Management’s Comment

Concur.

The Accident Injury Reports were completed. However, not all of these reports were entered into TOMIS.

In order to protect the integrity of the information entered into TOMIS, limited staff access is granted to staff in key positions at CoreCivic facilities. A further review of the number of staff granted access will be conducted to determine if sufficient staff has access and if additional access should be granted to reduce delays in entering this information. If it is determined that more access is needed, training will be conducted with the staff to detail the steps to be completed to ensure correct and timely entry of information.

We acknowledge there were also issues at the state-run facilities. That being noted, we are reinforcing a top-down approach to training and accountability for TOMIS incident entries. New employees in the basic correctional officer training program, the basic probation and parole training program, and the basic correctional professional training program are required to complete a week-long course on the intricacies of TOMIS. Additional training is provided, as needed.

The department is also working to include TOMIS refresher courses in its in-service training to be delivered either electronically through the Learning Management System (LMS) or through delivery at regional sites by institutional and community supervision instructors. This training will allow the department opportunities to strengthen the completeness, accuracy, and accountability that is not only required by policy but expected by our stakeholders.

A final contributing factor for the absence of the noted TOMIS entries for the Accident Injury Report is the lack of an established protocol between the medical staff and operational staff who both play critical roles in this process. A procedure will be formalized to outline the responsibilities associated with each entity in the process and to ensure that collaborative enforcement of accountability for TOMIS entries exists.

Observation 1 – Department policy does not formally define partial or total institutional lockdowns; therefore, correctional facility staff may not report them consistently in TOMIS

Lockdowns Defined

According to correctional security staff, in the correctional environment, the term lockdown is often used to describe when officers lock inmates in their cells to restrict inmate movement in response to an incident, such as a fight or a severe weather threat, or when security staff must perform a search for contraband. Officers lock inmates inside their cells to achieve routine tasks, such as during inmate count times³⁵ or at night, but they do not consider these actions lockdowns. According to correctional facility security staff, the staff formally log lockdowns that involve multiple inmates or multiple buildings on the

According to correctional security staff, only lockdowns that involve multiple inmates and/or multiple buildings on the prison compound are reported as an incident in TOMIS.

³⁵ The department's Policy 506.11 requires correctional officers to physically count the number of present inmates multiple times a day. Inmates must be locked in their cells in order to maintain an accurate count.

facility compound into the Tennessee Offender Management Information System (TOMIS) and report these lockdowns to the Department of Correction’s Central Communication Center. In TOMIS, lockdowns are classified into two categories:



- partial institutional lockdown, or
- total institutional lockdown.

From October 1, 2017, through April 12, 2019, the correctional facilities reported 78 combined total and partial lockdowns. See **Appendix B-9** on page 73 for the total number of reported lockdowns during this period at each correctional facility. Because the department’s policy regarding incident reporting does not distinguish between partial and total institutional lockdowns, we asked the security staff at the 6 correctional facilities we visited how they defined and reported lockdowns in TOMIS. Each facility consistently defined “total institutional lockdown” as all inmates on the compound locked in their cells for an extended period in response to a security threat, such as an inmate escape, riot, gang activity, severe weather, institution-wide search, or any other major incident. However, each facility defined partial institutional lockdowns differently. See **Table 11** for a summary of responses.

Table 11
Security Staff Responses on Reporting Partial Lockdowns

Correctional Facility	Partial Lockdowns Defined by Correctional Security Staff
Hardeman County Correctional Facility*	At least one entire housing pod. ³⁶
Northeast Correctional Complex	At least one entire housing unit.
Northwest Correctional Complex	Two or more housing units.
Trousdale Turner Correctional Center*	It depends on the lockdown’s length of time and the scope of the situation.
Turney Center Industrial Complex	One but up to three housing units.
Whiteville Correctional Facility*	At least one entire housing unit.

*Operated by CoreCivic.

Given the inconsistencies for defining partial lockdowns, correctional facility staff have not reported partial lockdowns the same, which impacts management’s ability to adequately monitor the use of or the number of lockdown incidents reported in TOMIS to ensure the partial lockdown meets the intended purpose of restricting the inmates’ movement. Without consistent partial lockdown expectations, management cannot ensure lockdown procedures are not abused.

Overall, the department should consider revising its policies to clearly define the types of scenarios that merit the use of a partial institutional lockdown so that reporting is more consistent, and the public understands what it means.

³⁶ In a correctional setting, a housing pod can be described as one wing in a larger housing building or unit.

Finding 7 – The Department of Correction and the Department of Finance and Administration’s Strategic Technology Solutions did not implement effective internal controls in two areas, increasing the risk of errors or data loss

The Department of Correction and the Department of Finance and Administration’s Strategic Technology Solutions (STS) did not effectively design and monitor internal controls in two areas. For these areas, we found internal control deficiencies related to one of the Department of Correction’s systems where both the department and STS did not adhere to state policies.

Ineffective implementation and operation of internal controls increases the likelihood of errors, data loss, and unauthorized access to department information. Pursuant to Standard 7.39 of the U.S. Government Accountability Office’s *Government Auditing Standards*, we omitted details from this finding because they are confidential under the provisions of Section 10-7-504(i), *Tennessee Code Annotated*. We provided the department and STS management with detailed information regarding the specific conditions we identified, as well as the related criteria, causes, and our specific recommendations for improvement.

Recommendation

The department and STS should coordinate to ensure that these control deficiencies are corrected by the prompt development, implementation, and monitoring of effective internal controls.

Management’s Comment – Department of Correction

Concur.

We will work with STS to implement improved internal controls.

Management’s Comment – Department of Finance and Administration’s Strategic Technology Solutions

We concur. STS will coordinate with TDOC [the Department of Correction] to ensure the identified weaknesses are promptly remediated with effective internal controls.

Observation 2 – The Department of Correction and the Department of Finance and Administration’s Strategic Technology Solutions did not provide adequate internal controls in two areas; however, the areas noted do not pose a critical risk to the state

The Department of Correction and the Department of Finance and Administration’s Strategic Technology Solutions (STS) did not design and monitor effective internal controls in two areas. For these areas, we found internal control deficiencies where both parties did not adhere to state policies and industry best practices. The risk associated with these conditions was reduced because both the department and STS implemented effective mitigating controls.

Pursuant to Standard 7.39 of the U.S. Government Accountability Office’s *Government Auditing Standards*, we omitted details from this observation because they are confidential under the provisions of Section 10-7-504(i), *Tennessee Code Annotated*.

Finding 8 – The department published inaccurate and incomplete inmate incident data in its fiscal year 2018 Statistical Abstract

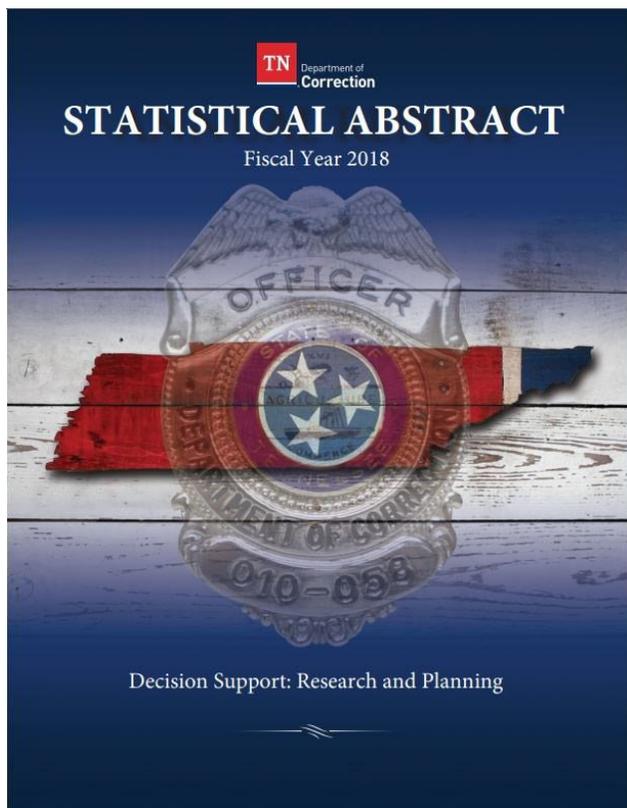
As a result of our testwork on deaths, serious incidents, and lockdowns, we interviewed Department of Correction management and reviewed the fiscal year 2018 Statistical Abstract to determine how the department compiles Tennessee Offender Management Information System (TOMIS) data for deaths, serious incidents, and lockdowns for the Statistical Abstract.

See the full methodology in Appendix B-10 on page 74.

Incident Summary Tables in the Statistical Abstract Is Inaccurate or Incomplete

In its Statistical Abstract each year, the department publishes a table called “TDOC Incident Summary by Incident Type and Facility” that shows how many of a given incident occurred at each correctional facility (both CoreCivic and state-managed) during the prior fiscal year. This table includes the type of incident (death, drugs, escape, injury, etc.); the incident code

(a three-letter abbreviation); a brief description of the incident; and the total number of incidents by facility. See the fiscal year 2018 incident summary table in **Appendix B-5** on page 65.



In its fiscal year 2018 Statistical Abstract, the department included 10 inactive incident types in the incident summary tables. If a reader examined the inactive incident types on the Statistical Abstract, they would see zero incidents reported at each correctional facility; however, the reader may interpret the zeros to mean zero occurrences rather than no recording of information. See **Appendix B-5** on page 65 for the 10 inactive incident types (highlighted in yellow) on the Statistical Abstract.

In addition, readers do not know that the department does not report all incident types on the Statistical Abstract. The department’s Policy 103.02, “Incident Reporting,” defines 166 incident types that facilities operations staff are required to routinely enter into TOMIS. The department, however, only reports 104 of them on the Statistical Abstract. Nonreported incident types include the following:

- Misdemeanor Arrest of Staff,
- Violation of State Law,
- Possession/Use/Introduction/Sale of Tobacco Products by an Employee,
- Solicitation of Staff,
- Weapon Discharge – Non-training,
- Defiance,
- Positive Drug Screen,
- Refused Drug Screen,
- Failure to Report as Scheduled,
- Offender Injury Accident,
- Possession/Selling/Use of Intoxicants,
- Institutional Shakedowns,
- Out of Place,
- Refused Cell Assignment,
- Sexual Harassment,
- Tampering With a Security Device or Equipment, and
- Use of Force – Security Restraints.

Furthermore, department management informed us that correctional facility operations personnel use the Rape incident category only when a rape allegation is substantiated by DNA testing and has been referred for outside prosecution. The department does not disclose this fact in the report.

Based on our review of past legislative hearings, we found that members of the General Assembly use the information in the Statistical Abstract to draw conclusions about prison operations and conditions. As a result, it is important that the department be transparent about information included in the tables.

During our audit, the department experienced turnover at the Director and Assistant Director level within the Decision Support: Research and Planning Division. The new Director stated that the turnover contributed to some of the issues. The Director also explained that Strategic Technology Solutions (STS) did not adequately communicate to the Research and Planning Division when incident categories were deactivated so that the division could exclude them from the abstract. The Director agreed that the incident summary table could be better labeled to clarify that it only includes certain, not all, correctional facility incidents.

In the *Standards for Internal Control in the Federal Government* (Green Book), Principle 13, “Use Quality Information,” stresses the importance of producing and using quality information. According to paragraphs 13.02 and 13.03,

13.02 Management designs a process that uses the entity’s objectives and related risks to identify the information requirements needed to achieve the objectives and address the risks. Information requirements consider the expectations of both internal and external users. Management defines the identified information requirements at the relevant level and requisite specificity for appropriate personnel.

13.03 Management identifies information requirements in an iterative and ongoing process that occurs throughout an effective internal control system. As change in the entity and its objectives and risks occurs, management changes information requirements as needed to meet these modified objectives and address these modified risks.

In Principle 15, “Communicate Externally,” the Green Book dictates that “Management should externally communicate the necessary quality information to achieve the entity’s objectives.” Paragraph 15.03 of the Green Book adds the following:

Management communicates quality information externally through reporting lines so that external parties can help the entity achieve its objectives and address related risks. Management includes in these communications information relating to the entity’s events and activities that impact the internal control system.

Department management stated that correctional facility staff responsible for reporting incidents were not appropriately trained. If staff do not report incidents consistently, it could undermine the accuracy of incident data provided to the General Assembly and members of the public in the department’s annual Statistical Abstract.

Recommendation

Department management should ensure that staff follow policy regarding incident reporting to ensure that the information entered into TOMIS is complete and accurate. Management of the department’s Decision Support: Research and Planning Division should ensure that all data from TOMIS that is included in the Statistical Abstract is accurate, up-to-date, and adequately labeled so that readers, including members of the General Assembly, can understand the reported information and make appropriate decisions.

Management’s Comment

Concur.

Department management understands the importance of accurate data entry and subsequent statistical distribution. Incident data entered into TOMIS is used by both internal and external stakeholders. As noted in comments related to other findings, we are engaged in a review of current policies and processes, associated with TOMIS incident entry, designed to ensure that we provide complete and accurate information to all interested parties.

Appendix B

Public Reporting of Inmate Deaths and Other Serious Incidents

Appendix B-1

Department Policies Governing Serious Incidents, Accidents, Injuries, and Deaths

Serious Incidents

- Policy 103.02, “Incident Reporting,” states that, at the time an incident occurs, the reporting staff member shall complete a draft incident report, which shall be reviewed for accuracy, modified if necessary, approved by the shift commander or appropriate department head, and then entered into TOMIS. The policy also requires the use of an incident report form for incidents involving serious injury or death of an inmate. The policy further requires the following for both CoreCivic and state-managed facilities:
 - all incidents resulting in death are to be reported to the Office of Investigations and Compliance Director immediately;
 - a Staff Assault Incident Review should occur within 24 hours with a completed written report within 72 hours of incidents involving assaults on staff;
 - approved incident reports should be entered into TOMIS within 8 hours of the incident’s occurrence/discovery and should contain the date and time of the incident; the location of the incident; the correct name and TOMIS ID number of each offender involved; the correct name and rank, if applicable, of each staff member involved; the correct name and affiliation of other persons involved; and the list of all disciplinary infractions to be issued in connection with the incident;
 - incident reports involving the death, serious injury, or escape of an inmate are to include the inmate’s name and any aliases; TOMIS ID; date of birth; race; date of admission to the department; county where convicted; offenses; sentence; release eligibility date and safety valve;³⁷ custody level; National Crime Information Center (NCIC) number;³⁸ and any other pertinent information excluding confidential medical or mental health information; and
 - incident reports concerning discovery of a weapon are to include specific information as to materials used to manufacture homemade weapons, where each weapon was found, and the circumstances of the discovery.
- Policy 103.15, “Central Communication Center,” states that the correctional facility’s shift commander or designee must report by telephone certain incidents, including Class A and Class B incidents, to the Central Communication Center within 30 minutes.

³⁷ The safety valve is the earliest possible release date for an inmate if there is an executive order regarding prison overcrowding. Not all inmates qualify for safety valve release, including those convicted of violent offenses.

³⁸ The NCIC is a national crime database maintained by the Federal Bureau of Investigation. All inmates are assigned an NCIC number.

- Policy 502.01, “Uniform Disciplinary Procedures,” states that no inmate charged with a disciplinary offense should be required to wait more than seven calendar days for his or her disciplinary hearing, unless the hearing is continued.
- Policy 506.08, “The Use of Force,” states that any use of force incident involving hard empty hand control³⁹ and above shall be reported to the department’s Office of Investigations and Compliance within 24 hours of the incident, and the Use of Force report must be submitted to the warden within 8 hours or by the end of the shift. When a use of force event occurs, correctional staff must complete various required documents including witness statements, the supervisor’s review report and checklist, and any other supplemental reports to document the event. Management refers to these documents collectively as the Use of Force packet.

Inmate Deaths

Policy 113.05, “Deaths and Autopsies,” indicates the following:

- The health care provider who performed the initial physical assessment of the deceased inmate at the facility completes the Accident/Incident/Traumatic Injury Report⁴⁰ and documents the physical observation and assessment of the deceased on the Problem Oriented Progress Report.
- The department’s Death in Custody Coordinator (the coordinator) obtains a certified copy of the death certificate from the Department of Health’s Office of Vital Records⁴¹ and forwards the original document to the facility where the inmate was housed.
- No later than seven days after an inmate’s death, the correctional facility’s health administrator completes the Health Services Mortality and Morbidity Summary. The facility’s medical director and the health services administrator sign the summary and place it in the inmate’s health record.
- Upon notification of a death in custody, the coordinator notifies the department’s Chief Medical Officer and other physician reviewers⁴² as designated. The attending physician at the facility that housed the inmate presents the death in custody case at the next scheduled Mortality and Morbidity Review Committee meeting.

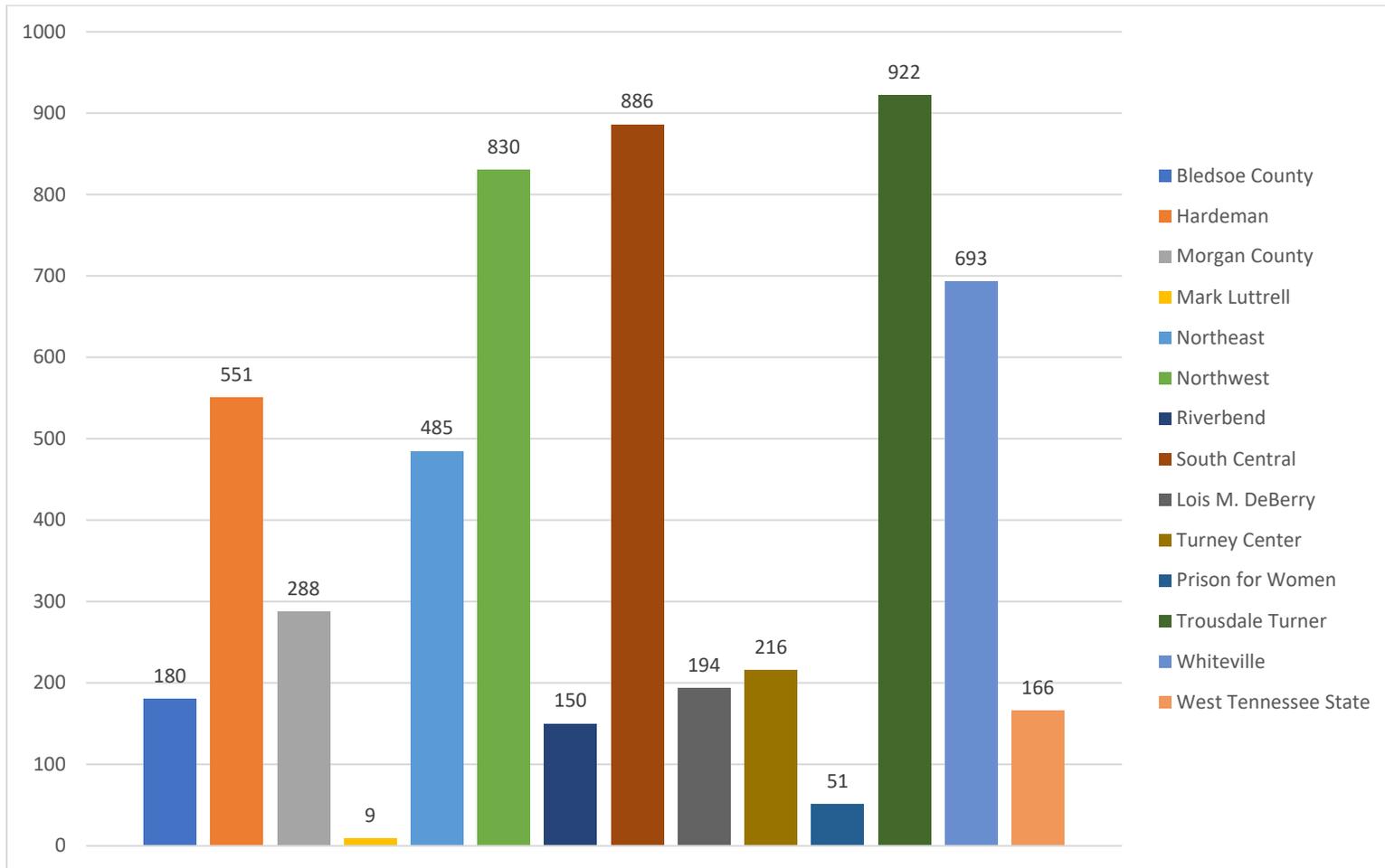
³⁹ Policy 506.08, “The Use of Force,” describes hard empty hand control as a manual control technique characterized by the use of an empty hand with such force that there is a potential for causing injuries, such as scratches; bruises; soft tissue injury; or, to a greater extent, bone fractures. This would include the arm bar, wrist lock, joint manipulation, strike, and pressure point pain compliance techniques.

⁴⁰ According to the department’s Chief Medical Officer, if the inmate died at a hospital, health services staff are not required to complete the Accident/Incident/Traumatic Injury Report.

⁴¹ The Death in Custody Coordinator works at the department’s central office and maintains a list of inmates who died in custody. The coordinator submits the list to the Department of Health on Fridays. Once the coordinator receives the death certificates from the Department of Health, she updates the list. It may take several weeks or months for the Department of Health to issue death certificates.

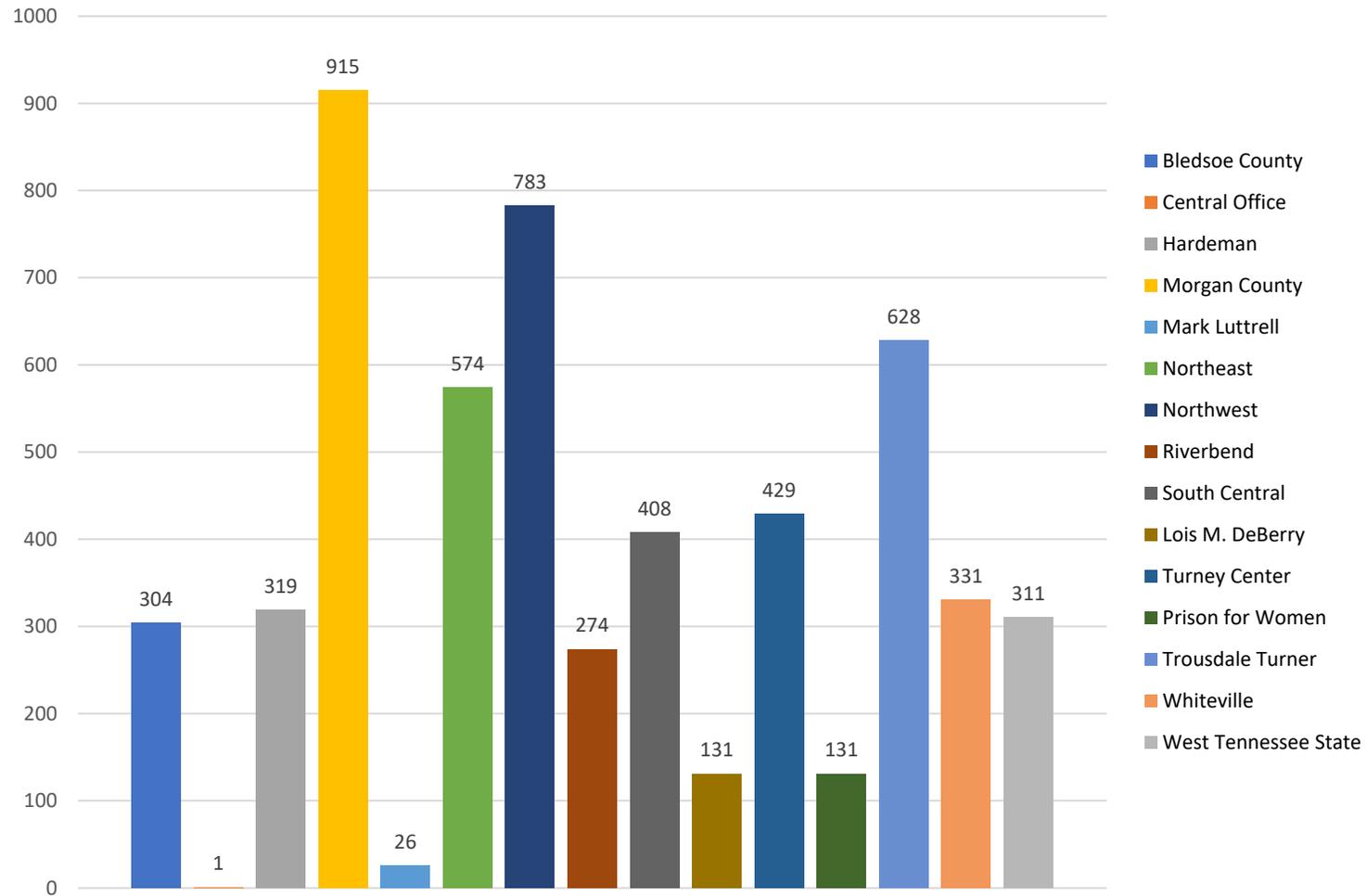
⁴² According to the Chief Medical Officer, the physician reviewers are physicians who participate in the discussion of inmate deaths by asking and answering pertinent questions surrounding an inmate’s death. The discussion includes clinical factors that may have contributed to the inmate’s death.

Appendix B-2
Summary of Class A Incidents (Those Involving Serious Risk to the Facility or Community) Reported by Location
October 1, 2017, Through April 12, 2019



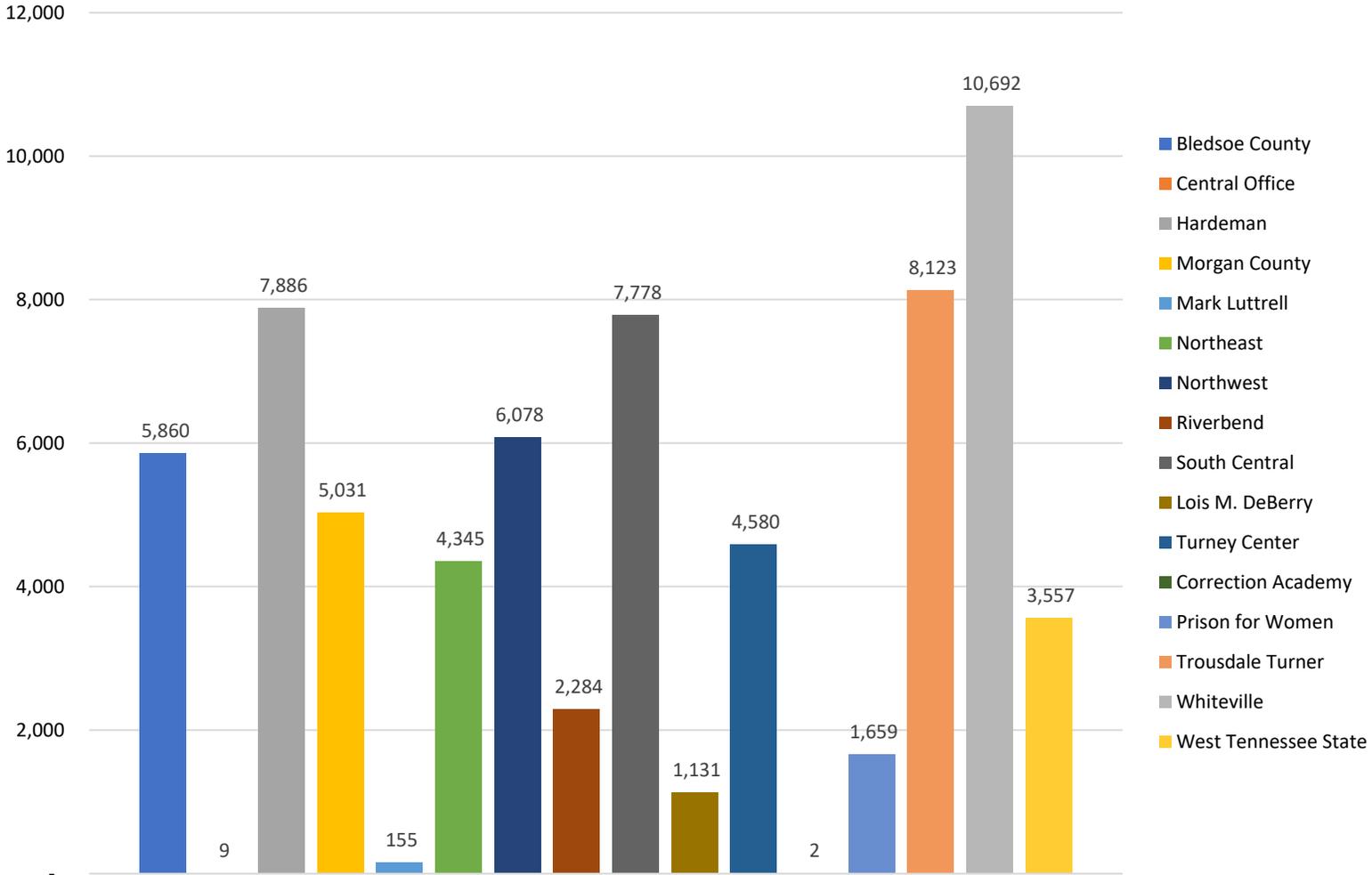
Source: Tennessee Offender Management Information System.

Appendix B-3
Summary of Class B Incidents (Those Involving Possible Risk to the Facility or Community) Reported by Location
October 1, 2017, Through April 12, 2019



Source: Tennessee Offender Management Information System.

Appendix B-4
Summary of Class C Incidents (Those Involving No Risk to the Facility or the Community) Reported by Location
October 1, 2017, Through April 12, 2019



Source: Tennessee Offender Management Information System.

Appendix B-5
TDOC Incident Summary by Incident Type and Prison for Fiscal Year 2018*
Pulled from the TDOC Statistical Abstract

TDOC Incident Summary by Incident Type and Prison: FY 2018

		BCCX	HCCF	MCCX	MLTC	NECX	NWCX	RMSI	SCCF	SPND	TCIX	TPFW	TTCC	WCFA	WTSP	Total
		Bledsoe County Correctional Complex	Hardeman County Correctional Facility	Morgan County Correctional Complex	Mark Luttrell Transition Center	Northeast Correctional Complex	Northwest Correctional Complex	Riverbend Maximum Security Institution	South Central Correctional Facility	DeBerry Special Needs Facility	Turney Center Industrial Complex	TN Prison for Women	Trousdale Turner Correctional Center	Whiteville Correctional Facility	West TN State Penitentiary	
Average Population		2,370	1,968	2,111	243	1,732	2,288	779	1,626	748	1,572	733	2,476	1,499	1,800	21,945
Inc Type	Incident Description															
Arrest	AFO FELONY-OFN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Arrest	AFS FELONY-STAFF	2	2	5	1	2	1	0	6	0	3	0	1	7	1	31
Arrest	AFV FELONY-VISITOR	19	2	16	0	6	1	0	2	0	10	1	1	2	6	66
Arson	ARI SER-INJ-PROP DMG>\$500-OPER DISRUP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Arson	ARD INJURY-PROP DMG >\$500-OPR DISRUP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Arson	ARP PROP DMG >\$500 OPER DISRUP	1	0	0	0	0	0	1	1	3	0	0	0	1	0	7
Assault	AOO OFN-WITHOUT WEAPON	44	24	8	0	16	33	6	33	12	13	7	46	27	16	285
Assault	AOW OFN-WEAPON	5	19	7	0	22	15	7	28	5	6	6	21	5	4	150
Assault	ASO STAFF-WITHOUT WEAPON	9	18	18	1	10	26	9	69	13	9	4	34	28	20	268
Assault	ASW STAFF-WEAPON	26	15	9	0	1	9	12	41	19	4	2	39	10	12	199
Assault	AVO VISITOR/GUEST-WITHOUT WEAPON	1	0	0	0	0	0	1	0	0	0	0	0	0	0	2
Assault	AVW VISITOR/GUEST - WEAPON	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DEA OFN-NATURAL	4	3	5	0	7	7	3	1	61	0	4	3	4	0	102
Death	DEC DEATH-OFN-EXEC-ELEC CHR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DEH OFN-HOMICIDE	0	2	0	0	0	0	0	1	0	0	0	0	0	0	3
Death	DEI OFN-EXEC-LETH INJ	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DES OFN-SUICIDE	0	1	0	0	1	0	1	1	2	1	1	1	1	2	12
Death	DOA OFN-ACCIDENT	0	1	0	0	0	0	0	0	0	0	0	0	0	0	1
Death	DEG STAFF-HOMICIDE (ON DUTY)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DEF STAFF-SUICIDE (ON DUTY)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DED STAFF-ACCIDENT (ON DUTY)	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DET STAFF (ON DUTY)-NATURAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DEV VISITOR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DVH VISITOR-HOMICIDE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DVS VISITOR-SUICIDE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DVA VISITOR-ACCIDENT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Death	DVN VISITOR-NATURAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbance	DIL TEMP. CONTROL LOSS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Disturbance	DIR THREAT CONTROL LOSS	0	1	0	0	0	1	0	0	0	0	1	0	0	0	3
Disturbance	DIS MINOR	0	4	4	0	4	3	4	1	0	1	3	0	1	3	28
Drugs	DFI INSIDE SECURE PERIMETER-NO POSS	0	29	7	0	7	7	3	4	0	0	0	0	2	0	59
Drugs	DFO OUTSIDE SECURE PERIMETER	0	1	0	0	3	0	0	1	0	0	0	0	0	0	5
Drugs	DRK CONFIS-SIGNIF AMT-STAFF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Drugs	DRL CONFIS-SIGNIF AMT-VISITOR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Drugs	DRN CONFISCATION-STAFF	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1
Drugs	DRO CONFISCATION-VISITOR	0	0	0	0	0	0	0	0	0	1	0	0	0	0	1
Drugs	DRP PARAPHERNALIA	49	18	43	0	35	66	25	15	6	45	2	63	6	14	387
Drugs	DRS POSSESSION / SELLING / USE	131	120	160	0	99	189	65	61	22	103	34	184	61	88	1,317
Drugs	IOP INTOXICANTS FOUND ON PROPERTY	0	0	2	0	0	0	0	0	0	0	1	0	0	0	3
Equip Prob	EPA MAJOR DISRUPTION	1	1	0	1	0	0	2	0	0	0	0	0	0	0	5

Please note that incidents reported may include more than one participant while other incidents are by definition about a single participant (ex: death or suicide).
Source: This report summarizes data entered by Facility Operations' personnel in accordance with TDOC policy 103.02.

*Highlighted codes are inactive codes in TOMIS.

TDOC Incident Summary by Incident Type and Prison: FY 2018 (cont.)

	BCCX	HCCF	MCCX	MLTC	NECX	NWCX	RMSI	SCCF	SPND	TCIX	TPFW	TTCC	WCEA	WTSP	Total
	Bledsoe County Correctional Complex	Hardeman County Correctional Facility	Morgan County Correctional Complex	Mark Luttrell Transition Center	Northeast Correctional Complex	Northwest Correctional Complex	Riverbend Maximum Security Institution	South Central Correctional Facility	DeBerry Special Needs Facility	Turney Center Industrial Complex	TN Prison for Women	Trousdale Turner Correctional Center	Whiteville Correctional Facility	West TN State Penitentiary	
Average Population	2,370	1,968	2,111	243	1,732	2,288	779	1,626	748	1,572	733	2,476	1,499	1,800	21,945
Escape ACA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escape ACM	0	0	0	0	0	0	1	0	0	0	1	0	0	0	2
Escape ESA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escape ESB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escape ESC	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Escape ESF	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escape ESH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escape ESI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Escape ESR	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire FII	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire FIP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire FIS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury IHA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury IHC	1	0	31	6	0	0	5	1	1	27	1	0	0	1	74
Injury IHB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury IJA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury IJB	36	0	49	8	19	5	16	13	6	10	6	0	16	3	187
Injury ILA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury ILB	4	0	1	0	0	1	3	0	0	0	3	0	0	1	13
Injury INB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Injury INC	37	9	3	0	0	11	12	13	58	5	11	12	9	26	206
Illness IOT	17	4	98	4	0	28	9	2	0	6	23	58	36	40	325
Illness ISH	10	0	15	2	3	3	2	2	1	2	1	0	4	7	52
Illness IVS	0	0	1	0	0	0	0	0	0	0	0	0	0	0	1
Illness IVM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other CIP	2	1	25	0	13	14	9	2	0	1	0	1	2	1	71
Other BTH	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other CON	163	188	115	1	80	207	113	154	47	160	79	129	143	78	1,657
Other PCT	19	36	292	6	225	394	84	102	11	87	6	148	57	50	1,517
Other PTO	50	25	88	0	46	120	77	15	37	65	44	55	12	44	678
Other PDA	9	0	6	3	1	16	9	0	6	1	9	0	0	5	65
Other SXM	43	7	95	0	132	140	107	153	29	48	20	254	23	259	1,310
Other RAP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other RIO	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other SBT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other HOS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other EHT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other PGA	41	39	27	0	21	17	3	62	2	21	0	23	23	8	287
Other PGM	130	12	50	0	2	54	13	18	3	32	2	13	22	5	356
Other ILP	0	2	0	0	0	2	3	7	0	0	0	2	2	0	18
Other ILT	0	1	0	0	0	1	2	5	1	0	0	4	7	0	21
Strike SKI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Strike SKS	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide SUA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Suicide SUC	12	1	1	0	3	1	1	2	2	1	2	2	1	6	35

Please note that incidents reported may include more than one participant while other incidents are by definition about a single participant (ex: death or suicide). Source: This report summarizes data entered by Facility Operations' personnel in accordance with TDOC policy 103.02.

*Highlighted codes are inactive in TOMIS.

TDOC Incident Summary by Incident Type and Prison: FY 2018 (cont.)

	BCCX	HCCF	MCCX	MLTC	NECX	NWCX	RMSI	SCCF	SPND	TCIX	TPFW	TTCC	WCFA	WTSP	Total
	Bledsoe County Correctional Complex	Hardeman County Correctional Facility	Morgan County Correctional Complex	Mark Luttrell Transition Center	Northeast Correctional Complex	Northwest Correctional Complex	Riverbend Maximum Security Institution	South Central Correctional Facility	DeBerry Special Needs Facility	Turney Center Industrial Complex	TN Prison for Women	Trousdale Turner Correctional Center	Whiteville Correctional Facility	West TN State Penitentiary	
Average Population	2,370	1,968	2,111	243	1,732	2,288	779	1,626	748	1,572	733	2,476	1,499	1,800	21,945
Use of Force UFC CHEMICAL AGENTS	3	76	7	0	13	3	12	79	9	2	0	95	95	7	401
Use of Force UFD DEADLY WEAPON	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Use of Force UFE ELEC RESTRAINTS	5	0	9	0	6	15	3	0	2	3	2	0	0	7	52
Use of Force UFL LESS THAN LETHAL	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Use of Force UFM MEDICAL	6	0	6	0	5	5	7	0	138	0	2	1	0	0	170
Use of Force UFP PHYSICAL	13	26	31	0	9	11	25	48	20	23	9	75	27	22	339
Weapon WAB AMMUNITION	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Weapon WAM AMMUNITION-SIGNIF AMT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Weapon WCF COMMERCIAL FIREARM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Weapon WCK COMMERCIAL KNIFE	1	4	0	0	0	1	0	0	0	2	0	0	2	1	11
Weapon WEB EXPLOSIVE	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Weapon WEX EXPLOSIVE-SIGNIF AMT	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Weapon WHF NON COMMERCIAL FIREARM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Weapon WHK NON COMMERCIAL KNIFE	5	131	76	0	173	426	37	240	2	96	0	328	139	68	1,721
Weapon WOT OTHER	11	1	16	0	4	6	4	1	1	5	1	16	0	3	69
Weapon WPC CLUB	0	0	0	0	1	1	0	0	0	0	0	2	0	0	4
Weapon WRM RAW MATERIALS	15	1	21	0	21	45	6	0	0	13	0	15	2	8	147
Weapon WTA CLASS A TOOL	0	0	0	0	0	1	1	0	0	0	0	0	0	2	4
Weapon WTB CLASS B TOOL	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Summary															
	BCCX	HCCF	MCCX	MLTC	NECX	NWCX	RMSI	SCCF	SPND	TCIX	TPFW	TTCC	WCFA	WTSP	Total
TOTAL	925	825	1,348	33	990	1,887	703	1,184	519	805	289	1,626	777	819	12,730
Rate per 100 - Total	39.0	41.9	63.8	13.6	57.2	82.5	90.3	72.8	69.4	51.2	39.4	65.7	51.8	45.5	58.0

Please note that incidents reported may include more than one participant while other incidents are by definition about a single participant (ex: death or suicide). Incident rates (per 100 inmates) are calculated on the basis of the average inmate population by facility and system wide. Source: This report summarizes data entered by Facility Operations' personnel in accordance with TDOC policy 103.02.

Source: Department of Correction website.

Appendix B-6 Detail of Testwork Related to Inmate Deaths

Our initial testwork relating to deceased inmates' health records revealed the following overlapping missing documents. Of the 38 files we reviewed,

- 12 files (32%) did not have the Accident/Incident/Traumatic Injury Report;
- 4 files (11%) did not have the Problem Oriented Progress Report;
- 23 files (61%) did not have the Mortality and Morbidity Summary; and
- 21 files (55%) did not have the inmate's certified death certificate.

The Chief Medical Officer provided the following missing documents after we requested them:

- 2 Accident/Incident/Traumatic Injury Reports;
- 3 Problem Oriented Progress Reports (1 inmate died at a hospital instead of at the facility, so staff did not need to complete the report);
- 9 Mortality and Morbidity Summaries and 14 Death Summaries, which the Lois M. DeBerry Special Needs Facility substituted for the required Mortality and Morbidity Summary;⁴³ and
- 21 missing inmate death certificates.

Appendix B-7 Summary of Incident-Related Issues Found During Correctional Facility Site Visits

At Whiteville Correctional Facility, we found the following:

- For 6 of 27 items (22%), the facility staff did not enter the incident into TOMIS within 8 hours of occurrence or discovery.
- For 18 of 27 items (67%), the body of the draft incident report did not match the information in TOMIS. Because CoreCivic managed this facility, CoreCivic staff provided us with their CoreCivic 5-1a and 5-1c forms and a few disciplinary forms that they found in a box, which we were able to compare to TOMIS.
- For 26 of 27 items (96%), facility staff did not report the incident to the department's Central Communication Center (CCC) within 30 minutes of occurrence or discovery.

⁴³ The Lois M. DeBerry Special Needs Facility did not record information on 14 of the Mortality and Morbidity Summary forms. The Chief Medical Officer allowed the facility to prepare a Death Summary in lieu of the Mortality and Morbidity Summary because it provided more detail than the Mortality and Morbidity Summary. Although the intent was to be more thorough, the facility did not address the completion of the Mortality and Morbidity Summaries as listed in policy.

- For 7 of 27 items (26%), facility staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 5 of 27 items (19%), staff did not submit a Use of Force report to the warden within 8 hours or by the end of the shift.
- For 9 of 27 items (33%), staff did not enter all required incident inmate information in TOMIS; specifically, they did not include descriptions of homemade weapons.

At Trousdale Turner Correctional Center, we found the following:

- For 3 of 25 items (12%), facility staff did not enter the incident information into TOMIS within 8 hours of occurrence or discovery.
- For 7 of 25 items (28%), the body of the draft incident report did not match the information staff entered into TOMIS. Because Trousdale is a CoreCivic facility, we compared the CoreCivic 5-1a and 5-1c forms to TOMIS.
- For 24 of 25 items (96%), staff did not report the incident to the CCC within 30 minutes of occurrence or discovery.
- For 4 of 25 items (16%), staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 2 of 25 items (8%), staff could not locate the Staff Assault Incident Review Report.
- For 7 of 25 items (28%), staff did not submit a Use of Force report to the warden within 8 hours or by the end of shift.
- For 9 of 25 items (36%), staff did not enter all required information related to the incident into TOMIS; specifically, staff did not include lists of disciplinary infractions, names of all persons involved, and descriptions of homemade weapons.

At Hardeman County Correctional Facility, we found the following:

- For 5 of 25 items (20%), facility staff did not enter the incident into TOMIS within 8 hours of occurrence or discovery.
- For 12 of 25 items (48%), the body of the draft incident report did not match the information entered into TOMIS. Because CoreCivic manages this facility, we compared CoreCivic 5-1a and 5-1c forms to TOMIS.
- For 24 of 25 items (96%), staff did not report the incident to the CCC within 30 minutes of occurrence or discovery.
- For 3 of 25 items (12%), staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 3 of 25 items (12%), staff did not submit a Use of Force report to the warden within 8 hours or by the end of shift.

- For 16 of 25 items (64%), staff did not enter all required information related to the incident into TOMIS; specifically, staff did not include
 - lists of disciplinary infractions,
 - the location of the incident,
 - the time of the incident,
 - the names of all persons involved, and
 - descriptions of homemade weapons.

At Northwest Correctional Complex, we found the following:

- For 2 of 26 items (8%), facility staff did not enter the incident into TOMIS within 8 hours of occurrence or discovery.
- For 26 of 26 items (100%), because staff could not provide draft incident reports, we could not compare them to the information in TOMIS.
- For 26 of 26 items (100%), staff did not report the incident to the CCC within 30 minutes of occurrence or discovery.
- For 7 of 26 items (27%), staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 1 of 26 items (4%), staff did not complete a Staff Assault Incident Review Report within 72 hours.
- For 15 of 26 items (58%), staff did not enter all required information related to the incident into TOMIS; specifically, staff did not include
 - lists of disciplinary infractions,
 - the location of the incident,
 - the time of the incident,
 - charges filed,
 - inmate TOMIS IDs,
 - the names of all persons involved, and
 - descriptions of homemade weapons.

At Turney Center Industrial Complex, we found the following:

- For 6 of 28 items (21%), staff did not enter the incident into TOMIS within 8 hours of occurrence or discovery.
- For 25 of 28 items (89%), because staff could not provide draft incident reports, we could not compare them to the information in TOMIS. For 3 incidents, we compared documentation from Use of Force packets to the TOMIS entries because the Use of Force packets contained first-hand accounts of the incidents.

- For 28 of 28 items (100%), staff did not report the incident to the CCC within 30 minutes of its occurrence or discovery.
- For 6 of 28 items (21%), staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 3 of 28 items (11%), staff did not submit a Use of Force report to the warden within 8 hours or by the end of the shift.
- For 17 of 28 items (61%), staff did not enter all required information into TOMIS; specifically, staff did not include the location of the incident, the names of all persons involved, and descriptions of homemade weapons.

At Northeast Correctional Complex, we found the following:

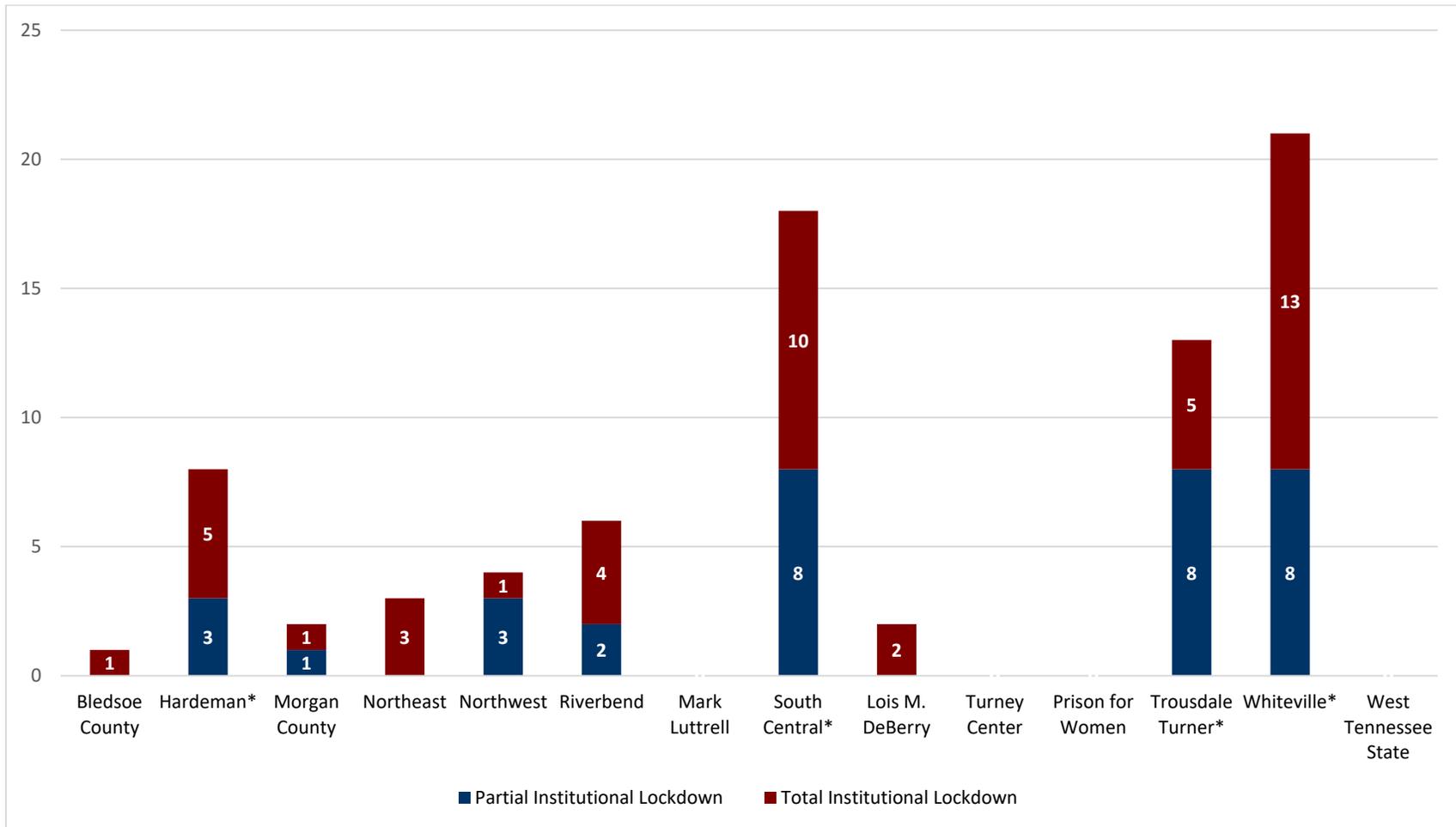
- For 7 of 25 items (28%), staff did not enter the incident into TOMIS within 8 hours of occurrence or discovery.
- For 24 of 25 items (96%), the body of the draft incident report either did not match what was entered into TOMIS or staff could not provide a draft incident report for comparison to TOMIS. For 3 incidents, we compared documentation from Use of Force packets to TOMIS entries because the Use of Force packets contain first-hand accounts of the incidents.
- For 24 of 25 items (96%), staff did not report the incident to the CCC within 30 minutes of its occurrence or discovery.
- For 7 of 25 items (28%), staff did not hold a disciplinary hearing within 7 calendar days of the incident.
- For 21 of 25 items (84%), staff did not enter all required information into TOMIS; specifically, staff did not include the location of the incident, the names of all persons involved, and descriptions of homemade weapons.
- Staff at Northeast's Carter County annex facility used incident report forms to record all initial incidents.

Appendix B-8
The Assistant Commissioner of Prisons' Expectations for Incident Reporting Related to Accidents, Injuries, and Illnesses

- Code 4 Medical Emergencies⁴⁴– “The reporting protocol would be dictated by the severity of the injury or the seriousness of the illness. If the event rises to the requirements outlined in [Policy] 103.02, ‘Incident Reporting,’ then the requirements of that policy would be followed.”
- Inmate Transports to Outside Hospitals for Injury/Illness – “An inmate could be transported to a hospital for an illness that is not life-threatening, yet the required care may be beyond the abilities of the infirmary. A TOMIS entry would be required.”
- Work-Related Injuries – “Offender work-related injuries that have been verified by the work supervisor should be entered on the incident screen, per Policy 103.02. The accident, incident, and traumatic injury form should also be completed.”
- Accidents With Injuries (Minor to Serious) – “Once security is notified of an inmate injury, no matter the level of severity, an incident would be entered into TOMIS under the appropriate incident code.”
- Inmate Injuries Consistent With an Altercation (Minor to Serious) – “The initial entry, prior to completed investigation, could be pending investigation. Depending on the outcome of the investigation, the final entry could be one of the following: 1) assault on offender with weapon or without, 2) fighting, 3) injury accident offender, or 4) injury self-inflicted.”

⁴⁴ This a radio code that correctional staff use when an inmate, staff member, or visitor is experiencing a medical emergency, such as serious chest pains, loss of blood, or other condition that would require health services staff to respond immediately to their location.

Appendix B-9
Total Number of Reported Lockdowns by Correctional Facility
October 1, 2017, Through April 12, 2019



*CoreCivic-managed correctional facilities.

Source: Tennessee Offender Management Information System.

Appendix B-10

Methodologies to Achieve Objectives

Death Reviews and Reporting

To achieve our objectives, we reviewed Department of Correction policies and interviewed the department's Chief Medical Officer and Death in Custody Coordinator to gain an understanding of the process that correctional facility and department staff follow to record an inmate's cause of death in TOMIS and to document the circumstances surrounding the death in the inmate's health record.

To determine the accuracy of inmate deaths recorded in TOMIS, we obtained a list of 171 inmate deaths recorded by facility security staff from October 1, 2017, through May 30, 2019, and compared it to narrative information that health services staff entered in the Online Sentinel Event Log to identify any natural deaths that could be misclassified.

As a result of this comparison, we identified 38 inmate deaths with questionable causes and compared the causes of deaths in TOMIS to the inmates' certified death certificates.

To determine whether the inmate's health record contained the proper documentation relating to the death and subsequent reporting of the death, we reviewed the inmate's health records and searched for documentation required in departmental Policy 113.05, "Deaths and Autopsies."

Other Incident Reporting

To achieve our objective, we interviewed staff at

- Whiteville Correctional Facility (operated by CoreCivic),
- Trousdale Turner Correctional Center (operated by CoreCivic),
- Hardeman County Correctional Facility (operated by CoreCivic),
- Northwest Correctional Complex,
- Turney Center Industrial Complex,
- Northeast Correctional Complex,
- the department's central office, and
- the Tennessee Correction Academy

to gain an understanding of the process to enter incidents into TOMIS and the type of supporting documentation that facility staff maintain. We reviewed department policies related to entering incidents and pulled a nonstatistical, random sample of Class A incidents at each of the six prisons we visited (see **Table 12**) and performed testwork to determine whether staff entered the incidents into TOMIS according to policy. We searched for original documentation to support the incident entries related to incidents involving staff assault, use of force, and disciplinary hearings. We also

determined if facility staff reported incidents to the Central Communication Center within the required timeframe.

**Table 12
Population and Sample Sizes for Incident Testwork**

Correctional Facility	Population Size	Sample Size Tested
Trousdale Turner Correctional Center	642	25
Hardeman County Correctional Facility	351	25
Whiteville Correctional Facility	693	27
Northwest Correctional Complex	96	26
Turney Center Industrial Complex	180	28
Northeast Correctional Complex	309	25
Total	2,271	156

Source: Compiled from auditor testwork.

Accident and Injury Reporting

To achieve our objective, we tested a random sample of 25 accident/injury entries made in the Accidents screen at the following correctional facilities and populations:

**Table 13
Accident/Injury Testwork Population Sizes**

Correctional Facility	Population Size
Hardeman County Correctional Facility	564
Northeast Correctional Complex	566
Northwest Correctional Complex	85
Turney Center Industrial Complex	299
Total	1,514

When we attempted to pull a sample of accidents and injuries at Whiteville Correctional Facility and Trousdale Turner Correctional Center, we found that health services staff did not make any entries in the TOMIS Accidents screen during our audit period, so we were unable to perform the same testwork at those facilities.

We also compared the entries that health services staff made in the Accidents screen to the entries that security staff made in the Incidents screen to see if health services staff reported any accidents or injuries that security staff did not.

Lockdown Reporting

To achieve our objective, we interviewed security staff at

- Hardeman County Correctional Facility (operated by CoreCivic),
- Trousdale Turner Correctional Center (operated by CoreCivic),
- Whiteville Correctional Facility (operated by CoreCivic),

- Northeast Correctional Complex,
- Northwest Correctional Complex, and
- Turney Center Industrial Complex

to gain an understanding of each prison's definition and reporting of lockdowns. We reviewed department policies for any references to lockdowns. From TOMIS, we extracted and examined a list of 74 reported lockdowns at all prisons for the period October 1, 2017, to April 12, 2019. We also reviewed the Central Communication Center's spreadsheet for any references to lockdowns.

Statistical Abstract

To achieve our objectives, we interviewed the Director and the Assistant Director of the Decision Support: Research and Planning Division; reviewed the department's Annual Reports and Statistical Abstracts from fiscal years 2016, 2017, and 2018; and obtained a list of current and retired incident codes to gain an understanding of how the division compiles the statistics in the reports. We also conducted testwork related to reporting incidents including deaths, accidents and injuries, and lockdowns at three CoreCivic and three state correctional facilities to identify issues with how correctional staff enter incident data into TOMIS.

INMATE SEXUAL ABUSE AND SEXUAL HARASSMENT INVESTIGATIONS

CHAPTER CONCLUSION

Finding 9 – Management did not ensure that state and CoreCivic correctional facilities staff followed policies and procedures for investigating sexual abuse and sexual harassment allegations and documented their results (page 82)

INMATE SEXUAL ABUSE AND SEXUAL HARASSMENT INVESTIGATIONS

General Background

Congress enacted the Prison Rape Elimination Act of 2003 (PREA) to address the problem of sexual abuse of people in U.S. correctional agencies. It applies to all public and private correctional facilities that house adult or juvenile inmates, as well as community-based agencies. It also mandates certain standards concerning detection and prevention of prison rape. The Tennessee Department of Correction is required to follow federal PREA standards, issued by the U.S. Department of Justice.



PREA seeks to eliminate sexual assaults and other sexual misconduct in correctional facilities across the country. The Act sets nationwide standards for how correctional facilities and jails should

- identify potential victims and aggressors of sexual abuse and harassment;
- limit cross-gender viewing and searches (male officers do not view female inmates in bathrooms or shower areas or conduct body searches, and vice versa);
- conduct PREA-related training and education for staff; and
- receive, respond to, and investigate allegations of sexual abuse and harassment.

The law also requires audits of all correctional facilities at least once every three years by a U.S. Department of Justice-certified PREA auditor.

Federal law describes two categories for classifying PREA allegations:

- sexual harassment, and
- sexual abuse.

PREA defines sexual harassment as

repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one inmate, detainee, or resident directed toward another; and repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

The definition for sexual abuse, however, is broad and includes nonconsensual sexual contact between inmates and consensual or nonconsensual sexual contact between inmates and staff. In the context of this law, rape is considered a form of sexual abuse. According to the department's Policy 502.06, "PREA Implementation, Education, and Compliance," the

department has a zero-tolerance policy regarding sexual acts between staff and inmates as well as between inmates, regardless of whether the act is consensual.

Screenings for Risk of Inmate Abuse or Victimization

The department's Policy 502.06.01, "Prison Rape Elimination Act (PREA) Screening, Classification, and Monitoring," states that the department is to provide a "safe, humane, and appropriately secure environment, free from threat of sexual abuse and sexual harassment for all inmates."

To help meet these standards, the department requires that every inmate receive a PREA screening upon entering the state's correctional system. By asking a series of confidential questions, the screening application helps correctional staff identify whether an inmate is at risk of being either sexually abusive or sexually victimized. See page 153 for more information relating to the department's PREA screening process.

PREA Allegation Reporting

Department policy categorizes PREA allegations as

- inmate-on-inmate sexual abuse,
- inmate-on-inmate sexual harassment,
- staff-on-inmate sexual abuse, and
- staff-on-inmate sexual harassment.

Federal PREA law requires the department to provide multiple ways for inmates and staff to privately report PREA allegations. The department's Policy 502.06.2, "Prison Rape Elimination Act (PREA) Allegations, Investigations, and Sexual Abuse Response Teams (SART)," makes the following reporting methods available:

- an internal correctional facility hotline;
- an external advocacy groups hotline;
- a PREA tip line;
- reporting directly to staff either verbally or in writing; and
- any other written communication.

The department created a web-based application called the PREA Allegation System (PAS) in which the correctional facility investigators and/or the facility PREA coordinator log allegations. According to department policy, these staff must log an allegation into PAS within 24 hours of receiving the allegation in order to initiate and track a prompt response to the allegation. Once the allegation is logged, department management can monitor and track the investigation's progress, as well as report on the investigation's findings. PAS assigns each PREA

allegation a unique allegation identification number to allow department management to more easily search and track allegations. Staff log

- the date of the alleged incident;
- the date the allegation was reported;
- the type of allegation;
- the alleged aggressor and victim;
- a description of the allegation;
- a description of the actions taken to investigate the allegation; and
- the results of the investigation.

Since staff use PAS as the primary PREA tracking system, they do not enter PREA allegation information into the Tennessee Offender Management Information System (TOMIS) unless and until the investigators substantiate the sexual assault, based on DNA tests, and send the case to a third-party litigator. The department uses the PAS data to prepare its annual PREA report. See **Appendix C-1** on page 86 for the number of PREA allegations that each correctional facility logged in PAS by type from October 1, 2017, to June 30, 2019.

The data entered into TOMIS, however, does not include the investigation's confidential details. We were told that staff enter the substantiated PREA cases into TOMIS as a means to report them in the department's Statistical Abstract.

PREA Investigations

According to the department's Policy 502.06.2, "PREA Allegations, Investigations and Sexual Abuse Response Teams," management must investigate every allegation of sexual abuse and harassment timely, efficiently, and confidentially in accordance with federal standards. When first responding staff receive an allegation, they should

- instruct inmates to not take any actions that could destroy physical evidence, such as washing hands, showering, brushing teeth, changing clothes, or going to the restroom;
- separate the alleged victim and abuser;
- preserve and protect the alleged crime scene until steps can be taken to collect any evidence;
- notify the Sexual Abuse Response Team;⁴⁵ and
- conduct the investigation.

⁴⁵ The Sexual Abuse Response Team is a coordinated response team of medical and mental health practitioners, facility investigators, and facility security leadership. The department's Office of Investigations and Compliance personnel are not part of this team.

Each correctional facility has an institutional investigator who investigates PREA allegations and reports investigation results. At the conclusion of the investigation, the investigator classifies the allegation as either substantiated, unfounded, or unsubstantiated.

Sexual Abuse Response Team Responsibilities

Each correctional facility is required to have a Sexual Abuse Response Team in place to coordinate the correctional facility's response to allegations. The team ensures that alleged victims of sexual abuse receive immediate medical and mental health attention. The time between when an alleged incident occurs and when it is reported is important because it can impact the amount of physical and DNA evidence collected. The department's Office of Investigations and Compliance personnel, located in field offices throughout the state, collect the physical evidence at the scene if physical evidence is present.

If a sexual abuse allegation is reported within 72 hours, the critical time period in order to collect evidence, as required by Policy 502.06.2, then the security shift supervisor who is notified of the allegation is required to initiate a Sexual Abuse Incident Check Sheet. The check sheet provides correctional facility personnel with a list of required notifications they must make, as well as tasks the first responders, medical and mental health personnel, and other Sexual Abuse Response Team members must perform. Management and staff use the check sheet to document the date and time that staff perform each required task. The check sheet is not required after 72 hours of the incident because evidence collection is not viable after this point; however, the allegation must still be reported and investigated.

At the conclusion of every substantiated or unsubstantiated sexual abuse allegation, the facility is required to conduct and document an incident review within approximately 30 days of the investigation's conclusion. Unfounded allegations do not require such a review. The Sexual Abuse Incident Review allows facility personnel to

- consider whether the allegation should lead to a change in policy to prevent the incident from occurring again or to provide better response to a similar event;
- consider if the incident was motivated by race, sexual orientation, gender identity, gang affiliation, or other motivating factors;
- examine the alleged location to determine if any physical barriers could have enabled abuse;
- assess the adequacy of the staffing levels in the area; and
- consider whether to deploy or change monitoring technology.

PREA Standards

Substantiated – Based on the evidence, the alleged event occurred.

Unfounded – Based on the evidence, the alleged event did not occur.

Unsubstantiated – Based on the evidence, the investigator could not determine whether or not the alleged event occurred.

The Sexual Abuse Response Team is responsible for ensuring that, upon the completion of the investigation, the required documentation is given to the institutional investigator for inclusion in the investigation file. See **Table 14** for a list of the investigation findings by allegation type for all correctional facilities from October 1, 2017, to June 30, 2019.

Table 14
PREA Investigation Findings by Allegation Type
October 1, 2017, to June 30, 2019

Allegation Finding	Inmate-on-Inmate Sexual Abuse	Inmate-on-Inmate Sexual Harassment	Staff-on-Inmate Sexual Abuse	Staff-on-Inmate Sexual Harassment	Total
Substantiated	8	12	32	6	58
Unsubstantiated	104	60	30	49	243
Unfounded	64	52	76	117	309
Investigation Ongoing ⁴⁶	20	4	3	3	30
Total	196	128	141	175	640⁴⁷

Source: The Department of Correction's PREA Allegation System.

For additional information on the department's PREA policies, action plan, response to allegations, and investigation information, visit the department's website (<https://www.tn.gov/correction/sp/prison-rape-elimination-act.html>), which also includes a link to the department's PREA Annual Report.

Audit Results

Audit Objective: Did the department and CoreCivic investigate and document PREA allegations in accordance with department policy and national PREA standards?

Conclusion: Based on our audit work, we found that both department and CoreCivic correctional facilities staff did not log PREA allegations timely, and staff at two state facilities, Turney Center Industrial Complex and Northeast Correctional Complex, did not maintain proper investigation documentation. See **Finding 9**.

⁴⁶ The "Investigation Ongoing" category represents any allegation that did not have a final finding listed with the allegation at the time of our review.

⁴⁷ This number does not include two allegations in the table in **Appendix C-1** on page 86 where no type or finding was entered into PAS.

Finding 9 – Management did not ensure that state and CoreCivic correctional facilities staff followed policies and procedures for investigating sexual abuse and sexual harassment allegations and documented their results

To determine if the Department of Correction and CoreCivic complied with department policy and federal PREA standards for the period of October 1, 2017, to April 11, 2019,

- we obtained a total population of 108 PREA allegations at Hardeman County Correctional Facility, Whiteville Correctional Facility, Northwest Correctional Complex, and Northeast Correctional Complex; and
- we selected a nonstatistical, random sample of 50 allegations from a population of 117 PREA allegations at Trousdale Turner Correctional Center and Turney Center Industrial Complex.

For the full methodology, including the breakdown of the population and sample sizes for each correctional facility we visited, see Appendix C-2 on page 86.

We also reviewed documentation in the department’s PREA Allegation System (PAS) and the investigative files.

Allegations Not Entered Into PAS Timely

Based on our testwork, we found that staff at each correctional facility did not enter PREA allegations into PAS within 24 hours of receipt, as required by the department’s Policy 502.06.2, “PREA Allegations, Investigations and Sexual Abuse Response Teams.” According to department management, correctional facility staff logged these PREA allegations into PAS when the investigations were completed, rather than within 24 hours of receiving the allegation as required. See **Table 15** for a summary of our testwork results.

**Table 15
Results of Testwork – Allegations Not Entered Timely**

Correctional Facility	Number of Items Tested	Number of Errors and Error Percentage of Allegations Logged After 24 Hours	Average Number of Days Late
Northeast	22	13 (59%)	15
Northwest	21	12 (57%)	5
Turney Center	25	15 (60%)	5
Trousdale Turner*	25	18 (72%)	10
Hardeman*	27	6 (22%)	3
Whiteville*	38	34 (89%)	10

*Operated by CoreCivic.

Additional Concerns Identified at South Central Correctional Facility

While examining statistics relating to the number of substantiated, unsubstantiated, and unfounded allegations, we noticed that South Central Correctional Facility staff had not entered any investigation results into PAS from April 17, 2019, to August 6, 2019, the date we pulled the statistics. Furthermore, using the facility's internal PREA allegation tracking spreadsheet, we found that staff did not enter four sexual abuse and one sexual harassment allegations made between June 18, 2019, and July 22, 2019.

According to the department's Director of Contract Monitoring, South Central's assistant warden, who was responsible for PREA reporting, transferred to the Hardeman County Correctional Facility in April 2019 but continued to serve as the interim assistant warden at South Central until the position was filled at the end of June. Additionally, South Central hired a new institutional investigator at the beginning of June 2019. According to the warden, the PREA information was not entered into PAS because no one at South Central had access to PAS during that time period.

Investigative Documentation Incomplete or Misclassified

During our testwork, we identified issues with investigative documentation at two state facilities, Northeast Correctional Complex and Turney Center Industrial Complex.

Northeast's PREA Reviews and Investigation Check Sheets

At the Northeast Correctional Complex, we found the following:

- For 7 of 22 PREA allegations tested (32%), staff did not complete a Sexual Abuse Incident Check Sheet to document any abuse allegations that were reported within 72 hours after the alleged incident occurred.
- For 2 of 22 PREA allegations tested (9%), staff determined that the allegations were either unsubstantiated or substantiated but lacked a completed Sexual Abuse Incident Review.⁴⁸

The department's Policy 502.06.2 states that

If the alleged sexual abuse occurred within a 72-hour time period of reporting, the security shift supervisor who is notified of the allegation shall initiate the Sexual Abuse Incident Check Sheet . . .

The facility shall conduct a Sexual Abuse Incident Review Report, at the conclusion of every sexual abuse investigation, including investigations in which the allegation has not been substantiated, unless the allegation has been determined to be unfounded.

⁴⁸ A Sexual Abuse Incident Review is not required if staff determine that the allegations of sexual abuse or harassment were unfounded.

Staff are required to use the Sexual Abuse Incident Check Sheets to document when they take the required steps to respond to an allegation. In addition, by preparing the Sexual Abuse Incident Review Report, management documents its evaluation of the events to help consider whether it should implement processes to prevent similar sexual abuse or harassment incidences from happening in the future. Based on our discussions with department management, the department had identified concerns with the completeness of the case files at Northeast and has appointed a new institutional investigator to conduct future investigations.

Turney Center's Investigation Results Misclassified

Based on our testwork at the Turney Center Industrial Complex, for 8 of 25 PREA allegations tested (32%), we found that the investigator did not include sufficient documentation in the investigation case files to support staff's final findings. Specifically, the institutional investigator marked the allegations as unfounded; however, we found that staff's descriptions of the event used a variation of the phrase "due to the lack of evidence," which suggested that staff should have classified the allegation as unsubstantiated rather than unfounded.

According to Title 28, *Code of Federal Regulations*, Part 115, Section 5,

Unfounded allegation means an allegation that was investigated and determined not to have occurred.

Unsubstantiated allegation means an allegation was investigated and the investigation produced insufficient evidence to make a final determination as to whether or not the event occurred.

For three of the eight allegations,⁴⁹ correctional facility staff apparently improperly concluded the allegations were unfounded and, based on that conclusion, did not require staff to complete the Sexual Abuse Incident Review.

After we discussed the misclassifications with department management, they determined that four of the eight allegations should have been classified as unsubstantiated rather than unfounded. Management stated that the remaining four allegations were correctly classified as unfounded, but correctional facility staff should have entered greater detail in the investigative report to justify the findings.

Overall Effect

If correctional facility staff do not log the PREA allegations into PAS timely (within 24 hours of receiving the allegation), department management cannot effectively track and monitor the status of investigations to ensure staff are following required policy when investigating and documenting serious allegations of sexual abuse and harassment. When correctional facility staff do not complete the check sheets or incident reviews when required, the department cannot ensure

⁴⁹ For four of the allegations misclassified as unfounded, correctional facility staff conducted the Sexual Abuse Incident Review even though it was not required. One other allegation involved sexual harassment, which did not require a review.

that facility staff took proper actions, including notifying facility management and medical and mental health personnel to collect physical evidence if physical evidence is present.

Management's incident review process allows department and facility management to evaluate the events to determine if they need to make any changes to prevent an alleged incident of sexual abuse from occurring again. Because many inmates do not report abuse out of fear of retaliation or shame, or because they do not believe that complaints of sexual abuse will result in any changes, the department's incident reporting may not capture the complete picture of inmate sexual abuse. If correctional facility staff do not properly understand how to classify allegation investigation results, there is an increased risk that management and staff will not properly review or even report critical sexual abuse and harassment allegations.

Recommendation

To ensure that PREA investigations are properly performed in accordance with departmental policies and federal standards, management should educate the correctional facility investigators and other facility personnel who are involved with PREA allegation investigations on the requirements of the investigations. The department should also monitor the information in PAS to ensure that correctional facilities are accurately and timely entering the required information.

Management's Comment

Concur.

Department management understands the importance of accurate data entry and subsequent statistical distribution. Incident data entered into TOMIS is used by both internal and external stakeholders. As noted in comments related to other findings, we are engaged in a review of current policies and processes, associated with TOMIS incident entry, designed to ensure that we provide complete and accurate information to all interested parties.

Appendix C Inmate Sexual Abuse and Sexual Harassment Investigations

Appendix C-1 Additional PREA Allegation and Investigation Information

**Table 16
PREA Allegations by Correctional Facility and Type
October 1, 2017, to June 30, 2019**

Facility	Inmate-on-Inmate		Staff-on-Inmate		Other	Total
	Sexual Abuse	Sexual Harassment	Sexual Abuse	Sexual Harassment	No Type Entered	
Bledsoe County Correctional Complex	17	26	16	32	1	92
Hardeman County Correctional Facility*	17	3	9	4	0	33
Morgan County Correctional Complex	9	22	17	19	0	67
Mark Luttrell Transition Center	0	0	0	1	0	1
Northeast Correctional Complex	6	3	8	8	0	25
Northwest Correctional Complex	19	4	1	2	0	26
Riverbend Maximum Security Institution	1	6	20	15	0	42
South Central Correctional Facility*	35	5	13	3	0	56
Lois M. DeBerry Special Needs Facility	1	15	7	14	0	37
Turney Center Industrial Complex	10	15	16	28	0	69
Tennessee Prison for Women	3	1	10	9	0	23
Trousdale Turner Correctional Center*	50	11	5	4	1	71
Whiteville Correctional Facility*	17	10	7	12	0	46
West Tennessee State Penitentiary	11	7	12	24	0	54
Total	196	128	141	175	2	642

*Operated by CoreCivic.

Source: The Department of Correction's PREA Allegation System.

Appendix C-2 Methodologies to Achieve Objective

To meet our objective, we obtained the Department of Correction's and CoreCivic's policies related to Prison Rape Elimination Act (PREA) matters, including screenings,⁵⁰ investigations, education, and monitoring. We discussed the investigative process with department personnel. To determine if the department and CoreCivic complied with department policy and federal PREA standards, we obtained a list of the PREA allegations for the following correctional facilities for the period of October 1, 2017, to April 11, 2019, and tested either the population or a nonstatistical, random sample of allegations and reviewed the documentation in the department's PREA Allegation System (PAS) and the investigative files.

⁵⁰ See page 153 for information about PREA screenings.

Table 17
PREA Allegation Population and Sample by Correctional Facility

Correctional Facility	Population	Sample Tested*
Hardeman County Correctional Facility†	27	–
Whiteville Correctional Facility†	38	–
Trousdale Turner Correctional Center†	61	25
Northwest Correctional Complex	21	–
Turney Center Industrial Complex	56	25
Northeast Correctional Complex	22	–

*If blank, the entire population was tested.

†CoreCivic-managed correctional facility.

INMATE MEDICAL AND MENTAL HEALTH SERVICES

CHAPTER CONCLUSIONS

Finding 10 – Department management disregarded controls over statewide procurement and established its own informal procurement and payment system without proper review and approval by oversight authorities (page 96)

Finding 11 – Centurion and Corizon did not meet contractual medical and mental health staffing levels (page 98)

Finding 12 – CoreCivic and state managed correctional facilities did not ensure that staff placed the required medical and mental health documents in the inmate files or completed the required documents in accordance with department policy (page 100)

Observation 3 – Staff at Northeast Correctional Complex left a box containing confidential employee and inmate health information in an open area, increasing the risk of unauthorized access to confidential information (page 102)

Observation 4 – We identified concerns with medication administration practices at two CoreCivic facilities during our site visits (page 103)

Finding 13 – CoreCivic did not have an adequate procedure in place to quickly access inmate medication administration records during an outage of its new electronic medication administration system (page 106)

Observation 5 – Management should evaluate the department's process of transporting inmates' medical files and medications when inmates are transferred between correctional facilities to determine the risks to inmates when medical files and medications do not arrive at the right destination (page 108)

INMATE MEDICAL AND MENTAL HEALTH SERVICES

General Background

The Department of Correction is responsible for providing medical, mental health, dental, and vision services to inmates incarcerated in the state's correctional facilities. To provide these services, the department contracts with the following vendors to provide services at state-run correctional facilities:

- Centurion of Tennessee, LLC., for primary medical services, and
- Corizon Health for mental health services.



The department also contracts with Clinical Solutions to operate the central pharmacy, which is located at the Lois M. DeBerry Special Needs Facility and fills prescriptions for the state facilities.

CoreCivic is responsible for providing medical and mental health services to inmates housed at its four correctional facilities. CoreCivic also contracts with Clinical Solutions to fill prescriptions at its facilities.

Access to Medical Services

Both state and CoreCivic correctional facilities have established hours each day for medical staff to evaluate and treat inmates for non-emergency health issues. In addition, the department requires state and CoreCivic each facilities to provide nursing coverage, as well as an on-call physician 24 hours per day, 7 days per week. Centurion is also required to contract with specialty care providers to ensure that inmates have access to specialized services when needed. Corizon is responsible for providing access to mental health practitioners 24 hours per day, 7 days per week.

Staffing Levels

Centurion and Corizon's contracts include a staffing pattern that describes the medical and mental health staffing levels required at the department's facilities. The medical and mental health staffing levels are subject to change when the department identifies changes in needs for clinical staffing at its facilities. Each month, the vendors submit a clinical staff vacancy report to the department, which denotes each vacant position for each facility the vendor operates for the department. The reports list the dates that the positions became vacant, which the department uses to determine when to assess liquidated damages. The department requires Centurion to fill clinical vacancies within 14 days of the position's vacancy, and non-clinical positions must be filled within 30 days. The department requires Corizon to fill all vacant positions within 31 days. According to CoreCivic's contracts, it has 45 days to fill all vacant medical and mental health positions. See page 127 for information related to CoreCivic's 45-day requirement, which applies to both correctional and medical/mental health staff.

When the Centurion and Corizon do not meet staffing requirements, the department is authorized to assess liquidated damages. Under Centurion's contract, the department can assess liquidated damages of \$200 per day after 14 days per clinical vacancy, while the department is

authorized to assess damages of \$250 per day after 31 days per Corizon's vacancies. We discuss the department's assessment of liquidated damages against Centurion and Corizon later in this chapter.

Medical and Mental Health Files



the inmates:

Department policies require clinical personnel at all correctional facilities to document the medical and mental health care of inmates. The correctional facilities must maintain complete and current files on each inmate, and all documents placed within the health record must be in chronological order in the appropriate section of the file. The following documents are critical for providing and continuing care for

- a health classification summary,
- a report of physical examination,
- a health history,
- a health questionnaire,
- a Health Services Major Medical Conditions Problem List,
- a medication administration record,
- physician's orders,
- a mental health evaluation, and
- a drug screening form.

When inmates enter the department's custody, department personnel assess them based on their medical and mental health appraisals, physical examinations, and health histories. The inmates are classified as Class A, B, or C inmates for medical purposes. Class A inmates have no restrictions and need no accommodations. Class B inmates have physical or mental conditions that might limit certain capabilities. Class C inmates have serious physical or mental limitations. Department personnel document their assessments on the health classification summary, report of physical examination, and health history.

In addition, when an inmate enters a correctional facility, the health services staff must complete the health questionnaire, which serves as a medical and mental health screening tool and allows staff to document that they instructed inmates about the process to receive medical and mental health care at the facility.

When an inmate's medical and mental health diagnoses require treatment, health services staff are required (by policy) to document this information on the Health Services Major Medical Conditions Problem List.

Health services staff use physician's orders to record treatment orders, and the orders provide the basis for the inmates' prescribed medications. Treatment orders outline the steps that staff must take to provide care to inmates with conditions serious enough to warrant care.

Health services staff complete mental health evaluations for inmates who

- require mental health intervention;
- have not received prior mental health treatment while in the department's custody; or
- discontinued mental health treatment and the mental health provider has no access to the most recent evaluation.

Also, when an inmate enters the department's custody, the inmate is required to undergo a drug screening upon entering the correctional facility. The intake facility staff document the initial drug screening on the Drug Screen Consent/Refusal form, which is then included in the inmate's medical file.

Prescribing and Filling Medications



Mid-level providers⁵¹ and physicians prescribe medications to inmates and document these prescriptions on their physician's orders. Department policy requires prescriptions listed on the physician's orders to include a diagnosis and stop date before the pharmacy contractor, Clinical Solutions, fills them, and the prescribing provider must document the prescribing diagnosis in the patient record. Health services staff order the prescribed medications through the electronic Center for Innovative Pharmacy Solutions System, and Clinical Solutions fills the orders.

Each month, medical staff transcribe the information from the physician's orders onto the medication administration record, a form used to document the administration of prescribed medications. By policy, this form must include the following information:

- inmate name and number and current month and year;
- date of order and start/stop date;
- name of drug, dose or strength, and dosage form;
- route of administration (oral, intravenous, or topical);
- time interval or frequency of administration;
- duration of order and/or automatic stop order;
- attending provider (physician, dentist, etc.); and

⁵¹ Mid-level providers are clinical professionals with advanced practice training that legally authorizes them to treat inmates and prescribe medications under protocols developed by a supervising physician. Such providers include certified physician assistants; nurse practitioners; or clinical nurse specialists with a master's level of training and a certificate of fitness, or a doctorate.

- initials of the nurse who transcribed the order.

Administering Medications

Each correctional facility has its own procedures for administering medications to its inmates. Some facilities use a medication window that is open during designated times of the day when inmates can walk up to get their medications, while other facilities deliver medications to inmates within their housing units. For some medications, like controlled substances, the administering medical staff must crush and/or float the medicine in small cups of water to minimize the possibility of inmates saving the medication under their tongues for hoarding or selling. Health services staff provide other medications, like blood pressure pills, to inmates to keep in their possession for self-administration.

The medication administration record serves as the official record of when and how health services staff administered each medication to an inmate. Each time a nurse administers a medication, the nurse is required to initial the medication administration record next to each dose provided. It is essential that staff administer medications accurately (that is, the right inmate, drug, dose, time of administration, and route of administration) to meet inmates' medicinal needs.

New Electronic Medication Administration Record

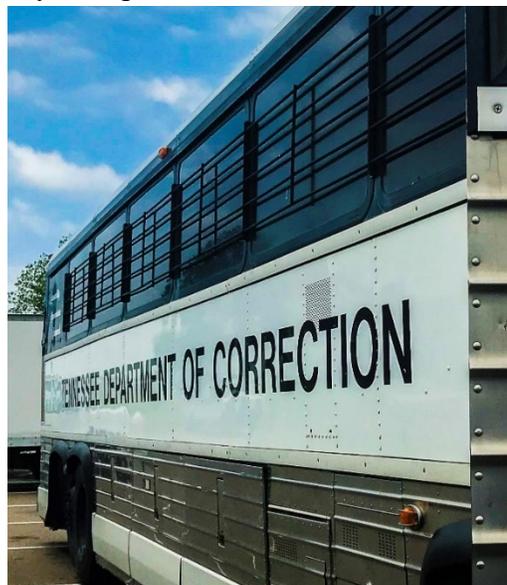
Between January and April 2019, CoreCivic gradually rolled out its new electronic Medication Administration Record System, developed by Health Care Systems, at its four Tennessee correctional facilities: Hardeman County Correctional Facility, South Central Correctional Facility, Trousdale Turner Correctional Center, and Whiteville Correctional Facility. CoreCivic worked with Clinical Solutions to host the electronic system through a virtual desktop, with the software installed on each health services computer requiring access at the CoreCivic facilities. Since the system is only accessible through a virtual desktop, it requires internet connectivity. The system uses a scanner and barcoding system to keep track of medications administered. It also interfaces with the Center for Innovative Pharmacy Solutions system to streamline the ordering of medications.

Transfer of Inmate Medical Records

Inmates can be transferred between correctional facilities either permanently or temporarily for various reasons, such as medical treatment, court dates, programming needs, or security reasons. Due to the distance between some correctional facilities, other correctional facilities serve as transit facilities, which house inmates overnight while they are being transported to the receiving facility.

According to department policy, when inmates are temporarily or permanently transferred to a new correctional facility, the inmates' individual health files transfer with them. Health services staff must coordinate with correctional facility transportation staff to ensure that health services staff prepare and package the health records for transfer with the inmates. The sending facility's health services staff must complete the following steps each time inmates and their health records leave a correctional facility:

- maintain copies of the inmate’s current medication administration record, a list of the inmate’s current medical problems, the last treatment plan note, and the most recent 48 hours of Problem Oriented Progress Records;⁵²
- complete a Transfer/Discharge Health Summary and place it in the inmate’s health record; and
- complete the Health Records/Medication Movement Document to alert the transportation official of the inmate’s special medical needs.



Health services staff package the health records and current medications in a manila envelope and tape a copy of the Health Records/Medication Movement Document to the outside of the package. Transportation staff who receive the records become responsible for ensuring the health files arrive at the final destination, and transportation and health services staff must sign the movement document to record the package’s chain of custody.

Online Sentinel Event Log

The department uses a web tool called the Online Sentinel Event Log (OSEL) to report clinical decisions requiring mediation from the central office or significant events that impact daily operations of health and behavioral health care services within the facility. These OSEL entries include, but are not limited to, medical emergencies; serious illnesses and injuries; infirmary and hospital admissions; suicide attempts; deaths; and missing medical records.

If an inmate arrives at the receiving facility without his or her health records or medication, then policy requires the receiving facility’s health services administrator to report the event in OSEL and immediately contact the sending facility to arrange for it to send the records as soon as possible.

Department’s Quarterly Monitoring

The department’s Office of Clinical Services performs quarterly monitoring at both the state and CoreCivic correctional facilities to determine whether the contractors are performing their duties in accordance with contract requirements and departmental policies. These quarterly reviews serve as the department’s main tool to assess contractor compliance. The department uses the number of findings from the reviews to calculate and assess liquidated damages against the contractors. See **Table 18** for the quarterly contract monitoring compliance rates for the six facilities we visited. In addition, see **Table 19** and **Table 20** for the department’s assessed and collected liquidated damages against Centurion and Corizon for areas of noncompliance during our audit period.

⁵² Medical personnel use Problem Oriented Progress Records to track an inmate’s medical conditions and problems.

Table 18
Quarterly Contract Monitoring Compliance Rates by Correctional Facility
For Fiscal Year 2019

Correctional Facility	Compliance Percentage (Health Services)	Compliance Percentage (Mental Health)
Trousdale Turner	18 of 29 (62%)	54 of 58 (93%)
Whiteville	18 of 26 (69%)	46 of 57 (81%)
Hardeman	23 of 27 (85%)	34 of 39 (87%)
Northwest	28 of 39 (72%)	39 of 41 (95%)
Turney Center	33 of 34 (97%)	46 of 51 (90%)
Northeast	44 of 48 (92%)	37 of 39 (95%)

Source: Auditors compiled results from the most recent quarterly monitoring reports obtained from the Department of Correction as of March 19, 2019.

Table 19
Centurion Assessed and Actual Liquidated Damages Collected
October 1, 2017, to June 30, 2019

Calendar Year	Contractual Amounts Paid by Department	Assessed Liquidated Damages	Actual Liquidated Damages Collected
October to December 2017	\$ 21,068,010.18	\$ 0	\$ 0
2018	\$ 80,353,938.67	\$ 598,600	\$92,020
January to June 2019	\$ 48,988,549.63	\$ 964,410	\$ 0
Total	\$150,410,498.48	\$1,563,020	\$92,020

Source: Data extracts from Edison, the state's accounting system, and liquidated damage assessment letters provided by the department.

Table 20
Corizon Assessed and Actual Liquidated Damages Collected
October 1, 2017, to June 30, 2019

Calendar Year	Contractual Amounts Paid by Department	Assessed Liquidated Damages	Actual Liquidated Damages Collected
October to December 2017	\$ 3,527,064.57	\$ 0	\$0
2018	\$15,262,242.68	\$377,750	\$0
January to June 2019	\$10,314,455.01	\$236,750	\$0
Total	\$29,103,762.26	\$614,500	\$0

Source: Data extracts from Edison, the state's accounting system, and liquidated damage assessment letters provided by the department.

Facility Fire and Safety Duties

Each correctional facility has a designated Fire and Safety Officer (FSO), who is responsible for compiling monthly statistics related to any accidents and injuries that occur within the facility. In order to create the monthly report, the correctional facility's medical staff provides Accident/Incident/Traumatic Injury Reports to the FSO.

The FSOs review the monthly statistics to identify any trends related to safety at the facility. For example, if multiple people fall and injure themselves in the same spot, the FSO would look for an underlying issue (such as a water leak or an uneven sidewalk) and repair it to prevent further injuries. Each FSO compiles the statistics in a spreadsheet and sends them to the department's Director of Safety Programs. The department's Safety Programs Office does not collect accident and injury statistics from any of the CoreCivic correctional facilities because CoreCivic has its own corporate procedure for tracking accidents and injuries.

Audit Results

1. Audit Objective: Did the correctional facilities adequately staff medical and behavioral health personnel to provide care for the inmates?

Conclusion: Centurion and Corizon did not meet the minimum medical and mental health staffing requirements, and the department did not adequately enforce contract requirements related to staffing medical and mental health positions. See **Finding 11**.

2. Audit Objective: Did Centurion and Corizon prepare and maintain critical medical and mental health documentation in accordance with department policy and contract requirements?

Conclusion: Based on our testwork, we determined that Centurion and Corizon did not prepare and maintain important medical and mental health documentation in accordance with department policy and contract requirements. See **Finding 12**.

3. Audit Objective: Did the department assess liquidated damages for noncompliance and collect those damages from Centurion and Corizon for identified areas of contract noncompliance?

Conclusion: We found that the department assesses liquidated damages for identified areas of contract noncompliance; however, the department does not collect the majority of assessed monetary damages due to a value-added credit system that offsets most of the damages. See **Finding 10**.

4. Audit Objective: Did the correctional facilities administer inmate medications in accordance with department policy?

Conclusion: Based on our observations of nurses administering medications at multiple correctional facilities, we identified concerns regarding the administration of medication and recording the delivery of medications to inmates at two CoreCivic facilities. See **Observation 4**.

5. Audit Objective: Is CoreCivic's new electronic medication administration record system operating effectively?

Conclusion: Based on our observations, CoreCivic did not have a backup plan in place in the event its health services staff could not access the system when its facilities lost internet connectivity. See **Finding 13**. We also found that CoreCivic staff often experienced login problems and connectivity issues. See **Observation 4**.

6. Audit Objective: Did the inmates experience delays in medical care when transferring from one correctional facility to another?

Conclusion: Although we were unable to determine if inmates experienced breaks in medical care, the department should evaluate the inmate transfer process to ensure inmate medical files are also properly transferred. See **Observation 5**.

7. Audit Objective: Did the department take proper measures to ensure that Fire and Safety Officers secured documents containing confidential health information at the correctional facilities?

Conclusion: During a walkthrough of the warehouse facility at the Northeast Correctional Complex, we found that the Fire and Safety Officer did not properly secure boxes containing Accident/Incident/Traumatic Injury Reports, which contain confidential health information related to serious injuries and illnesses. See **Observation 3**.

Finding 10 – Department management disregarded controls over statewide procurement and established its own informal procurement and payment system without proper review and approval by oversight authorities

Although the Department of Correction management had formal contracts in place for two medical service vendors, management failed to follow the state’s established contract amendment process when it decided to informally modify the contract terms involving vendor liquidated damages. Specifically, management designed and implemented a “value-added credit system” to issue credits to a vendor for performance outside the scope of its formal contract with the department. Under the modified arrangement, when the department issues credits to the vendor, the vendor is allowed to use the credits to reduce any assessed or future liquidated damages resulting from the vendor’s noncompliance with contract requirements.

We found that both medical services vendors, Centurion and Corizon, benefited from the department’s value-added credit system. Although the credit system was not authorized through proper contract amendments, the department issued each vendor credits to offset liquidated damages. The department had assessed both vendors a combined total of approximately **\$2.1 million** for contract noncompliance issues; however, by negating the damage assessments through the value-added credit system, the department **only collected damages of \$92,020 from Centurion and \$0 from Corizon** during our audit period.

Value-Added Credits and Assessed Liquidated Damages

We obtained the department's list of the vendors' self-reported efforts for which the Chief Medical Officer issued credits (see **Appendix D-1** on page 109). Based on our review of the list, we found instances where the department issued credits for areas not included in the contract; it appears the department also issued credits for existing contract requirements. Given the conditions noted in **Finding 11** related to vendor nonperformance, we question management's decision to implement the informal value-added credit system.

We sought additional clarity from staff within the state's Central Procurement Office (CPO) on both of these contracts and the related liquidated damages clause. According to CPO, Centurion's contract, which was executed in 2013 and again in 2018, has more permissive language in regard to assessing liquidated damages, allowing more flexibility for negotiations of liquidated damages. Corizon's contract, however, which was executed in 2016, is absolute and requires the vendor to pay damages through invoice adjustments. Despite the contract language differences regarding liquidated damages, CPO agreed that neither contract allows for the value-added credit system.

Management's Rationale for the Credit System

According to the department's Chief Financial Officer (CFO), the contracts between Centurion and Corizon both state that the department "may assess" liquidated damages, which he stated means *it is at the department's discretion whether to collect any damages*. Additionally, the CFO explained that sometimes the department will pursue a contract amendment, but sometimes the amendment process takes too long.

Criteria and Impact of Improper Contracts Terms and Condition

By creating new terms and conditions outside the normal contract process, management has subjected the state to the risk of financial repercussions from potential litigation, including risks associated with vendor solicitation and contract negotiations. In addition, management's modification to the liquidated damages process was not formally reviewed or approved by the state's contract oversight authorities, the Central Procurement Office, the Office of the Comptroller of the Treasury, and the Fiscal Review Committee, all of whom protect the state's interests.

According to the *Comprehensive Rules and Regulations of the Central Procurement Office*, Section 0690-03-01-.17(h), "Entire Agreement, Amendments, Modifications, Renewals or Extensions,"

All contracts subject to these Rules shall contain a provision that provides that the contract reflects the entire agreement of the parties and that there are no other prior or contemporaneous agreements that modify, supplement or contradict any of the express terms of the contract. All contracts shall further provide that any amendments, modifications, renewals or extensions to the contract shall be in writing and signed by all parties who signed the Base Contract.

Recommendation

Chief executives of each state entity should take direct responsibility for issuing, monitoring, and managing their entity's respective vendor contracts; however, they cannot operate outside the contracts' authority.

Department management should review every contract currently in place and evaluate whether management is allowing vendors to perform services outside the scope of the contract. If so, management should amend the contract immediately to include those services in the contract.

Management's Comment

Concur.

Department management interpreted language in the contract to be discretionary with regard to the implemented remedies that were done in the best interest of the department and the state.

Department management agrees that based upon the auditors' findings and interpretation of the contract, we will review all contracts currently in place and going forward amend contracts to include services if they are being performed out of scope.

Finding 11 – Centurion and Corizon did not meet contractual medical and mental health staffing levels

To determine if Centurion and Corizon complied with contractual staffing levels, we selected a nonstatistical, random sample of five months within the audit period at the three state-managed correctional facilities we visited.

See the full methodology in Appendix D-5 on page 120.

Based on our analysis of the five monthly clinical staffing reports that we obtained and reviewed for Northwest Correctional Complex, Turney Center Industrial Complex, and Northeast Correctional Complex, we determined that Centurion and Corizon did not meet the medical and mental health staffing requirements outlined in their respective contracts. Specifically, Centurion and Corizon did not always fill vacancies within the required timeframe.⁵³ (See **Tables 20-25** in **Appendix D-2** on page 113.) The vendors' staff at the facilities are working a considerable number of overtime hours to cover for these vacant positions. See **Table 21** for an example of total overtime hours for the five months selected at the three correctional facilities.

⁵³ The department assessed Centurion and Corizon liquidated damages for contract noncompliance; however, the department allowed for an informal value-added credit system, which offset the liquidated damages assessments. See **Finding 10** for details.

Table 21
Number of Overtime Hours Per Facility⁵⁴ Per Month⁵⁵

Facility	Month 1	Month 2	Month 3	Month 4	Month 5
Northeast	177.37	106.58	164.87	196.75	196.00
Turney Center	214.27	320.25	365.50	492.25	366.50
Northwest	594.75	481.65	642.00	895.00	625.75

Source: Monthly medical timesheet documentation for Northeast Correctional Complex, Turney Center Industrial Complex, and Northwest Correctional Complex obtained from the Department of Correction.

According to the contract, Centurion is “responsible for adequate staffing at each State facility.” Corizon’s contract states that it will also “provide adequate and qualified staff to fulfill its obligations.” Even though Centurion’s contract provides for 14 days to fill clinical vacancies, we found that the department allows Centurion 30 days due to the difficulties in advertising the vacancies, holding interviews, and completing the hiring process; however, this allowance is not listed as a provision of the contract. Corizon’s contract states that all vacancies should be filled within 31 days, its normal contract requirement. For our analysis of clinical staffing reports, see **Appendix D-2** on page 113.

According to management, the contractors experienced challenges in hiring staff, particularly behavioral health staff, because professionals have to move to rural areas where the facilities are located. Management stated that this is a nationwide clinical problem and is not limited to the correctional field.

We could not determine if inmates suffered from lack of care, but potential risks exist if facilities do not have adequate medical and mental health staff. Inmates could remain untreated or could be treated by overworked, overly tired personnel who have to work long hours due to vacancies.

Recommendation

The department should work with Centurion and Corizon to develop and enhance recruiting of medical and mental health professionals to staff these positions at the correctional facilities.

Management’s Comment

Concur.

Staff shortages exist; however, there was no determination that inmate care suffered as a result. The “positions” that were vacant did not go unfilled. For the most part, shifts were covered and the services were provided. In any cases where the shifts were not covered, liquidated damages were calculated.

⁵⁴ Based on the total number of overtime hours reported in Centurion’s timesheet documentation.

⁵⁵ Months referenced in the table are the months listed in the respective correctional facility’s table in **Appendix D-2** on page 113. For example, at Northeast, we analyzed staffing for the months of March, April, July, November, and December 2018.

Also, many of the things mentioned in the recommendation are things the agency already does. Standing meetings where staffing is discussed are held regularly and frequently, at least four times per month with our vendor partners. We meet with Centurion, on a bi-weekly basis (twice per month) and CoreCivic and Corizon on a monthly basis (once per month).

The focus of these meetings is committed to staffing, specifically to identify strategies to review, augment and improve staffing and personnel resources. Staffing resources, techniques and strategies are discussed and developed.

At each of these meetings we review vacancies and collaborate with the vendor to develop innovative strategies to enhance recruitment and retention and other techniques to attract the best and the brightest medical providers are developed and discussed.

It is important to recognize that the staffing challenges we encounter are not solely a contractual compliance challenge or a correctional health care problem. Hiring sufficient staff, both medical and security, to work in a correctional setting is in fact a statewide as well as a national challenge.

According to the Tennessee Board of Nursing Statistics, RNs not practicing in the target counties range from 3 to 7%, likewise the percent of LPNs not practicing ranges from 3 to 7%. “A 2019 report released by Nursing Solutions, Inc. estimated the shortage of registered nurses will reach 1.13 million by 2024. The U.S. Health Resources and Service Administration projected Tennessee will only be able to meet half of the demand for registered nurses by next year.”

The department will continue to work with Centurion and Corizon to develop and enhance recruiting of medical and mental health professionals to staff positions at the correctional facilities.

Finding 12 – CoreCivic and state-managed correctional facilities did not ensure that staff placed the required medical and mental health documents in the inmate files or completed the required documents in accordance with department policy

To determine if the inmates’ medical files have the required medical and mental health documentation as required by policy, we tested a nonstatistical, random sample of 294 inmates from a total population of 726 inmates who were likely to have documented medical and mental health conditions at the six correctional facilities we visited from April 2019 through June 2019.

For the full methodology, including the breakdown of the population and sample sizes for each correctional facility we visited, see Appendix D-5 on page 120.

Based on our review of the sample of inmate medical files, we found instances where health services staff did not file medical and mental health documentation as required or did not complete the documentation in accordance with Department of Correction policy. We performed testwork during site visits at six correctional facilities (three state-managed and three CoreCivic-operated), and we found numerous instances of noncompliance. Specifically, we noted the following:

- medical staff did not always include key information on the medical administration records;
- medical staff did not always include initial drug screenings in the medical files;
- we could not locate physical and mental health exams in all medical files we reviewed;
- we could not locate mental health evaluations for all inmates with documented mental health conditions in our sample;
- medical staff did not always include physician’s orders in patient files;
- we could not locate mental health treatment plans for all inmates with documented mental health conditions in our sample; and
- we could not locate health classification summaries in all medical files we reviewed.

See **Chart 22** for a summary of our testwork results. The detail of noncompliance for incident reporting is located on **Appendix D-4** on page 118.

Chart 22
Number of Errors by Noncompliance Type and Correctional Facility

	Correctional Facilities					
	Whiteville	Trousdale Turner	Hardeman	Northwest	Turney Center	Northeast
Missing Key Information in Medical Administration Records	13	13	17	19	14	6
Missing Initial Drug Screenings	21	1	9	14	21	10
Missing Physical and Mental Health Exams	3	-	6	-	-	-
Missing Mental Health Evaluations	7	-	4	2	-	2
Missing Physician’s Orders for Medications	-	-	3	-	-	-
Missing Mental Health Treatment Plans	-	-	3	-	-	-
Missing Health Classification Forms	-	-	-	-	2	-

Source: Auditor testwork results.

According to management, the missing or incomplete medical information is likely a result of human error and staff not following departmental policies related to documentation of medical and mental health assessments and treatment plans. We could not determine if patients did not receive care; however, not ensuring that health services staff properly document inmate medical and mental health assessments and treatment plans, including prescriptions, increases the risk that inmates

- will not receive the appropriate medical and mental healthcare treatment or services;
- will not receive appropriate prescriptions to achieve the desired therapeutic effect; and
- could potentially hurt themselves, other inmates, and staff if ailments are left untreated.

Recommendation

Department management should immediately review its training of all staff responsible for medical administration and its monitoring of vendors who provide medical and mental health services at its facilities to ensure that the medication administration records contain documentation required by the department. Furthermore, the department should review all inmate medical files to ensure they are accurate and complete.

Given the issues identified, the department should evaluate its risk assessment and include additional controls or process changes to reduce the likelihood of accidental medical injuries to inmates under its care.

Management's Comment

Concur.

The Department has an old and cumbersome paper health records system. So it is true that required medical and mental health documents were not always in the inmate files or that staff had not always completed the required documents in accordance with department policy. Therefore, it is a top priority for our agency to transition from paper to electronic medical records to keep pace with healthcare industry standards.

Department management will also review its training of all staff responsible for medical administration and its monitoring of vendors who provide medical and mental health services at its facilities to ensure that the medication administration records contain documentation required by the department.

Observation 3 – Staff at Northeast Correctional Complex left a box containing confidential employee and inmate health information in an open area, increasing the risk of unauthorized access to confidential information

While performing a walkthrough of Northeast Correctional Complex's warehouse on June 11, 2019, we observed a large box of paperwork in an open area. While looking through the boxes, we found various facility-related documentation, including Accident/Incident/Traumatic Injury Reports, which contain protected health information, for both inmates and employees from October 2017 through December 2018. Furthermore, we observed two correctional officers in and around the warehouse area who could have accessed the files. According to the prison's Fire and Safety Officer, she placed the boxes in the warehouse from approximately December 2018 to June 11, 2019, to make more storage space in her office. She intended to send the boxes to the records

section of the warehouse but had not at this point. After we brought the issue to her attention, she moved the boxes to her office and secured them behind a locked door.

The department's Policy 113-52, "Release of Protected Health Information," states that the protected health information of any inmate is confidential and should only be used, shared, or disclosed in accordance with policy. It also states that

any employee who possesses confidential information in his/her office shall lock office doors and/or filing cabinets that contain protected health information. No information of this nature shall be stored in general view in any location within the facility. An employee shall report any suspected tampering of files to his/her immediate supervisor.

By not properly securing confidential documents, management increases its risk that confidential health information and sensitive incident-related details could be seen by staff or inmates. The Accident/Incident/Traumatic Injury Reports contain incident witness statements, increasing the risk of inmate retaliation if inmates see these reports. Furthermore, because some documents contained health information, there is an increased risk of potential violations of the federal Health Insurance Portability and Accountability Act.⁵⁶

Department of Correction and correctional facility management should ensure that all sensitive records are properly secured to prevent unauthorized access by facility staff or inmates.

Observation 4 – We identified concerns with medication administration practices at two CoreCivic facilities during our site visits

The Department of Correction's Policy 113.71, "Administration/Distribution of Medication," requires the following procedures when distributing medications to promote the safe management of pharmaceuticals consistent with legal and professional standards of care:

- The medication administration record is to be used as a permanent record of medication administered/distributed to an inmate. Upon administration or distribution of a prescribed medication, all pertinent information shall be recorded on the medication administration record.
- Nursing personnel shall verify that they have the right inmate, drug, dose, time of administration, and route of administration before administering/distributing a medication.
- Certain medications, like those ordered to treat mental health disorders, require direct observation therapy, which means face-to-face observation and monitoring by a qualified health professional of an inmate taking their medications.

⁵⁶ The federal Health Insurance Portability and Accountability Act requires health care providers and health care insurers to maintain the privacy and security of individually identifiable health information.

- All psychotropic drugs, controlled medications, [tuberculosis] prophylaxis/treatment medication, and drugs requiring parenteral administration are to be administered only on a dose by dose basis crushed, and under water, unless directed otherwise by the provider.
- If a medication is not administered, the nurse shall enter the appropriate code in accordance with the legend indicated on the approved medication administration record(s).

The department's policy does not explicitly outline physical safety requirements regarding medication administration; however, according to Paragraph 10.03 of the *U.S. Government Accountability Office's Standards on Internal Controls*, which serves as best practice for states,

Management designs appropriate types of control activities for the entity's internal control system. Control activities help management fulfill responsibilities and address identified risk responses in the internal control system.

The same section also lists physical control over vulnerable assets as a common control activity category, suggesting that "Management establishes physical control to secure and safeguard vulnerable assets."

During our visits to correctional facilities, we observed nurses administering medications at Hardeman County Correctional Facility, Trousdale Turner Correctional Center, Northeast Correctional Complex, Northwest Correctional Complex, and Turney Center Industrial Complex. Based on our observations, we identified the following medication administration concerns at two of the CoreCivic facilities.

Hardeman

- Nurses were repeatedly and unexpectedly logged out of the new electronic medication administration records system (eMARs) and/or experienced login difficulties, which could impact the nurses' ability to record information regarding medication distribution or administration.
- The electronic medication administration records, which nurses use to administer medication, did not always print correctly for the nurses; reports had intermittent blanks rather than the department-defined codes showing that the inmate took or did not take the medication; reports were missing KOP⁵⁷ information; reports were missing medication start and stop dates; and reports printed with undefined codes.
- Although department policy requires "face-to-face observation and monitoring by a qualified health professional of an inmate taking their medication," we observed nurses relying on correctional officers to ensure inmates swallowed their medications before leaving the clinic rather than the nurses ensuring inmates swallowed their pills.

⁵⁷ KOP stands for keep on person, which is medication that inmates are allowed to keep in their cells rather than having to obtain it from the nurse each day.

- Nurses apparently double-scanned some medications into eMARs in an attempt to get caught up with scanning medications that had been administered earlier in the day. Facility staff told us that the nurses were delayed in entering medication data due to a system outage earlier in the day and had to perform duplicate scans when the system was available. While we could not determine if this resulted in inmates not receiving medications, management must ensure that it implements proper controls to reduce the risk of inmates not receiving medications or receiving duplicate doses due to system outages.

Trousdale Turner

- Nurses informed us that they had difficulties logging into eMARs and often lost connectivity to the system, which could result in medication distribution/administration information going unrecorded.
- The medication administration reports did not print correctly; reports had intermittent blanks rather than the department-defined codes showing that the inmate took or did not take the medication; reports were missing medication start and stop dates; and reports printed with undefined codes.
- One nurse told us that she was administering psychotropic medications and/or controlled substances, but we did not observe her crush or float any of the medications as required by policy.
- We observed three inmates walk away with their medications without waiting for a nurse to watch them swallow even though policy requires “face-to-face observation and monitoring by a qualified health professional of an inmate taking their medication.”
- As nurses were administering medications to a pod, several inmates entered the common area of the unit and were allowed to stand very close to the medication cart behind the nurses as they administered medications, posing a potential risk to the security and safety of nursing staff and medications. While department policy does not explicitly outline physical safety requirements for staff who administer medications, management has a responsibility to establish physical controls to secure and safeguard vulnerable assets, including both the medical staff and the medications.

CoreCivic’s Regional Health Services Director indicated that nurses experienced login and intermittent connectivity issues with the new eMARs system because only 25 users across all 4 CoreCivic-managed facilities could log in to the virtual desktop concurrently. If nurses did not log out when not actively using the system, nurses attempting to access eMARs might not be able to log in to the system. Additionally, the department’s Associate Director of Medical Services indicated that poor internet speeds could also cause some of the system connectivity issues. The department’s Chief Medical Officer stated that because eMARs is so new, CoreCivic is working through the bugs, but it intends to perfect the system at the CoreCivic facilities and eventually transition to using it at the department-managed facilities.

The department's Chief Medical Officer indicated that some of the problems could be due to turnover and lack of refresher training. The effects of poor physical controls surrounding the administration of medications are wide-ranging and include increased risks of

- physical harm to nurses, officers, and inmates;
- inmates stealing pills;
- inmates not taking critical medications; and
- inmates trading or selling pills.

The Chief Medical Officer should ensure that health services staff distribute medication to inmates in accordance with department policy and medical industry standards to ensure that inmates receive their medications in a safe, controlled environment. The department should continually provide training to health services staff at the correctional facilities to ensure that knowledge is not lost when there are periods of high turnover.

Finding 13 – CoreCivic did not have an adequate procedure in place to quickly access inmate medication administration records during an unexpected outage of its new electronic medication administration system

During our visit to Hardeman County Correctional Facility on May 14, 2019, the facility experienced a localized internet outage that affected the ability of staff at both Hardeman County and Whiteville health services to log in to the electronic medication administration records system (eMARs) to obtain records. The outage lasted from approximately 7:00 a.m. to 1:00 p.m.; as a result, staff could not quickly identify inmates who needed morning medications. To obtain the medication records during the outage, CoreCivic's Regional Health Services Director emailed the records from a remote site to the Department of Correction's onsite contract monitor, who used his personal cellular Wi-Fi device to access email and print the records.

Based on our real-time observations during the internet outage and review of the instructions provided by the Regional Health Services Director, we found that CoreCivic had a procedure in place for a nurse at each facility to save a nightly backup of inmates' medication administration records onto one designated desktop so the facility would be able to access and print the files in the event staff could not access eMARs. This procedure, however, did not take into consideration that new users who had never logged in to the desktop would not be able to log into it. Only three users had the ability to log into the desktop to retrieve the backup, and none of those individuals were onsite the day of the outage.

According to Critical Element CP-2, "Take Steps to Prevent and Minimize Potential Damage and Interruption," of the U.S. Government Accountability Office's *Federal Information System Control Audit Manual* (FISCAM),⁵⁸

⁵⁸ FISCAM provides a methodology for performing information system control audits in accordance with generally accepted government auditing standards.

File backup procedures should be designed so that a recent copy is always available. . . . Staff should be trained in and aware of their responsibilities in preventing, mitigating, and responding to emergency situations.

Additionally, FISCAM Critical Element CP-3, “Develop and Document a Comprehensive Contingency Plan,” states,

A contingency plan or suite of related plans should be developed for restoring critical applications; this includes arrangements for alternative processing facilities in case the usual facilities are significantly damaged or cannot be accessed. Agency/entity-level policies and procedures define the contingency planning process and documentation requirements. Furthermore, an entity wide plan should identify critical systems, applications, and any subordinate or related plans. It is important that these plans be clearly documented, communicated to affected staff, and updated to reflect current operations. . . . In addition, the plan should address entity systems maintained by a contractor or other entity (e.g., through service level agreements).

CoreCivic’s Regional Health Services Director stated that eMARs is brand new, and CoreCivic had not anticipated all the scenarios that could go wrong during an internet outage. Not having an adequate plan in place to retrieve inmate medication administration records during a system outage increases the risk that inmates may not receive their prescribed medications. During our audit fieldwork, the department’s Director of Contract Monitoring for CoreCivic facilities provided us documentation that showed CoreCivic created a new, formal disaster recovery plan for eMARs on July 1, 2019.

Recommendation

In the event of an internet outage, natural disaster, or other event that may prevent users from accessing electronic copies of inmates’ medication administration records, the department should be able to ensure that the right inmate gets the right medication at the right time. The department should ensure that CoreCivic facilities follow and test their new disaster recovery process for saving and retrieving emergency medication administration records.

Management’s Comment

Concur.

Department agrees with the audit recommendation and is requiring a revision to the individual CoreCivic Institution’s Emergency Operations Plan, Policy #506.20, Section VI.(D)(4), “Emergency Medical Services Plan,” to include the new disaster recovery process for saving and retrieving EMR records that contain site specific information. This plan will be tested in accordance with policy #506.20 and be added to contract monitoring and exam instruments to ensure the framework of the procedure is in place to respond in the event of an emergency internet outage.

Observation 5 – Management should evaluate the department’s process of transporting inmates’ medical files and medications when inmates are transferred between correctional facilities to determine the risks to inmates when medical files and medications do not arrive at the right destination

While performing testwork at Northwest Correctional Complex during the week of May 20, 2019, health services staff could not find an inmate’s medical file that we requested for our testwork. We found that the file was missing from April 14, 2019, until May 23, 2019. According to the facility’s Health Services Administrator, this inmate had a chronic health condition and had to be admitted to Nashville General Hospital. As a standard procedure, when inmates are admitted into Nashville area hospitals, the facility’s health services staff temporarily transfer the inmates’ medical files to the Lois M. DeBerry Special Needs Facility. In this instance, due to a miscommunication, when the hospital discharged the inmate, staff at Lois M. DeBerry did not transfer the inmate’s file back to Northwest.

To determine whether correctional facilities experienced delays in receiving inmate medications or medical files, we reviewed all of the entries in the Online Sentinel Event Log (OSEL) from October 1, 2017, to June 30, 2019. We identified approximately 800 instances where facility health services staff made an entry in OSEL when inmates arrived at a receiving institution without all of their medications; medical paperwork (such as medication administration records); and/or medical files. We found, however, that the information in OSEL is limited because health services staff do not always enter the name of the sending facility or update the entry when they actually receive inmates’ medical information. Furthermore, we observed that correctional facilities’ health services staff took alternative steps, such as creating temporary medical files and contacting the central pharmacy or the prior facility’s staff, to obtain the necessary information in order to serve the inmates.

Although we were unable to determine if inmates experienced a break in medical care due to the lack of medical files, management should evaluate the entire process, identify risks to inmates, and develop controls to mitigate those risks.

**Appendix D
Inmate Medical and Mental Health Services**

**Appendix D-1
Department’s Assessed Liquidated Damages and Offsetting Value-Added Credits for
Centurion and Corizon**

**Excerpts From Department-Provided Exhibit of Centurion’s Liquidated Damages
Applied to Value-Added Services
(Unaudited)**

Value Added Services –Centurion

<p>1. TPFW restructuring of staffing – comprehensive evaluation of staffing patterns based on significant increases in diagnostic intakes (avg. 5-10 per week to 50-75 per week) and establishment of a new intake housing unit requiring in-unit health services delivery TPFW required additional staffing resources. Staffed the unit above contract matrix more than one year. Also two CNTs for ADL care.</p> <p>2. TPFW Support during restructure - staff were secured from other sites and required bonus pay in addition to housing to support the mission during the review and restructuring phase to ensure care delivery</p>	<p style="text-align: center;">2.0 FTEs LPN Intake 2.0 CNTs Infirmery care 2.8 FTES LPN Housing unit (represents 7 day/week;2 shifts per day)</p> <p style="text-align: center;">Implemented in Fall 2016</p>	<p style="text-align: right;">\$121,002 \$76,760 \$169,403 ST:\$367,166</p> <p style="text-align: center;">Estimated additional cost \$225,000</p> <p style="text-align: right;">\$592,166</p>
<p>3. DSNF – added .5 MD FTE to meet newly identified patient care needs for extended hours to evaluate hospital returns and transfers from other facilities on afternoon chain</p>	<p style="text-align: center;">Implemented in Fall 2016</p>	<p style="text-align: right;">\$114,978</p>
<p>4. PTRAX secured and enhanced scheduling system for on-site patient scheduling; eliminating paper ‘appointment book’ system previously utilized. System auto generates inmate passes to match TDOC controlled movement passes and Master call out. Off-site scheduling component added to track specialist care. Infirmery bed management added.</p>		<p style="text-align: right;">\$220,075</p>

<p>7. <u>Envolv/Nurtur</u> – Centene implemented in the correctional setting a telephonic health coaching program comparable to those used with community patients. Initial patient population consisted of diabetics but patients with CAD (cardiac) have been added. Patients receive monitored calls from a health coach specializing in a specific area of need such as diet or exercise. Review of patient lab results indicates an average decrease in <u>HgA1c</u> of 2 points for diabetic patients.</p>	<p>Implemented 2014</p>	<p>\$146,305</p>
<p>8. <u>RubiconMD</u> – remote consultation of specialist by provider. Indirect telehealth visit reduces need to send patient off-site or allows for specific, directed care</p>		<p>\$30,000</p>
<p>9. No Rate Increase received 9/1/17 – See email sent October 3rd, 2019 for explanation</p>		<p>\$850,000</p>
<p>Total</p>		<p>\$2,043,524</p>

**Excerpt From Department-Provided Exhibit of Corizon's Liquidated Damages Applied to Value-Added Services
(Unaudited)**

TN BHS Out of Scope items					
ITEM	Description of SERVICE	Hours	Cost	Expenses	Total
Specialized treatment treatment groups as part of the development of the new curriculum for the sex offender program. Each individual that was enrolled in the SOTP program was reviewed for selection into the new programming. The treatment team is made up of a psychologist, specialized therapist, and LCSW. All individual were deemed appropriate for continuing in the SOTP. Treatment Team groups within the Sex Offender Program	Additional treatment teams were administered with the Sex Offender Program to assist in the transition of individuals from the program to the living outside the incarcerated environment and transitioning to housing placement if required.	31	\$45.00	\$0.00	\$1,395.00
in response to the Public Safety Act of 2016, TDOC enhanced the Sex Offender Treatment Program to ensure program was evidenced based. In addition, the program was enhanced to include curriculum considered best practice for treating sex offenders. Modification of Sex Offender Program Reg. Dir	TDOC requested the SOTP be reviewed and revised to reflect the most updated treatment for sex offenders in a correctional setting. The program selected was the Jill Stinson Model. The regional manager was responsible for researching and implementing the new programming. The regional manager trained the facilitators in the model and designed the program.	200	\$85.00	\$0.00	\$17,000.00
A recreational therapist was assigned an addtionnal duty of providing recreational activities to the operational staff. This was to support the staff working extended shifts and boarding between shifts. Recreation Therapist services to non-MH Health Program	DeBerry Special Needs Facility requested that the vendor have the recreational therapists provide various activities for the staff working double shifts. The staff was required to board between shifts and the activities provided stress relief to the taxed staff. This is essential given the time the Correctional Officers were spending on the job/overtime and to assist in maintaining grounded mental health.	500	\$45.00	\$0.00	\$22,500.00

<p>A comprehensive, integrated, systematic and multi-tactic crisis intervention approach to manage critical stress after traumatic events for all employees, under the umbrella of the Tennessee Public Safety Network (TPSN), a non profit agency providing critical incident stress debriefings statewide. CISM Training</p>	<p>TDOC requested to have the vendor provide staff to participate in the CISM training and be part of the CISM. Trainings are conducted annually and a refresher class is offered annually to have individuals trained for Critical Incidents. A licenesed mental health provider is required to be part of the formal debriefings. Corizon sends five to six individuals to be part of the team and trainings. This paramount as staff is exposed to trauamatic events and can develop trauma like symptoms. This can render staff ill or ineffective if they are not supported appropriately. The team was deployed for the murder of Debra Johnson and subsequent escape of the assailant which occurred during the audit and delayed some of our responses to you, the multiple executions at RMSI over the last 2 years, and for any event that may negatively impact our staff.</p>	320	\$75.00	\$2,000.00	\$26,000.00
<p>A comprehensive, integrated, systematic and multi-tactic crisis interveention approach to manage critical stress after traumatic events for all employees, under the umbrella of the Tennessee Public Safety Network (TPSN), a non profit agency providing critical incident stress debriefings statewide. CISM Training CISM (Cummings)</p>	<p>TDOC requested to send a psychologist to Sumner County to help those Probation officers who were involved with Mr. Cummings. Mr. Cummings was arrested in a high profile mass murder event in which he was the alleged suspect in eight murders.</p>	60	\$75.00	\$100.00	\$4,600.00
<p>TDOC has established and opened two of three housing untis for for veterans to be housed together. The inmates will receive programming and specialized case management. The program began in spring 2019. Housing Training (Vet and Recovery)</p>	<p>TDOC requested the vendor to provide training to the staff that will be involved in the veteran's program. The training was conducted by a LADAC and covered areas of substance abuse with the veteran population. The programs are at BCCX and TCIX. A program will be developed at NWCX.</p>	120	\$65.00	\$500.00	\$8,300.00
<p>Total</p>					\$820,605.00

Appendix D-2
Analysis of Monthly Clinical Staffing Reports for Centurion and Corizon
By State-Managed Correctional Facility

Tables 23, 24, and 25 provide an overview of the facility vacancies under the Centurion contract.

Table 23
Northeast Correctional Complex Vacancies (Centurion)⁵⁹

	March 2018	April 2018	July 2018	November 2018	December 2018
Contract FTE ⁶⁰	51.20	51.20	51.20	51.20	51.20
FTE Filled	50.20	50.20	51.20	49.20	47.20
FTE Vacancies	1.00	1.00	0.00	2.00	4.00
% of FTE Positions Filled	98.0%	98.0%	100.0%	96.1%	92.2%
% of FTE Positions Vacant	2.0%	2.0%	0.0%	3.9%	7.8%
Missed Hours per Week Due to Vacancies	40	40	0	80	160
# of Inmates ⁶¹	1,755	1,785	1,750	1,692	1,693
# of Licensed Practical Nurses (LPNs)	21.60	21.60	21.60	21.60	21.60
# of Registered Nurses (RNs)	11.60	11.60	12.60	11.60	10.60
Inmates per LPN	81.25	82.64	81.02	78.33	78.38
Inmates per RN	151.29	153.88	138.89	145.86	159.72

Source: Monthly medical timesheet documentation and staffing matrices for Northeast Correctional Complex obtained from the Department of Correction.

Table 24
Turney Center Industrial Complex Vacancies⁶² (Centurion)

	October 2017	February 2018	June 2018	July 2018	August 2018
Contract FTE	46.40	46.40	46.40	47.80	47.80
FTE Filled	44.40	44.40	43.40	43.40	46.00
FTE Vacancies	2.00	2.00	3.00	4.40	1.80
% of FTE Positions Filled	95.7%	95.7%	93.5%	90.8%	96.2%
% of FTE Positions Vacant	4.3%	4.3%	6.5%	9.2%	3.8%
Missed Hours per Week Due to Vacancies	80	80	120	176	72
# of Inmates	1,625	1,546	1,606	1,604	1,604
# of LPNs	16.80	16.80	15.80	15.80	17.40

⁵⁹Includes the main site in Johnson County and the annex in Carter County.

⁶⁰ FTE stands for full-time equivalent. It equals a unit that indicates the employed person's workload. An FTE of 1.0 is equal to one full-time employee, while an FTE of 0.5 equals half the workload of a full-time employee.

⁶¹ Based on the number of inmates listed at the facility for the month in the department's Bed Space Report.

⁶² Includes the main site in Hickman County and the annex in Wayne County.

	October 2017	February 2018	June 2018	July 2018	August 2018
# of RNs	9.40	10.40	10.40	10.40	10.40
Inmates per LPN	96.73	92.02	101.65	101.52	92.18
Inmates per RN	172.87	148.65	154.42	154.23	154.23

Source: Monthly medical timesheet documentation and staffing matrices for Turney Center Industrial Complex obtained from the Department of Correction.

Table 25
Northwest Correctional Complex Vacancies (Centurion)

	January 2018	May 2018	July 2018	September 2018	January 2019
Contract FTE	62.70	62.70	68.00	68.00	68.00
FTE Filled	53.30	56.50	61.50	63.30	60.10
FTE Vacancies	9.40	6.20	6.50	4.70	7.90
% of FTE Positions Filled	85.0%	90.1%	90.4%	93.1%	88.4%
% of FTE Positions Vacant	15.0%	9.9%	9.6%	6.9%	11.6%
Missed Hours per Week Due to Vacancies	376	248	260	188	316
# of Inmates	2,319	2,354	2,342	2,362	2,008
# of LPNs	21.20	21.20	24.00	25.40	25.00
# of RNs	9.4	12.6	12.8	14.60	10.8
Inmates per LPN	109.39	111.04	97.58	92.99	80.32
Inmates per RN	246.70	186.83	182.97	161.78	185.93

Source: Monthly medical timesheet documentation and staffing matrices for Northwest Correctional Complex obtained from the Department of Correction.

Tables 26, 27, and 28 provide an overview of the hours missed each month for behavioral health employees under Corizon's responsibility. It is important to note that although Corizon provides the service, it uses a number of state-employed clinical staff who have continued to work at the state-run facilities. In the event the state employees end state service, Corizon will assume the responsibility to fill the vacancy as stated in the contract.

Table 26
Northeast Correctional Complex Analysis (Corizon)⁶³

	March 2018	April 2018	July 2018	November 2018	December 2018
Required Hours	2,279.20	2,175.60	2,279.20	2,103.20	2,175.60
Worked Hours	1,772.00	1,560.75	1,957.75	1,672.25	1,750.75
Missed Hours	507.20	614.85	321.45	430.95	424.85
Missed 8-hour Days	63.40	76.86	40.18	53.87	53.11
Percentage of Hours Worked	78%	72%	86%	80%	80%
Percentage of Hours Missed	22%	28%	14%	20%	20%

⁶³Includes the main site in Johnson County and the annex in Carter County.

	March 2018	April 2018	July 2018	November 2018	December 2018
Positions Required	16	16	16	15	15
Positions Filled	16	14	15	13	14
Positions Vacant	0	2	1	2	1

Source: Monthly behavioral health timesheet documentation and staffing matrices for Northeast Correctional Complex obtained from the Department of Correction.

Table 27
Turney Center Industrial Complex Analysis (Corizon)⁶⁴

	October 2017	February 2018	June 2018	July 2018	August 2018
Required Hours	2,235.20	2,032.00	2,301.60	2,235.20	2,520.80
Worked Hours	1,894.75	1,522.50	2,089.00	2,058.25	2,202.50
Missed Hours	340.45	509.50	212.60	176.95	318.30
Missed 8-hour Days	42.56	63.69	26.58	22.12	39.79
Percentage of Hours Worked	85%	75%	91%	92%	87%
Percentage of Hours Missed	15%	25%	9%	8%	13%
Positions Required	16	15	16	15	15
Positions Filled	15	14	16	15	15
Positions Vacant	1	1	0	0	0

Source: Monthly behavioral health timesheet documentation and staffing matrices for Turney Center Industrial Complex obtained from the Department of Correction.

Table 28
Northwest Correctional Complex Analysis (Corizon)

	January 2018	May 2018	July 2018	September 2018	January 2019
Required Hours	3,256.80	3,256.80	2,763.20	2,672.00	2,888.80
Worked Hours	2,639.48	2,549.25	2,374.50	2,328.00	2,458.00
Missed Hours	617.32	707.55	388.70	344.00	430.80
Missed 8-hour Days	77.17	88.44	48.59	43.00	53.85
Percentage of Hours Worked	81%	78%	86%	87%	85%
Percentage of Hours Missed	19%	22%	14%	13%	15%
Positions Required	21	19	20	21	20
Positions Filled	21	19	19	20	19
Positions Vacant	0	0	1	1	1

Source: Monthly behavioral health timesheet documentation and staffing matrices for Northwest Correctional Complex obtained from the Department of Correction.

⁶⁴Includes the main site in Hickman County and the annex in Wayne County.

Appendix D-3
Analysis of Monthly Clinical Staffing Reports for CoreCivic-Managed
Correctional Facilities

Table 29
Whiteville Correctional Facility Vacancies (CoreCivic)

	November 2017	March 2018	August 2018	September 2018	December 2018
Contract FTE	25.85	25.85	26.05	28.25	25.50
FTE Filled	16.05	17.05	24.25	27.25	25.50
FTE Vacancies	9.80	8.80	1.80	1.00	0.00
% of FTE Positions Filled	62.1%	66.0%	93.1%	96.5%	100.0%
% of FTE Positions Vacant	37.9%	34.0%	6.9%	3.5%	0.0%
Missed Hours per Week Due to Vacancies	392	352	72	40	0
# of Inmates	1,499	1,510	1,527	1,518	1,501
# of LPNs	4	9	10	10	9
# of RNs	2	6	5	7	6
Inmates per LPN	374.75	167.78	152.70	151.80	166.78
Inmates per RN	749.50	251.67	305.40	216.86	250.17

Source: Monthly medical and behavioral health staffing documentation for Whiteville Correctional Facility obtained from the Department of Correction.

Table 30
Hardeman County Correctional Facility Vacancies (CoreCivic)

	September 2018	October 2018	November 2018	March 2019	April 2019
Contract FTE	37.05	37.05	36.05	31.15	31.05
FTE Filled	35.15	36.05	36.15	36.15	36.15
FTE Vacancies	1.90	1.00	-0.10	-5.00	-5.10
% of FTE Positions Filled	94.9%	97.3%	100.3%	116.1%	116.4%
% of FTE Positions Vacant	5.1%	2.7%	-0.3%	-16.1%	-16.4%
Missed hours per Week Due to Vacancies	76	40	-4	-200	-204
# of Inmates	1,998	1,983	1,989	1,977	1,976
# of LPN	13	13	13	13	13
# of RN	8	9	9	9	9
Inmates per LPN	153.69	152.54	153.00	152.08	152.00
Inmates per RN	249.75	220.33	221.00	219.67	219.56

Source: Monthly medical and behavioral health staffing documentation for Hardeman County Correctional Facility obtained from the Department of Correction.

**Table 31
Trousdale Turner Correctional Center Vacancies (CoreCivic)**

	June 2018	July 2018	August 2018	November 2018	December 2018
Contract FTE	45.91	45.91	49.93	51.83	51.83
FTE Filled	45.63	45.63	52.88	49.28	51.28
FTE Contract Vacancies	0.28	0.28	-2.95	2.55	0.55
% of FTE Contract Positions Filled	99.4%	99.4%	105.9%	95.1%	98.9%
% of FTE Positions Vacant	0.6%	0.6%	-5.9%	4.9%	1.1%
Missed Hours per Week Due to Vacancies	11.2	11.2	-118	102	22
# of Inmates	2,552	2,549	2,549	2,507	2,523
# of LPNs	15	15	20	16	19
# of RNs	10.28	10.28	11.28	11.28	10.28
Inmates per LPN	170.13	169.93	127.45	156.69	132.79
Inmates per RN	248.25	247.96	225.98	222.25	245.43

Source: Monthly medical and behavioral health staffing documentation for Trousdale Turner Correctional Center obtained from the Department of Correction.

Appendix D-4
Detailed List of Errors Found in Inmate Medical File Review by Correctional Facility

At Whiteville Correctional Facility,

- in 13 of 16 medical files we reviewed (81%), medication administration records did not contain key required information about the inmates' prescribed medication, including start dates, order dates, number of KOP pills given,⁶⁵ and department-approved codes;
- for 3 of 60 medical files tested (5%), staff did not provide inmates instruction on how to receive medical care and staff did not document the physical and mental health exam for the inmates' duration of their time served; and
- for 7 of 60 medical files tested (12%), staff did not document that they performed a mental health evaluation for inmates with known mental health conditions.

At Trousdale Turner Correctional Center,

- we determined that for all 13 medical files tested (100%), health services staff did not include key information about inmates' medication on the medication administration record, including the start and stop date, dosage, order date, number of KOP pills given, name of the prescribing doctor, and discontinue date.

At Hardeman County Correctional Facility,

- for 17 of 18 medical files tested (94%), staff did not include key information about inmates' medication on the medication administration records, including the dosage information, number of KOP pills given, order date, and start date;
- for 6 of 60 medical files tested (10%), staff did not instruct inmates on how to receive medical care and did not document that they performed the inmates' physical and mental health exams for the duration of their time served;
- for 3 of 60 medical files tested (5%), we could not find a physician's order to corroborate prescriptions listed on the medication administration records;
- for 4 of 60 medical files tested (7%), we could not find a mental health evaluation for inmates with documented mental health conditions; and
- for 3 of 60 medical files tested (5%), we could not find a mental health treatment plan for inmates with documented mental health conditions.

At Northwest Correctional Complex,

- for 19 of 25 medical files tested (76%), health services staff did not include key information about inmates' medication on the medication administration records,

⁶⁵ KOP stands for keep on person, which is medication that inmates are allowed to keep in their cells rather than having to obtain it from the nurse each day.

including the dosage information, start date, number of KOP pills given, order date, correct number of pills, and frequency of administration;

- for 2 of 60 medical files tested (3%), staff did not document in the files that they performed a mental health evaluation for inmates with known mental health conditions; and
- for 1 of 60 medical files tested (2%), we could not locate the mental health treatment plan for an inmate with a documented mental health condition.

At Turney Center Industrial Complex,

- for 14 of 27 medical files tested (52%), health services staff did not include key information about inmates' medication on the medication administration records, including the start and stop date, number of KOP pills given, and prescriptions that were listed on a physician's order;
- for 2 of 27 medical files tested (7%), we could not locate the inmate's health history;
- for 1 of 27 medical files tested (4%), we could not locate a physical examination for the inmate; and
- for 1 of 27 medical files tested (4%), staff did not instruct the inmate on how to receive medical care and staff did not document that they performed the inmate's physical and mental health exam for the duration of the inmate's time served.

At Northeast Correctional Complex,

- for 6 of 25 medical files tested (24%), health services staff did not complete key information about inmates' medication on the medication administration records, including the start and stop date, dosage information, and prescriptions that were listed on a physician's order; and
- for 2 of 60 medical files tested (3%), we could not locate a mental health evaluation for inmates with known mental health conditions.

Additionally, at each facility tested, we identified several instances where health services staff did not place the inmate's initial drug screening in the inmate's medical file.

Appendix D-5
Methodologies to Achieve Objectives

To meet our objectives, we obtained and reviewed the department’s contracts with Centurion and Corizon to ascertain their contractual obligations for staffing and filling vacancies and providing medical and mental health services. We reviewed applicable department policies related to maintaining and organizing health records, specifically

- physician’s orders;
- medical and mental health screenings;
- medication administration records;
- mental health evaluations and treatment plans;
- initial inmate drug screenings; and
- health classifications.

We obtained the department’s last four clinical quarterly monitoring reports for the correctional facilities listed in **Table 32** to determine the areas the department identified as the main issues in the audit. To determine the facilities’ compliance with department policy and contractual requirements and to determine a level of assurance on the quality of care that the inmates are receiving in Tennessee’s correctional facilities, we obtained reports generated from the Tennessee Offender Management Information System. We specifically targeted inmates who were listed as Class B or “limited duty”⁶⁶ who were likely to have documented medical or mental health conditions. Using these reports as our populations, we tested a nonstatistical, random sample of inmates at the six correctional facilities during our site visits. We then obtained the inmates’ medical files (including old volumes) to identify if the facility staff were following department policies and contract requirements by maintaining the required documentation in the files.

Table 32
Medical and Mental Health Testwork Sampling Plan

Correctional Facility	Population Size	Sample Size
Whiteville Correctional Facility*	76	60
Trousdale Turner Correctional Center*	203	25
Hardeman County Correctional Facility*	189	60
Northwest Correctional Complex	138	60
Turney Center Industrial Complex	29	29
Northeast Correctional Complex	91	60

*CoreCivic-managed facilities.

To determine Centurion’s and Corizon’s compliance with staffing requirements, we obtained their contract staffing requirements. During our site visits, we selected a nonstatistical,

⁶⁶ Class B or “limited duty” indicates inmates with physical or mental conditions that place certain restrictions on their capabilities.

random sample of five months within the audit period. We obtained and analyzed the staffing reports and timesheet documentation for each month sampled to determine

- the number of staff vacancies for each month;
- whether Centurion and Corizon adequately staffed the required positions; and
- whether the department assessed liquidated damages where appropriate.

We interviewed health services staff at Whiteville Correctional Facility, Hardeman County Correctional Facility, Trousdale Turner Correctional Center, Northwest Correctional Complex, Turney Center Industrial Complex, and Northeast Correctional Complex and spoke with the department's Director of Clinical Quality Assurance and the Chief Medical Officer to determine the general procedures for inmate health care, as well as the process for moving inmates and their medical files and medications between facilities. We also reviewed entries made in the department's Online Sentinel Event Log that involved missing medical records or medications to determine whether inmates who were transferred arrived at other facilities with their medical records and medications.

We visited three state correctional facilities (Northeast, Northwest, and Turney Center) and three CoreCivic-managed facilities (Hardeman County, Trousdale Turner, and Whiteville) and observed each facility's medication administration process and spoke with various nurses and health administrators. We also met with CoreCivic's Regional Health Services Director to discuss the eMARs system.

To determine the amount of medical and mental health liquidated damages the department assessed and collected, we interviewed the department's Chief Financial Officer and the Chief Medical Officer to gain an understanding of the process the department uses to identify areas of contract noncompliance, assess liquidated damages, and collect damages. We also reviewed

- assessment letters issued to Centurion and Corizon;
- payments made to Centurion and Corizon; and
- invoices where liquidated damages had been deducted from October 1, 2017, to July 31, 2019.

CORRECTIONAL STAFFING AND DEPARTMENT TURNOVER

CHAPTER CONCLUSIONS

Matter for Legislative Consideration – Department of Correction Retirees (page 123)

Observation 6 – Both CoreCivic and state-run facilities are operating with minimal staff, resulting in increased staff overtime and/or the temporary closure of noncritical posts (page 130)

Observation 7 – Despite ongoing challenges, the department is working to develop tangible strategies to retain correctional officers at its facilities (page 133)

Finding 14 – As noted in the prior audit, CoreCivic staffing reports still contain numerous errors (page 135)

CORRECTIONAL STAFFING AND DEPARTMENT TURNOVER

MATTER FOR LEGISLATIVE CONSIDERATION – DEPARTMENT OF CORRECTION RETIREES

A provision of state law may warrant further study. Section 41-24-112(c), *Tennessee Code Annotated*, the Private Prison Contracting Act of 1986, states, “In no event will a department employee be allowed to retire and receive benefits while continuing employment with a facility contractor.” This law raises the question about whether a department retiree receiving state retirement benefits can accept a position with any CoreCivic-managed correctional facility.⁶⁷

Based on our discussion with management, the department does not have any procedures to ensure that department retirees collecting state retirement benefits do not accept positions with CoreCivic. Furthermore, based on discussion with department management, we found that the department believes that the Private Prison Contracting Act only applies to the South Central facility because the state contracts directly with CoreCivic for this one facility; the department believes the act does not apply to the other three CoreCivic facilities because the state contracts directly with the local government that then subcontracts with CoreCivic.

According to department management and the Comptroller of the Treasury legal staff, based on the statute as currently written, we are uncertain if department employees can retire and accept positions with CoreCivic-managed state facilities or other CoreCivic-managed institutions.

Correctional Facility Staffing Levels

State contracts with both CoreCivic (South Central Correctional Facility) and local governments (which subcontract with CoreCivic for facility management of Trousdale Turner Correctional Center, Whiteville Correctional Facility, and Hardeman County Correctional Facility) require each facility to submit to the state an operations plan that addresses how each facility will meet contract requirements, including but not limited to the following:

Critical posts must be staffed regardless of the correctional facility’s circumstances; failing to do so jeopardizes the safety and security of inmates, staff, and the community.

- *Contract staffing patterns* – the staffing patterns list the designated posts and the number of officers CoreCivic will use per shift per post. The Department of Correction approves CoreCivic’s proposed staffing pattern.⁶⁸
- *Staffing rosters (i.e., daily shift rosters)* – daily personnel assignments are authorized

⁶⁷We compared a department retirement list and CoreCivic rosters to a list of department retirees receiving retirement benefits for the audit period. We noted one individual who worked for the Trousdale Turner Correctional Center and received State of Tennessee retirement benefits between October and November 2018. We also noted one individual who is receiving retirement benefits while working for a CoreCivic-run detention center, Silverdale, in East Tennessee.

⁶⁸ To manage each facility, CoreCivic also uses “operational” staffing patterns, which list the designated posts and number of officers per shift approved by the department and also list additional posts and staff per shift that are not contracted positions and are not necessarily on the daily shift rosters.

for each shift. The rosters show the active officer posts, the officers scheduled per post, and the officers' attendance.

- *Critical posts* – facility management decides whether posts are critical and lists them in bold on the staffing rosters. According to the department's Policy 506.22, critical posts must be staffed regardless of institutional circumstances because leaving the posts unstaffed would jeopardize the security or safety of the facility, staff, inmates, or community.
- *Noncritical posts* – facility management decides which posts can be left unstaffed without jeopardizing security and lists them on the staffing rosters. According to the department's Policy 506.22, management may leave noncritical posts unstaffed in lieu of authorizing overtime.

The operations plans establish the policies and procedures the facilities are required to follow in all areas covered by the contract. The department's Policy 506.22 states that the "plan shall not be altered, amended, modified, revised or supplemented without the prior written approval by the State." For each CoreCivic-operated facility, the warden must obtain prior approval from the department's Assistant Commissioner of Prisons for each contract budget staffing pattern and the corresponding daily staffing rosters.

The CoreCivic facilities have an operational budget that includes the positions required by the contract, as well as other supplemental positions that exceed the contract requirement for number of staff.

The department requires its own facilities to follow the same standards as CoreCivic and to obtain approval from the Assistant Commissioner of Prisons prior to making any changes to the daily staffing rosters. Noncritical posts can be closed to move correctional officers to critical posts without prior approval when staff call in or do not show up for work. Like CoreCivic facilities, state facilities must send copies of the daily staffing rosters for each shift to the department's Assistant Commissioner of Prisons for review. The department initiated this process in response to the November 2017 performance audit.

Results of Prior Audit

In the department's November 2017 performance audit, we reported that shortages in correctional officer staffing may have prevented the Trousdale Turner and Whiteville facilities from meeting staffing obligations and may have limited their ability to effectively manage the inmate populations assigned to them. Both facilities operated with fewer than the approved minimum number of correctional officer staff and did not follow staffing pattern guidelines. Trousdale Turner did not have all staffing rosters and left critical posts unstaffed on several days.

In response to the prior audit, the department submitted its corrective action plan to the Comptroller's Office in 2018. The department's plan included efforts to add two contract monitors to perform on-site monitoring at each of the CoreCivic-operated facilities to ensure CoreCivic complies with the state and local government contracts. We observed the monitors and their process for writing Noncompliance Reports (NCRs) to note any CoreCivic facility noncompliance identified during the monitoring reviews. The department uses the NCRs to assess liquidated

damages against CoreCivic for identified noncompliance.

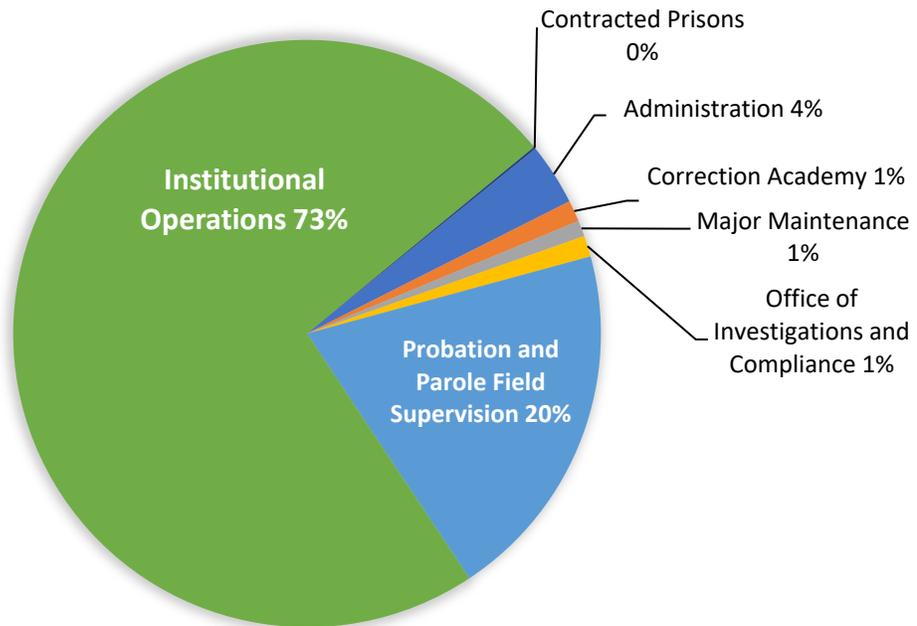
Current Audit

During the current audit, we performed site visits at the Trousdale Turner and Whiteville facilities to determine if department and CoreCivic management corrected the issues noted during the prior audit. We also extended our work to another CoreCivic-operated facility, Hardeman County, as well as the state-operated facilities: Turney Center, Northwest, and Northeast.

Department Staffing Statistics and Turnover

The department has 6,440 approved full-time positions according to the state’s fiscal year 2020 budget; as of July 22, 2019, 5,450 positions were filled. As shown in **Chart 2**, the majority of the department’s workforce—4,724 positions, or 73%—is located at the facilities. For a breakdown of fiscal year 2020 positions at each state-managed correctional facility, see **Appendix E-1** on page 139.

Chart 2
Department of Correction
Fiscal Year 2020 Budgeted Positions by Business Unit



Source: Tennessee State Budget, Fiscal Year 2019–2020.

Department Separation Statistics

We analyzed the department’s separation data for fiscal years 2018 and 2019 (through December 31, 2018); see **Table 33**. Management of the facilities monitors turnover on a monthly

and fiscal-year basis. In addition, the department participates in the Tennessee Department of Human Resources' exit survey program and receives feedback from exit surveys to enhance the department's retention efforts.

Table 33
Department of Correction Turnover Rates
Fiscal Years 2018 to 2019 (Through December 31, 2018)

Fiscal Year	Separations	Average Employees per Year	Turnover Rate
2018	1,676	6,601.0	25.4%
2019	861	6,611.5	13.0%

Source: Edison, the state's enterprise management system.

Based on our analysis of department turnover, **Table 34** shows the top 10 positions with the highest turnover for fiscal years 2018 through 2019 (through December 31, 2018).

Table 34
Top 10 Positions with Turnover
Fiscal Years 2018 to 2019 (Through December 31, 2018)

Positions
Correctional Officer
Probation/Parole Officer
Correctional Corporal
Correctional Counselor
Correctional Sergeant
Correctional Clerical Officer
Probation/Parole Manager
Secretary
Registered Nurse
Correctional Teacher

Source: Edison, the state's enterprise management system.

Our review showed that approximately 70% of the separations during this period were entry-level security staff, known as correctional officers, who primarily resigned from or abandoned their positions (see **Appendix E-2** on page 140 for more details). According to management, most correctional officers leave after one year of service; from years two to five, the turnover rate decreases. In April 2018, the Commissioner created the Retention Task Force to develop strategies to retain correctional officers. For more information about the task force's strategies, see **Observation 7** on page 133.

For the CoreCivic facilities' turnover statistics, see Appendix E-3 on page 141.

CoreCivic Staffing Oversight

CoreCivic is a private prison contractor that operates 4 of the state's 14 correctional facilities for the Tennessee Department of Correction. The four private prisons are

- Hardeman County Correctional Facility,
- South Central Correctional Facility,
- Trousdale Turner Correctional Center, and
- Whiteville Correctional Facility.

As a contractor, the department requires CoreCivic to submit staffing reports to the department's contract monitors at the facilities each month; the staffing reports must include

- names of the new hires and terminations,
- the position numbers associated with positions,
- reasons for terminations, and
- all vacant positions within their staffing patterns and the number of days each position has been vacant.

The correctional facilities use monthly staffing memos to report information on new hires, terminations, and staffing vacancies to the department. The information reported within each memo should accurately reflect the staffing activities within the CoreCivic facilities to ensure compliance with the terms set in each contract. The monthly staffing memos also allow the department to determine the security needs for the CoreCivic facilities.

CoreCivic Contract Requirements

For staffing and vacancies, we summarized CoreCivic's contractual responsibilities in **Appendix E-4** on page 143. With the exception of Hardeman County, CoreCivic must fill vacancies within 45 days and provide the department with reports showing new hires, terminations, and position vacancies with the number of days vacant.

Department Oversight and Liquidated Damages

The positions reported within the monthly staffing reports could contain all positions within each job class of contract-approved positions. Some examples of job classes include

- correctional officers,
- academic/vocational instructors,
- administrative clerks,
- licensed practical nurses, and
- registered nurses.

Each contract, excluding Hardeman County's contract, also requires CoreCivic to fill all vacant staffing positions within 45 days if the position is an approved contracted position. Because the CoreCivic facilities hire more staff than their approved staffing pattern to cover for the

continuous turnover they experience, CoreCivic is not required to report or track extra positions with the other contracted positions.⁶⁹ See the **Staffing Levels** section beginning on page 123 for more information on approved and operational staffing patterns.

The contract monitors for the department

- review the monthly staffing reports for accuracy,
- use the reports to ensure compliance with the contract staffing requirements, and
- issue any notices of noncompliance for contract violations.

As a result of their review of the compliance instruments,⁷⁰ department policies, and contract provisions, the contract monitors issue notices of noncompliance to the facility. Department management meets monthly to discuss the areas of noncompliance noted and the seriousness of the deficiency and to calculate liquidated damages.

The department has the discretion to alter the damage amounts it assesses for noncompliance. According to the department's General Counsel, if the damages are not proportionate to the costs CoreCivic incurred, such as salaries, benefits, and overtime, the department cannot enforce the damages pursuant to case law. For instance, for areas of noncompliance such as staffing vacancies and critical posts, the department considers the percentage of time a post was vacant and the amount of overtime CoreCivic paid to keep the critical posts staffed as a way to offset the amount of liquidated damages owed for that period. Furthermore, when the department issues a damages assessment letter, CoreCivic can appeal the assessment within 30 days of receiving the letter.

Results of Prior Audit

In the department's November 2017 performance audit, we found that Trousdale Turner's and Hardeman County's staffing reports contained numerous errors, rendering the reported staffing information unreliable. We noted the following issues in the staffing reports:

- missing position numbers for vacancies;
- vacancies carried over to subsequent months without adding the additional number of vacant days;
- positions left vacant for more than 30 days that were not listed on previous month's report;
- different job titles with the same position number;

⁶⁹ CoreCivic is required to meet specific staffing patterns, which list the designated posts and number of correctional officers per shift; the department approves the staffing patterns. CoreCivic may hire additional staff beyond the approved staffing pattern to manage each facility.

⁷⁰ Compliance instruments are the standards set for CoreCivic operations that contract monitors review to ensure compliance. The instruments are generated from a mixture of American Correctional Association (ACA) accreditation standards, departmental policies, and contract provisions.

- hires and terminations that did not reconcile to the number of vacancies; and
- reports that did not contain the number of filled positions, the inmate population, and the officer-to-inmate ratio.

In response to this finding, department management stated that it instructed Trousdale Turner to include position numbers as recommended in the audit report as the best mechanism for reporting vacancies.

Current Audit Work

To follow up on the prior finding, to verify that CoreCivic included contractually required reporting requirements and to verify the overall accuracy of the staffing reports, we reviewed staffing reports at four CoreCivic facilities for the period October 2018 through January 2019.

Audit Results

1. Audit Objective: Did department management correct the prior audit finding by ensuring that CoreCivic staffed critical posts?

Conclusion: Based on our review, we found that the department added monitors at each CoreCivic facility and CoreCivic had improved its critical post staffing.

2. Audit Objective: Did department management ensure that all state facility posts were staffed appropriately?

Conclusion: Based on our review, department management did not ensure that wardens at both the state and CoreCivic facilities staffed all approved posts. See **Table 36**.

While both the state and CoreCivic facilities covered critical posts, both still were unable to hire a sufficient number of correctional officers. As a result, facilities have temporarily closed noncritical posts and required staff to work overtime to cover critical posts. See **Observation 6**.

3. Audit Objective: Did department management make any changes in the way posts are designated as critical or noncritical?

Conclusion: Based on our review, department management made reasonable changes in the way posts are designated as critical or noncritical.

4. Audit Objective: Are there any notable differences in staffing patterns between CoreCivic and state-run facilities?

Conclusion: Based on our review, staffing patterns at CoreCivic facilities and state-run facilities are very similar in regard to the number of correctional officers for each post. One difference we found was that the CoreCivic facilities have

supplemental security staff positions on their operational staffing pattern. This means they have staff in excess of the contract requirement for staffing. Overall, we found that facilities were operating with minimal staff given the facilities' needs. We also noted a difference between how the state and CoreCivic facilities complete the daily staff rosters. State facilities do not include the time staff arrive at each post, whereas CoreCivic's facilities do. We believe documenting staff arrival times provides management with better data for monitoring the sufficiency of staffing.

- 5. Audit Objective:** Did the department experience any turnover that affected the department's ability to meet its mission?

Conclusion: Although the department is relying on overtime to maintain correctional facility staff levels (see **Observation 6** on page 130), management is working to improve its efforts to recruit and retain correctional officers to alleviate the overtime burden on current correctional staff, thereby allowing the department to continue to meet its mission. See **Observation 7**.

- 6. Audit Objective:** Did the department correct the prior audit finding by ensuring that CoreCivic's monthly staffing reports accurately reflected correctional officer vacancies and turnover rates?

Conclusion: Despite the department's corrective action and its efforts to accurately track staffing positions month-to-month, we once again found errors in CoreCivic facilities' monthly staffing reports. See **Finding 14**.

- 7. Audit Objective:** Did department management appropriately assess and collect liquidated damages due to CoreCivic's failure to staff vacancies at its correctional facilities?

Conclusion: Based on our audit work, management appropriately assessed and collected liquidated damages against CoreCivic for staffing vacancies at its facilities. See **Appendix E-6** on page 146 for assessment amounts per correctional facility.

Observation 6 – Both CoreCivic and state-run facilities are operating with minimal staff, resulting in increased staff overtime and/or the temporary closure of noncritical posts

While department management took steps to address the staffing of critical posts at both state and CoreCivic facilities, the department and CoreCivic have had to increase overtime for correctional officers and/or temporarily close noncritical posts, such as recreational posts, which may negatively impact inmate behaviors. These measures are at best temporary, and without a long-term solution to hire and retain officers, the department and CoreCivic increasingly risk losing existing staff whose long hours have affected their physical and emotional health. See **Table 35**.

**Table 35
Inmate and Correctional Officer Staffing Data**

Facility	Inmate Population (as of June 30, 2018)	Ratio of Correctional Officer Series⁷¹ to Inmates	Average Number of Monthly Overtime Hours⁷²	Average Monthly Overtime Costs⁷³
State Facilities				
Northwest	2,363	1:10	10,073	\$205,049
Northeast	1,795	1:06	11,495	\$240,508
Turney Center	1,606	1:08	8,737	\$173,478
CoreCivic Facilities				
Trousdale Turner	2,552	1:14	15,771	\$282,676
Hardeman	1,991	1:09	10,344	\$147,326
Whiteville	1,519	1:09	8,986	\$130,229

Source: TDOC Budget and Fiscal Office; CoreCivic, Human Resources Director.

At the facilities we visited, we found that, on average, the facilities operated with fewer than the approved number of correctional officers (see **Table 36**). In most cases, recreation and transportation posts were consistently under-staffed or closed. These positions are designated as noncritical; however, if these noncritical positions are not properly staffed, the facilities may not be able to provide inmates with programming and services like recreation time or transportation to and from medical appointments, which may negatively impact inmate behaviors. See **Table 36** for a summary of approved correctional officer posts for each shift and the average number of filled posts we observed as filled.

⁷¹ “Correctional Officer Series” includes correctional officers and senior correctional officers only.

⁷² Average monthly overtime hours were calculated for the months of October 2018 through January 2019.

⁷³ Average monthly overtime costs were calculated for the months of October 2018 through January 2019.

Table 36
Summary of Correctional Officer Posts on Approved Daily Rosters
October 2018 to January 2019

Facilities	Average Approved Correctional Officer Posts ⁷⁴		Average Filled Correctional Officer Posts ⁷⁵		Average Number of Correctional Officer Posts Unfilled (per Shift)		Average Number of Correctional Officer Posts Unfilled
	1st Shift	2nd Shift	1st Shift	2nd Shift	1st Shift	2nd Shift	Average Total
State Facilities							
Northwest (Site 1)	98	45	60	34	38	11	49
Northwest (Site 2)	29	29	19	19	10	10	20
Northeast	115	47	86	39	29	8	37
Turney Center	99	27	67	24	32	3	35
CoreCivic Facilities							
Trousdale Turner	51	36	42	32	9	4	13
Hardeman	77	51	77	44	0	7	7
Whiteville	60	40	42	32	18	8	26

Source: TDOC and CoreCivic facility daily shift rosters and logbooks.

Realities of Correctional Facility Staffing

Wardens must deal with emergencies during daily facility operations. Inmate altercations between staff or other inmates, medical issues with inmates, and discovery of contraband may require the warden to close critical posts for short periods to move correctional officers from one area to another. But we found that the department allows management to make emergency staffing changes differently at state versus CoreCivic facilities. For example, all facilities may restrict inmate movement (generally known as a “lockdown”) in a specific area so that officers can help transport inmates to a hospital. This restriction can result in closing critical posts for a short time. However, the department automatically penalizes CoreCivic when it does not maintain critical posts during a lockdown but does not penalize state facilities for the same deficiency. In effect, the department has not afforded CoreCivic the same flexibility when responding to emergencies.

In certain non-emergency circumstances, both state and CoreCivic facilities commonly move security staff from noncritical posts to help cover critical posts. Some facilities use supervisory and/or supplemental staff to cover noncritical posts as an extension of their daily duties. For example, a facility may use unit management staff to escort and monitor their unit’s inmates during recreation periods. In this situation, the recreation post shown on the roster is designated closed, but the service is still provided, and the post is temporarily covered by unit supervisory staff.

⁷⁴ First and second shifts are 12 hours long. Each facility also has an eight-hour day shift that we included in the first-shift figures.

⁷⁵ Our observations are based on a review of correctional officers on the approved staffing rosters and the posts designated on the rosters. If a post is not reflected on the approved roster or if the roster does not reflect the filling of that post, we are not able to account for it.

Responsibilities of Correctional Officers

Given that correctional officers experience higher stress levels due to the potential for daily violence and confrontations with inmates, the department and CoreCivic must strive for increased pay and benefits for staff filling this position. Correctional officers are required to maintain order and provide for the safety, security, care, and direct supervision of inmates during all phases of activity in a facility. To fulfill these job duties, correctional officers need to be able to think on their feet in order to determine the best way to approach and solve problems in their units, including using interpersonal, critical-thinking, and negotiation skills to defuse issues between inmates. Officers also need to be intuitive and able to interpret behavioral patterns to anticipate likely problems before they escalate.

As of July 1, 2019, the department's starting pay for correctional officers was approximately \$32,500 annually; the correctional officers receive a 5% increase after completing one year of service. With the new starting salary, the state implemented an across-the-board 7% increase to existing employees to align their salaries with the new starting salaries. For more information about the department's efforts to retain correctional officers, see **Observation 7**.

The Negative Effect of Overtime on Both Officers and Inmates

Regularly requiring staff to work overtime can lead to lower morale, compromised critical thinking skills, and increased staff turnover, which put staff, inmates, and the community at risk. Without sufficient staff to cover posts so that facilities can provide inmates with recreation time and/or transportation to medical services, inmates may experience low morale, heightened frustration, and denial of medical treatment, which may lead to increased behavioral issues and unmet medical needs.

Observation 7 – Despite ongoing challenges, the department is working to develop tangible strategies to retain correctional officers at its facilities

According to the department's human resources (HR) management, the HR team spends a significant amount of funds and effort toward recruiting and retaining correctional officers. **Table 37** shows the number of separations and turnover rates at each facility for fiscal years 2018 and 2019 (through December 31, 2018).

Table 37
Turnover Rates by Correctional Facility Location
Fiscal Years 2018 and 2019 (Through December 31, 2018)

Facility Location	Fiscal Year 2018		First 6 Months of Fiscal Year 2019	
	Separations	Turnover Rate	Separations	Turnover Rate
Bledsoe County	216	30.2%	104	14.5%
Lois M. DeBerry	156	30.7%	61	12.0%
Mark Luttrell	42	26.3%	27	16.9%
Morgan County	233	33.9%	120	17.4%
Northeast	105	21.3%	61	12.4%

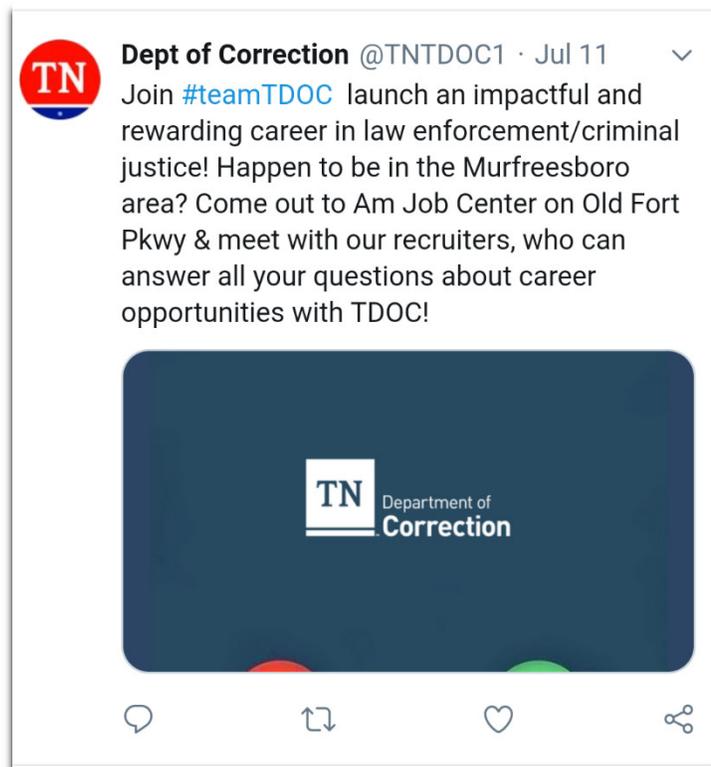
Facility Location	Fiscal Year 2018		First 6 Months of Fiscal Year 2019	
	Separations	Turnover Rate	Separations	Turnover Rate
Northwest	207	32.2%	75	11.7%
Riverbend	122	35.1%	74	21.3%
Prison for Women	0	0.0%	59	24.3%
Turney Center	125	28.7%	60	13.8%
West Tennessee State	117	17.5%	78	11.7%

Source: Edison.

Recruiting

According to HR management, recruiting efforts take place near the facilities. The department draws candidates from the correctional facility's home county as well as neighboring counties. To be considered, a candidate must have a high school diploma. HR management also stated that it takes a certain type of person to handle the work of a correctional officer. To expand their reach, management recruits at the following locations and uses the following methods:

- Fort Campbell, Kentucky;
- Tennessee Department of Labor and Workforce Development career centers;
- colleges and universities;
- career fairs (offsite or at the facilities);
- churches;
- county fairs and barbeque festivals;
- high schools;
- radio;
- the department's website and social media accounts;
- billboards; and
- placing flyers on vehicles in parking lots.



Source: Department of Correction Twitter feed. Posted July 11, 2019.

HR management stated that economic development can negatively impact the department's ability to successfully recruit. If businesses move into an area and can match the department's starting salary for correctional officers, candidates may choose to accept a position at a company that offers a better work environment. Management

also stated that the department has a difficult time recruiting in Davidson County, primarily due to pay and the county's current construction boom. Furthermore, compared to the state's current starting salary of \$32,500, Davidson County government offers a higher salary—\$37,177.61 per year—to correctional trainees, with an increase to \$40,542.65 after completing eight weeks of training.

Staff Retention

The department's HR management uses employee exit surveys to enhance staff retention efforts, especially for correctional officers. Through the Commissioner's Retention Task Force, the department developed the following strategies to retain correctional officers:

- The correctional officer starting salary increased to \$32,500,⁷⁶ effective July 1, 2019. After one year, the correctional officer is given an additional 5% salary increase. According to HR management, this starting salary increase moved Tennessee from the bottom to nearly the top of correctional officer pay among Tennessee's contiguous states.
- Existing employees received a 7% across-the-board pay increase to bring their salaries in line with the new starting salaries.
- As of July 15, 2019, the department is working with the Tennessee Department of Human Resources to develop staff supervisor training and on-the-job training for new correctional officers.

Management should continue its efforts to recruit, hire, and retain correctional officers. As part of its retention efforts, the department should work with current correctional officers to determine if the newly implemented strategies are working and make adjustments or implement additional strategies as needed to maintain facility safety and to meet its mission.

Finding 14 – As noted in the prior audit, CoreCivic staffing reports still contain numerous errors

We reviewed each CoreCivic facility's monthly staffing report for the period October 2018 through January 2019, including Hardeman County Correctional Facility, Trousdale Turner Correctional Center, South Central Correctional Facility, and Whiteville Correctional Facility.

See the full methodology in Appendix E-7 on page 147.

The prior audit identified multiple inconsistencies with CoreCivic staffing reports. As part of its corrective action, the department redesigned the monthly staffing reports that CoreCivic submits to contract monitors for review that addressed some of these issues by adding position numbers and hire/termination dates. Although we recognize that CoreCivic management improved the monthly staffing reports since the prior audit, we still found errors on the staffing

⁷⁶ According to salary.com, as of July 30, 2019, the average correctional officer annual salary in the United States was \$44,872, with wages ranging from \$39,950 to \$49,799.

reports even though correctional facility contract members review them weekly. Based on our review during the current audit, we found that the reports

- showed positions on the monthly staffing memos that did not reconcile to the monthly staffing reports;
- had duplicate entries for vacant positions;
- listed positions with the same position numbers (each position should have a unique position number); and
- did not always have hiring dates associated with the filled positions.

Furthermore, we reviewed the staffing reports and noted numerous positions that were vacant for over 45 days, which directly correlate to the correctional officer staffing and overtime issues:

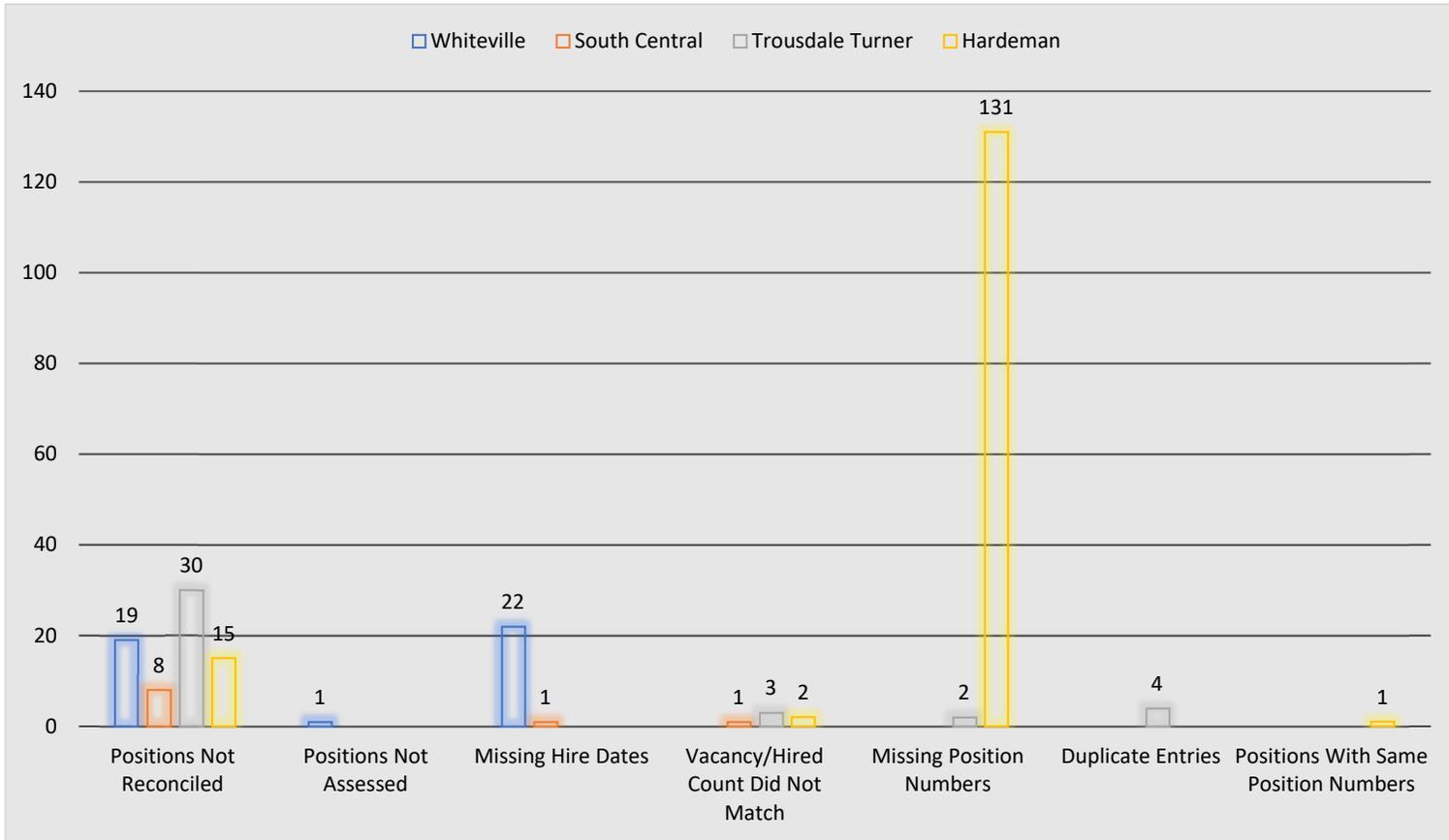
- Whiteville – 75 vacant positions;
- South Central – 67 vacant positions; and
- Trousdale Turner – 83 vacant positions.

For Hardeman, the department provided us with two sets of monthly staffing memos and vacancy reports for November and December 2018 that contained discrepancies in the staffing information reported for those months. Due to the discrepancies between the two reports, we could not conclude on relevant staffing information for those two months, including whether positions were vacant for over 45 days (although, according to its contract, Hardeman is not required to fill vacancies within 45 days). As a result, although CoreCivic reported 95 vacant positions that exceeded 45 days from October 2018 through January 2019, we could only review vacancies for the months of October 2018 and January 2019, which showed 91 vacant positions that exceeded 45 days.

We found one instance with Whiteville where the department did not assess damages for a vacant position that was over the 45-day fill requirement. We summarize our review of monthly staffing reports for each facility in **Chart 3**.⁷⁷

⁷⁷ We generated the error totals based on the number of errors we noted within each CoreCivic facility monthly staffing report.

Chart 3
Summary of Staffing Report Errors by Facility



Source: Results of audit testwork.

See **Appendix E-5** on page 144 for a list of specific deficiencies relating to our review of the monthly staffing reports.

Based on our discussions with CoreCivic management, their facility human resources staff cannot easily copy and paste or move the staffing information into the forms the department requires them to use. Staff must manually enter the information each month, which could lead to errors when reporting newly hired or vacant positions.

Inaccurately reporting and/or omitting staffing and vacancy information on the monthly staffing reports increases the risk that the department may not be able to track CoreCivic's vacant correctional officer positions to meet the security needs of its correctional facilities, thereby preventing the department from properly overseeing CoreCivic's contract requirements.

Recommendation

The Department of Correction should ensure that CoreCivic's monthly vacancy and staffing data for all CoreCivic correctional facilities are complete and accurate, as required by the facility's contract. If the reports are not accurate, the department should issue CoreCivic a report of noncompliance until CoreCivic resolves the errors and should assess the appropriate amount of liquidated damages.

Management's Comment

Concur.

The Department continues to pursue more suitable report structures that the contractors will provide to improve month to month vacancy and staffing data reporting and monitoring processes.

The Department of Correction has issued noncompliance reports for inaccurate monthly staffing reports to contractors of Hardeman Correctional Facility (HCCF), Trousdale Turner Correctional Center (TTCC) and Whiteville Correctional Facility (WCFA). South Central Correctional Facility (SCCF) has been issued noncompliance reports for vacancies over 45 days. Contractors for all four of the facilities have been assessed liquidated damages.

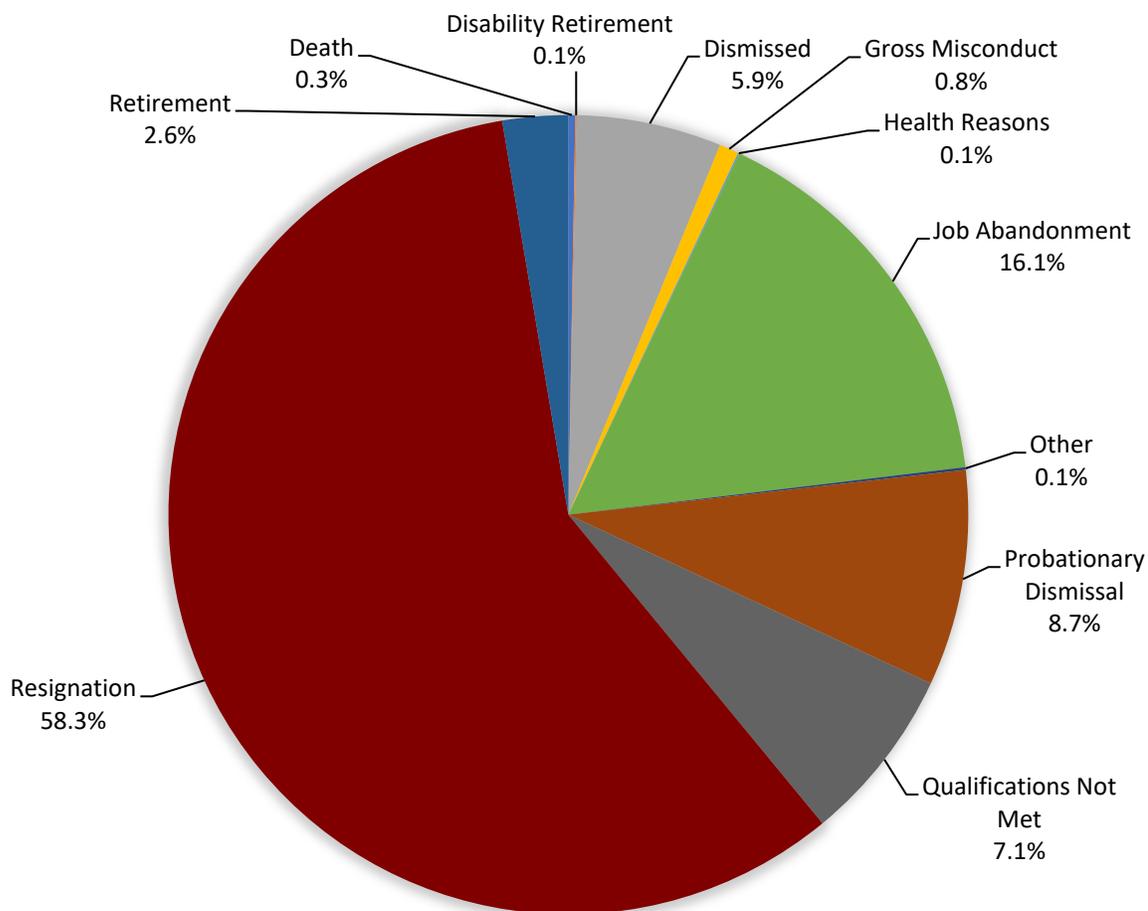
Appendix E
Correctional Staffing and Department Turnover

Appendix E-1
Department of Correction
Fiscal Year 2020 Budgeted Positions by Correctional Facility Location

Correctional Facility Location	Number of Positions
Bledsoe County Correctional Complex	691
Lois M. DeBerry Special Needs Facility	497
Mark Luttrell Transition Center	157
Morgan County Correctional Complex	658
Northeast Correctional Complex	474
Northwest Correctional Complex	615
Riverbend Maximum Security Institution	335
Tennessee Prison for Women	231
Turney Center Industrial Complex	414
West Tennessee State Penitentiary	652
Total	4,724

Source: The Budget document, Fiscal Year 2019–2020.

**Appendix E-2
Department of Correction
Correctional Officer Separations by Type**



Source: Edison, the state's enterprise management system.

**Appendix E-3
CoreCivic Turnover**

We also analyzed CoreCivic’s separation data for fiscal years 2018 and 2019 (through December 31, 2018); see **Table 38**. Similar to the state, CoreCivic experienced high turnover in correctional staff; however, CoreCivic’s turnover at the facility level is significantly higher than the state-managed facilities. At CoreCivic, most of the separated employees abandoned their jobs, were terminated, or resigned. See **Table 39** for a full list of separation reasons during this period.

**Table 38
CoreCivic Turnover Rates
Fiscal Year 2018 and 2019 (Through December 31, 2018)**

Facility Location	2018		2019	
	Separations	Turnover Rate	Separations	Turnover Rate
Hardeman County Correctional Facility	207	53%	92	25%
South Central Correctional Facility	289	95%	151	47%
Trousdale Turner Correctional Center	241	78%	125	25%
Whiteville Correctional Facility	233	76%	83	26%

Source: CoreCivic management.

Table 39
CoreCivic Reasons for Separation
Fiscal Year 2018 and 2019 (Through December 31, 2018)

Separation Reasons	Number of Separations
Job Abandonment - No Rehire	330
Terminated for Cause - No Rehire	241
Resigned - Other	189
Resigned - No Rehire	146
Personal Reasons	103
Other Employment	100
Failed to Give Notice	49
Failed to Give Notice - No Rehire	48
Resigned Under Investigation - No Rehire	36
Resigned - No Reason Given	26
Failed to Return From Leave	21
Retirement	20
Policy/Contraband	17
Job Dissatisfaction	14
Policy/Procedure Violation	14
To Attend School	10
Relocation	10
Dissatisfied With Pay	8
Death	7
Leave - Max Leave Expired	7
Unsatisfactory Performance	6
Failed Background Screening	6
Leave - Military (After 30 Days)	3
Layoff/Facility Closure	3
Terminated - Prison Rape Elimination Act Violation - No Rehire	2
Resigned During Prison Rape Elimination Act Investigation - No Rehire	2
Failed Background Screening - No Rehire	1
Unsatisfactory Performance - No Rehire	1
Falsification of Records	1
Grand Total	1,421

Source: CoreCivic Management.

**Appendix E-4
CoreCivic Contract Requirements**

**Table 40
Staffing and Vacancy Due Dates for Each Correctional Facility**

Correctional Facility	Contract Requirements		
	Vacancy Fills	Monthly Staffing Assignments	Position Information
Hardeman	No contract requirement	15th of every month	5th & 15th of every month
South Central	45 days	5th of every month	5th of every month
Trousdale Turner	45 days	15th of every month	15th of every month
Whiteville	45 days	By the 15th of prior month	15th of every month

Source: Respective CoreCivic contracts.

**Table 41
CoreCivic’s Contractually Required Position Information**

Correctional Facility	Reporting Requirements
Hardeman	Report the previous month’s <ul style="list-style-type: none"> • compliance with the staffing pattern, • security post assignments, and • monthly post assignments.
Trousdale Turner and South Central	Report the previous month’s <ul style="list-style-type: none"> • names of employees hired, including positions; • number of employees voluntarily or involuntarily terminated, with the reason and position; and • number of positions vacant and number of days.
Whiteville	Report the previous month’s <ul style="list-style-type: none"> • names of employees hired, including positions; and • number of employees voluntarily or involuntarily terminated, with the reason and position.

Source: Respective CoreCivic contracts.

Appendix E-5
Deficiencies Noted Related to CoreCivic Monthly Staffing Reports

Whiteville Correctional Facility

- Although CoreCivic reports both new hires and terminations monthly, we could not reconcile 19 positions reported on the monthly staffing memo over a 4-month period to positions on the monthly staffing report that tracks the days vacant for each position.
- On the monthly staffing memos, staff did not list hire dates associated with the 22 positions that were filled.

South Central Correctional Facility

- Although CoreCivic reports both new hires and terminations within a reporting period, we could not reconcile eight positions reported on the monthly staffing memos to the monthly staffing report that tracks the days vacant for each position.
- During the month of November 2018, the total reported vacancies did not match the number of employees reported on the monthly staffing memo.
- One new-hire position on the monthly staffing report did not list the termination date or days vacant count associated with the position.

Trousdale Turner Correctional Center

- Although CoreCivic reports both new hires and terminations within a reporting period, we could not reconcile 30 positions reported on the monthly staffing memos to the monthly staffing report that tracks the days vacant for each position.
- In October 2018 and January 2019, CoreCivic reported a total number of employees that did not match the number of employees reported on the monthly staffing memo.
- For two new-hire positions on the monthly staffing memos, staff did not list position numbers associated with the positions being filled.
- During January's reporting period, CoreCivic reported four duplicate entries for the same positions becoming vacant.

Hardeman County Correctional Facility

- Although CoreCivic reports both new hires and terminations within a reporting period, we could not reconcile 15 positions reported on the monthly staffing memo to the monthly staffing report that tracks the days vacant for each position.
- On the monthly staffing memos, staff did not list positions numbers associated with the 131 new-hire and terminated positions.

- In November and December 2018, CoreCivic reported a total number of employees that did not match the number of employees reported on the monthly staffing memo.
- We found one instance where two different positions shared the same position number in the same reporting period.

**Appendix E-6
CoreCivic Staffing
Liquidated Damages Assessments**

Whiteville Correctional Facility					
	Oct. 2018	Nov. 2018	Dec. 2018	Jan. 2019	Total
Original Assessment	\$160,893.60	\$150,616.80	\$190,566.60	\$191,572.40	\$693,649.40
Adjusted Assessment	\$44,169.67	\$26,190.55	\$91,916.44	\$97,059.63	\$259,336.29
Difference	\$116,723.93	\$124,426.25	\$98,650.16	\$94,512.77	\$434,313.11
% of Original Assessment*	27%	17%	48%	51%	37%

Trousdale Turner Correctional Center					
	Oct. 2018	Nov. 2018	Dec. 2018	Jan. 2019	Total
Original Assessment	\$166,450.64	\$104,220.64	\$54,716.80	\$120,751.50	\$446,139.58
Adjusted Assessment	-	-	-	-	-
Difference	\$166,450.64	\$104,220.64	\$54,716.80	\$120,751.50	\$446,139.58
% of Original Assessment*	100%	100%	100%	100%	100%

South Central Correctional Facility					
	Oct. 2018	Nov. 2018	Dec. 2018	Jan. 2019	Total
Original Assessment	\$25,655.32	\$27,727.24	\$61,902.28	\$77,316.20	\$192,601.04
Adjusted Assessment	-	-	-	-	-
Difference	\$25,655.32	\$27,727.24	\$61,902.28	\$77,316.20	\$192,601.04
% of Original Assessment*	100%	100%	100%	100%	100%

* "% of Original Assessment" is the percentage of the adjusted assessment against the initial assessed liquidated damage total.

Source: Noncompliance Reports and the legal Adjusted Assessment Letters issued to the CoreCivic facilities by the Department of Correction.

Appendix E-7 Methodologies to Achieve Objectives

For this audit, we analyzed correctional officer staffing for three state-operated facilities:

- Northeast Correctional Complex,
- Northwest Correctional Complex, and
- Turney Center Industrial Complex,

and three CoreCivic-managed facilities:

- Hardeman County Correctional Facility,
- Trousdale Turner Correctional Center, and
- Whiteville Correctional Facility.

To achieve our objectives, we gained an understanding of the staffing-level requirements; reviewed applicable policies and state and federal guidance; interviewed applicable personnel and management; and performed walkthroughs of the facilities. To determine if each facility warden properly staffed posts as required by the approved staffing pattern, we tested a random, nonstatistical sample of 240 daily staffing rosters, 40 rosters at each of the six facilities visited from October 2018 to January 2019. We randomly selected five days from each month and tested the daily rosters for both day and night shifts. To determine whether the wardens made any changes in the way posts are designated, we reviewed the request for post changes and the daily rosters that department management approved for the period October 2017 through May 2019. We also analyzed the staffing patterns between CoreCivic and state-run facilities to determine if there were any noticeable differences in the number of required staff.

We reviewed the department's turnover rates to gain an understanding of turnover trends. We compared the department's turnover rates to national rates obtained from the U.S. Department of Labor's Bureau of Labor Statistics. We analyzed turnover rates at the department level, as well as at each facility location to examine trends by location. We interviewed department human resources staff to gain an understanding of their process to monitor turnover and to determine its impact on the department's mission.

To meet the objectives and gain an understanding of CoreCivic's efforts to correct the prior audit finding relating to correctional officer vacancies and turnover rate, we interviewed the Director of Contract Monitoring and the Correctional Administrator responsible for the CoreCivic facilities. We also obtained the contract monitors' training plan and department policies, as well as the April 2018 monthly staffing report for each CoreCivic facility.

For testwork, we examined each CoreCivic facility's monthly staffing report for the period October 2018 through January 2019, including Hardeman County Correctional Facility, Trousdale Turner Correctional Center, South Central Correctional Facility, and Whiteville Correctional Facility, to determine if CoreCivic's reports accurately reflected correctional officer vacancies and

turnover rates. We compared the staffing reports to each other for reporting consistency, to the monthly staffing memos, and to the operating contract requirements.

To determine if the department accurately assessed liquidated damages against CoreCivic for failing to fill vacancies within 45 days, we obtained the noncompliance reports for each facility (except Hardeman County) associated with the sample of monthly staffing reports we tested, as well as the original and revised liquidated damages assessments (if CoreCivic appealed the assessment).⁷⁸ We also reviewed CoreCivic invoices in Edison to determine if the department recouped the assessments.

⁷⁸ According to the contract with Hardeman County, this facility is not contractually required to fill vacancies within 45 days.

INMATE SERVICES AND SUPPORT

CHAPTER CONCLUSIONS

Finding 15 – State and CoreCivic correctional facility personnel did not consistently administer required inmate screenings that are used to prevent sexual abuse in correctional facilities (page 160)

Finding 16 – State and CoreCivic facility personnel did not perform inmate orientation within three days of arrival at the facility or did not consistently maintain a signed Orientation Acknowledgement Form in the inmate institutional file (page 163)

Observation 8 – Northwest Correctional Complex and Turney Center Industrial Complex impeded inmates’ access to information relating to healthcare, including access to grievance and sick call forms (page 165)

Observation 9 – State and CoreCivic correctional staff did not properly maintain class and job documentation in accordance with department policy (page 166)

Observation 10 – Trousdale Turner Correctional Center did not conduct the minimally required random drug screenings of the inmate population, and Whiteville Correctional Facility, Turney Center Industrial Complex, and Northwest Correctional Complex did not consistently and accurately record screening results in TOMIS (page 167)

INMATE SERVICES AND SUPPORT

Inmate Admission and Intake Process

Per the department's policies and its *Classification User's Guide*, TDOC accepts all inmates into physical custody at one of two classification diagnostic centers: the Bledsoe County Correctional Complex or the Tennessee Prison for Women. These centers also function as correctional facilities with their own assigned inmate populations.

Both centers receive and process inmates sent from the state's 95 counties. These inmates may be first-time convicted felons, former felons returning to TDOC on a new conviction, parole violators, or probation or community correction violators. The counties are responsible for transporting these inmates to the diagnostic centers.⁷⁹

The department uses several processes, such as inmate assessments, inmate classification, Risk Needs Assessments, sexual abuse risk screenings, and random drug screenings, to ensure inmates are placed in a correctional setting and are provided with the appropriate services that allow the inmates to become successful within the correctional environment and upon release.

Upon the inmate's arrival at a diagnostic center, diagnostic center personnel review the inmate's paperwork for authorization of the inmate's confinement. This authorization may be either a copy of the judgment order, a copy of the parole violation warrant and/or revocation, or a probation revocation order. If a county jail originally housed the inmate, jail personnel will also provide the state's diagnostic personnel with an Inmate Admissions Assessment form. Once diagnostic personnel confirm the authorizing paperwork, the inmate proceeds to intake.

Every inmate must pass through the department's intake process, called an initial diagnostic or initial classification, at one of the two diagnostic centers. TDOC policies require diagnostic personnel to complete this intake process within 14 business days of the inmate's arrival. Classification begins with inmate orientation, continues with several inmate examinations and assessments, provides for establishing inmate files to memorialize the examinations and assessments (including the inmate's understanding), and concludes with the inmate's first incarceration classification hearing. A panel appointed by the warden of the diagnostic center determines which TDOC facility will house the inmate.⁸⁰

⁷⁹ The only exceptions to this are TDOC backup inmates, inmates returning from a court appearance or medical facility, or escapees. Backup inmates are TDOC sentenced felons who serve their sentences at local jails under a contractual agreement between the county and TDOC, a practice that partially relieves overcrowding at TDOC facilities. Inmates returning to TDOC from a court-ordered appearance or medical facility return to their assigned facilities. Tennessee law enforcement agencies transport escapees to the nearest TDOC facility, pending further transfer to the institution where the escape occurred. Female escapees must go to the Tennessee Prison for Women.

⁸⁰ The panel consists of the Associate Warden of Treatment as chairperson (the Chief Correctional Counselor serves as the alternate chairperson when the Associate Warden is unavailable), a ranking correctional officer to represent the security team, a correctional counselor to represent the treatment team, a clinical services professional, and the institutional inmate job coordinator if needed. Per TDOC policy, the Contract Monitor of Operations serves as the alternate chairperson at private facilities.

The following activities do not need to occur in a certain order, so long as diagnostic personnel perform them before the classification hearing:



- **Orientation** – TDOC policies mandate that each inmate must undergo a thorough orientation program within three days of arrival at any TDOC facility. This is to ensure the inmate learns the rules and procedures of that facility, what sanctions exist for unsatisfactory behavior, and what programs are available that can provide new job, educational, and behavior skills.
- **Testing** – The inmate receives medical and dental examinations, a drug screening, an educational assessment, and a mental health appraisal. The inmate must also receive a Prison Rape Elimination Act (PREA) screening within 72 hours of arrival and a Risk Needs Assessment to help management devise a program for the inmate.
- **Initial Custody Assessment** – Diagnostic personnel complete this at initial intake to determine whether an inmate should live alone in a cell or with other inmates, and whether to hold the inmate in maximum, close, medium, or minimum custody. This assessment considers such factors as the inmate’s history of violence, severity of the current offense, and prior convictions or disciplinary hearings.
- **Programs and Placement** – Diagnostic personnel use the classification process to create appropriate facility placement and program recommendations for the panel to consider based on inmate information gathered during the initial diagnostic. These recommendations help determine what jobs and classes provided by TDOC might be best for the inmate.

These initial classification efforts give diagnostic personnel the tools to build a comprehensive account of each inmate that will best inform the panel’s choice of facility for that inmate. Personnel gather all possible information about the inmate for review and consideration in case any material is missing or incomplete in one source.

Inmate Admissions Assessment Forms (Inmate Intake)

The Tennessee Department of Correction’s Division of Prisons *Classification User’s Guide* requires diagnostic personnel to use the Inmate Admissions Assessment form to help the panel determine whether to house an inmate in a single cell or with another inmate.⁸¹ The form has two parts, A and B. County jail personnel must complete part A of this form before the inmate transfers to TDOC custody, to provide the diagnostic receiving facility with information regarding an inmate’s circumstances and behavior while at the jail. This is the only form carrying information about the inmate that originates with jail personnel.

Part A of the Inmate Admissions Assessment has 11 questions for jail personnel to answer:

- how long the jail housed the inmate;

⁸¹ Other documentation considered for this question includes the National Crime Information Center (NCIC) report, classification scale, pre-sentence investigation, and the inmate’s file from any previous TDOC incarceration, sexual behavior, or victims of sexual assault (all are described later in this chapter).

- whether the inmate was the victim or perpetrator of violence or rape while in the jail;
- whether the jail housed the inmate in a single or double cell;
- if there were other inmates with whom this inmate was incompatible;
- if the inmate tried to escape while at the jail;
- if jail personnel suspected the inmate of trafficking drugs while in jail;
- if the inmate was violent while in the jail;
- if the inmate has known medical or mental health problems;
- whether the inmate smokes;
- if jail personnel suspect the inmate is a gang member;
- and whether jail personnel think this inmate should be in a double cell.



The warden's designee at the diagnostic receiving facility completes part B of the form and signs it to indicate that facility personnel received and reviewed the information and determined the inmate's cell arrangement (single or double). This form serves as critical documentation of the inmate's behaviors or tendencies while housed in a local jail prior to entering TDOC custody and the facility's basis for housing decisions. Finally, facility staff file the form in the inmate's institutional file as part of the inmate's institutional record.

The inmate's institutional file follows the inmate throughout his or her time served in TDOC facilities and is not considered complete without a full record of the inmate's conduct while incarcerated, including time spent in jail.

Inmate Classification Process

General Background

TDOC Policy 401.08, "Classification Hearing Process," and the Division of Prisons *Classification User's Guide* define classification as an ongoing inmate evaluation process that considers the behavior, circumstances, and needs of individual inmates as they progress through the justice system. In other words, the department's goal is to place an inmate in the best possible environment where he or she will cope best with the reality of incarceration. The two diagnostic centers, Bledsoe and Tennessee Prison for Women, are responsible for the inmate classification process.

Classification and Reclassification Process

The diagnostic center's warden must establish a classification panel that is responsible for reviewing an inmate's circumstances to determine the best environment during the incarceration period.

Each classification panel consists of a chairperson, a ranking correctional officer, a correctional counselor, a clinical services professional,⁸² and an institutional inmate job coordinator⁸³ (if needed), who are responsible for making recommendations concerning inmate custody levels⁸⁴ as well as the facility location and programs⁸⁵ to which the inmate is assigned. The panel makes these recommendations by majority decision during a hearing with the inmate.

Before making their decision, the panel considers several factors during the inmate's initial classification review, including

- inmate criminal history;
- court recommendations;
- disciplinary records;
- staff observations of the inmate; and
- jail assessments.



Each classification review culminates in a hearing with the inmate and the panel. The facility must notify the inmate in writing at least 48 hours before the date of the scheduled hearing; however, the inmate can waive his or her right to notification. The hearing must occur within 14 business days of the inmate's admission into the state correctional system.

Annual reclassification hearings allow for regular custody assessment of inmates to ensure they receive the proper facility restrictions, programs, services, and resources paired to their circumstances. The classification panel will reassess the inmates at each annual hearing and make recommendations for custody level changes, programs, and facility assignments as it sees fit. The counselor or case manager that prepares the reclassification should record the conclusions of the panel and any significant remarks in the Tennessee Offender Management Information System (TOMIS), along with the date of the hearing.



The panel documents its classification and reclassification decisions with the Offender Classification Summary, which captures the hearing information, panel participation, and inmate awareness. This summary document also serves as a record of the panel's comments, justification of its recommendations, and final approval as evidenced by the panel member's signatures. The inmate must also sign the Summary to document his or her presence at the hearing. If the inmate refuses to sign the Summary, a member of the panel notes the inmate's refusal on the Summary. An inmate's refusal to sign does not invalidate the hearing or the panel's recommendations.

⁸² A member of the medical team that provides physical and behavioral health services at the facility.

⁸³ Institutional staff person responsible for assigning inmates to programs, maintaining job registers and descriptions, and coordinating sentence credit policy requirements, among other duties.

⁸⁴ Custody level refers to the level of inmate supervision necessary for the protection of inmates, staff, and the community. Levels range from least restrictive (minimal trustee) to most restrictive (maximum).

⁸⁵ The term "program" describes a range of vocational and academic opportunities the department makes available to inmates based upon an assessment of their needs. Depending on their classification, inmates may have access to an array of programs, including farm and livestock operations; various industries; institutional and community service work assignments; and mental health, treatment, and social services.

The presence of this signed and completed form in the inmate's institutional file confirms the inmate was present at the hearing, given the opportunity to participate, and made aware of the panel's final decision. While the panel's classification decision is recorded in TOMIS, the actual Summary document is the department's official record of the inmate's participation in the process.

Risk Needs Assessments (RNAs)

TDOC Policy 513.09, "Risk Needs Assessments (RNA) for Institutions and Transition Centers," defines an RNA tool as an assessment instrument completed by an RNA-certified user⁸⁶ who uses face-to-face "motivational interaction and interview techniques" to collect useful information about an inmate to identify the inmate's characteristics, traits, problems, or issues that may increase the risks that the inmate will commit another crime. Using this tool, correctional personnel design the inmate's case management plan to reduce those risks.

RNA-certified users at the department's intake facilities⁸⁷ must give every inmate an assessment as part of the initial classification process. Users at all facilities perform reassessments of inmates every 12 months.

RNA-certified users administer the inmate's assessment by using the Static Risk Offender Needs Guide – Revised (STRONG-R) as an assessment tool. Specifically, certified users, trained by software provider Vant4ge, use the STRONG-R to assess inmate needs and predict recidivism based on inmate responses and criminal history. Users complete, save, and print the STRONG-R results using the software application, Vant4gePoint. The inmate signs the printed report, known as an RNA Needs report, and facility staff file it in the inmate's institutional file.

The certified user notes the inmate's signature in TOMIS. If the inmate refuses to sign, a facility staff member will sign and date the RNA Needs report to acknowledge the inmate's refusal to sign, and facility staff will enter the notation in TOMIS. The certified user also marks the proposed STRONG-R assessment in Vant4gePoint as unable to complete. According to facility staff, however, inmates still receive programming if they refuse to sign and date the RNA Needs report.

A signature on the RNA Needs report from either the inmate or the certified user confirms the inmate was present for the assessment and given the opportunity to participate and is the supporting evidence for the accompanying entries in TOMIS and for programming placement. Should Vant4gePoint be unavailable for any reason in the future, a physical copy of the inmate's most recent assessment may be retrieved from the inmate's institutional file.

PREA Screenings

Congress enacted the Prison Rape Elimination Act of 2003 (PREA) to address the problem of sexual abuse of persons in U.S. correctional agencies. It applies to all public and private correctional facilities that house adult or juvenile inmates as well as community-based agencies.

⁸⁶ A certified user is an individual who has successfully completed a user certification course for the STRONG-R, facilitated by a trainer certified by Vant4ge.

⁸⁷ The department's intake facilities are Bledsoe County Correctional Complex and the Tennessee Prison for Women.

It mandates certain standards concerning detection and prevention of prison rape. The Tennessee Department of Correction must follow federal PREA standards issued by the United States Department of Justice.

TDOC Policy 502.06.01, “Prison Rape Elimination Act (PREA) Screening, Classification, and Monitoring,” states that the department is to provide a “safe, humane, and appropriately secure environment, free from threat of sexual abuse and sexual harassment for all inmates.”

To help meet these standards, the department requires that every inmate receive a PREA screening upon entry into the state’s correctional system. Classification teams and health services staff at each correctional facility perform the PREA screenings using the department’s PREA Screening application. Through a series of questions, the screening application helps staff identify whether an inmate is either at risk of being sexually abusive or sexually victimized. Pursuant to federal PREA standards, these questions are confidential. Using the screening results, staff make informed decisions concerning inmate housing, cell assignments, work, education, and other program assignments. The goal of the screening is to separate those inmates with a high risk of committing sexual abuse from potential victims.

Staff administer these screenings when an inmate first enters department custody at an intake correctional facility (or diagnostic center) and again when the inmate arrives at the assigned correctional facility.

Once the inmate arrives at the assigned facility, a PREA screening must take place within 72 hours. Facility staff screen the inmate again within 30 days to consider any additional circumstances or information that may have come to light since the inmate first arrived.

See additional results of PREA testwork in the Sexual Abuse and Sexual Harassment section of this report.

Orientation Process at Assigned Correctional Facility

TDOC Policy 404.05, “Orientation Unit,” mandates that every inmate must participate in a cognitive orientation program within three calendar days of arrival at a correctional facility. A cognitive orientation program is an informational program designed to familiarize an inmate with the rules of the institution, such as expectations, procedures, and levels of disciplinary action. The Division of Prisons *Classification User’s Guide* defines orientation as the basis for making inmates aware of available programs that can provide new job, educational, and behavior skills. Facility staff also use the orientation to observe inmate behavior and identify any special problems. Information provided to the inmate at orientation includes a copy of the institutional or department inmate handbook, Prison Rape Elimination Act (PREA) awareness literature, a description of programs and services available at the prison, an explanation of the TDOC disciplinary and security threat group (STG) procedures, and a brief explanation of the major aspects of a felony sentence.

Correctional facility staff use the Orientation Acknowledgement Form to document the completion of the inmate’s orientation. It is the responsibility of the designated orientation unit

staff at the prison to perform the orientation within the three-day limit and to record the orientation in TOMIS. The Orientation Acknowledgement Form includes signatures of the inmate, the inmate representative if present, the Correctional Counselor, the Classification Coordinator, the Health Services Designee, and the Associate Warden of Treatment or Chief Counselor. Once completed, the orientation unit staff will place the form in the inmate institutional file as proof the inmate acknowledged receipt of orientation materials.

Access to Grievance Forms and Required Informational Postings at the Assigned Correctional Facility

According to Tennessee Department of Correction Policy 501.01, “Inmate Grievance Procedures,”

inmates can file grievances, or written complaints, concerning

- the substance or application of a written or unwritten department policy or practice;
- any single behavior or action toward an inmate by staff or other inmates; or
- any condition or incident within the department or correctional facility that personally affects the inmate.

The policy also states,

Access to the grievance procedure: Inmate Grievance, and locked grievance depositories,⁸⁸ shall be made available for use by all inmates. Inmates shall have unimpeded access to these grievance forms. For general population inmates, the grievance forms shall be openly available for pickup without the need for a request to staff.



The inmates are also permitted to inquire about and request healthcare services, including scheduled and unscheduled sick call.⁸⁹ According to Policy 113.30, “Access to Health Care,” “Written instructions explaining access to health care services shall be posted in all living areas and shall be in terms that can be understood by all inmates.”

The correctional facilities must also post the Prison Rape Elimination Act (PREA) hotline numbers in the inmate common areas (i.e., living areas where inmates socialize, play games, make calls, etc.) so that inmates may report allegations of sexual abuse and harassment to the department; inmates also receive this information in an inmate handbook when they arrive at the facility, as required by department Policy 502.06.3, “Medical, Mental Health, Victim Advocacy and Community Support Services for PREA Victims.”

⁸⁸ A grievance depository is a locked box where inmates can insert their grievance forms.

⁸⁹ A sick call is an organized method by which inmates are evaluated and treated for non-emergency health care requests by qualified health care professionals.

Results of Prior Audit Regarding Grievance Forms

During the November 2017 performance audit, we found that Trousdale Turner Correctional Center management did not provide grievance forms in one housing pod⁹⁰ and sick call request forms in two pods. Inmates had to request these forms from the correctional officer on duty. We also found that the officer in one of those units did not have sick call forms for approximately four hours. In addition, only one pod out of four we visited had posted instructions for obtaining medical care.

Management concurred with the finding and stated that the facility contract monitor noted multiple deficiencies, leading the department to increase the number of audits conducted at Trousdale.

Current Audit Follow-up

We returned to Trousdale and extended our work at the following CoreCivic and state-managed correctional facilities:

- Hardeman County Correctional Facility (CoreCivic-managed);
- Whiteville Correctional Facility (CoreCivic-managed);
- Northwest Correctional Complex;
- Turney Center Industrial Complex; and
- Northeast Correctional Complex.

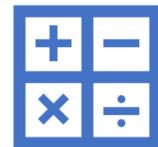
Inmate Classes and Jobs Documentation

Classes and Jobs

The Tennessee Department of Correction provides inmates with opportunities to complete their education while they are incarcerated. The educational system is fully accredited by the Tennessee Department of Education to ensure the highest level of education for incarcerated individuals. A variety of academic and career technical programs, such as Adult Basic Education (high school equivalency), Career Management Success, and Career and Technical Education allow inmates to obtain an education

and learn a skill that will translate to employment upon their reentry into society.

The correctional facilities have licensed instructors and a principal on staff who work with the inmates to provide educational services. Inmates are also paid by the hour to attend these classes. Attendance records act as the primary source of information to document inmates’ class attendance hours as well as the inmates’ wages for attending class. Department Policy 117.01 requires facility management to “maintain accurate educational records. . . .”



The department also provides inmates the opportunity to have jobs while incarcerated. Correctional facilities offer a number of different types of jobs, depending on the inmate’s skill level, work history, disciplinary history, and other factors, such as medical qualifications or job availability. For example, Turney Center Industrial Complex and Hardeman County Correctional Facility provide well-behaved inmates the opportunity to work in the Retrieving Independence Program, where the inmates work with and train puppies to become specially trained service dogs. For each inmate with a job, the department maintains a job file that contains all of the

⁹⁰ A pod is a smaller area within a housing unit where inmates with similar custody levels and programming needs live.

documentation for the inmate’s work history while incarcerated. The file includes job register requests, job interview documents, job recommendations, job acknowledgment forms, and other job-related items, such as medical documentation to qualify or disqualify the inmate for a job. Department Policy 505.07 requires inmates to sign job acknowledgment forms to show that they understand the requirements and duties of each job, to whom they report, the amount of money the inmate will earn for the job, and where to report to work. The correctional facility’s job coordinator is responsible for placing the required forms in inmate job files.

Results of the Prior Audit Regarding Inmate Classes and Jobs Documentation

In the department’s November 2017 performance audit report, we reported that CoreCivic did not properly document attendance for inmates housed and assigned to classes or jobs at Trousdale Turner Correctional Center, a CoreCivic-managed facility. We also found that when CoreCivic facility staff were able to provide the inmate attendance records, facility staff had inaccurately recorded inmates’ attendance.

Management concurred with the finding and stated that the facility contract monitor noted multiple deficiencies at this facility, leading the department to increase the number of audits conducted at Trousdale.

Current Audit Follow-up

We returned to Trousdale Turner and extended our work at the following CoreCivic and state-managed correctional facilities:

- Hardeman County Correctional Facility (CoreCivic-managed);
- Whiteville Correctional Facility (CoreCivic-managed);
- Northwest Correctional Complex;
- Turney Center Industrial Complex; and
- Northeast Correctional Complex.

Random Drug Screenings

To combat inmate alcohol and drug use, the Tennessee Department of Correction and CoreCivic conduct random drug screenings each month. The department’s central office selects a monthly random sample of inmates from each correctional facility and sends to the facilities a listing that includes the names of approximately 5% of the facility’s population. According to department Policy 506.21, “Inmate Drug Testing,” “At a minimum, each correctional facility shall test 2.5 percent of the institution’s in-house population each month.”

The facility’s drug screening coordinator then determines when during the month the facility will perform the drug screen of the selected inmates. If an inmate’s specimen tests positive for alcohol and drugs, the drug testing coordinator must send positive field screenings to a third-party lab for analysis to confirm the test results and identify the types of drugs in the specimen.

If an inmate tests positive for drugs or alcohol or refuses a random drug screening, the inmate faces potential disciplinary action, such as fines, loss of privileges, and mandatory drug testing. In fact, the facility drug screening coordinator enters an incident in the Tennessee Offender Management Information System (TOMIS), to initiate the process of disciplinary action including actions taken. According to department Policy 502.01, “Uniform Disciplinary Procedures,” the department has seven calendar days to hold a disciplinary hearing.

Audit Results

1. **Audit Objective:** Did the department ensure that correctional facility staff completed the required Inmate Admissions Assessment form?

Conclusion: Based on audit work performed, we found that facility staff completed the Inmate Admissions Assessment forms.

2. **Audit Objective:** Did the department ensure inmates received a classification hearing as required by department policy?

Conclusion: Based on testwork performed, we found that inmates received a classification hearing as required by department policy.

3. **Audit Objective:** Did the department ensure inmates received written notice of their classification hearing at least 48 hours in advance?

Conclusion: Based on testwork performed, we found in either the inmate institutional files or in TOMIS, the department provided inmates with 48-hour notice of the upcoming hearing.

4. **Audit Objective:** Did the department ensure Offender Classification Summaries were present in inmate institutional files?

Conclusion: We found at the Trousdale Turner facility that the Chief Counselor kept six Offender Classification Summaries on a shelf in her office rather than in the inmate's institutional files as required by policy.

5. **Audit Objective:** Did the department ensure Risk Needs Assessments were filed in inmate institutional files?

Conclusion: Based on our review, correctional facility staff placed the Risk Needs Assessments in the inmate institutional files.

6. **Audit Objective:** Did the department consistently screen inmates for histories of aggressive sexual behavior or sexual abuse/victimization within 72 hours and again within 30 days of arrival to their assigned correctional facility?

Conclusion: Based on testwork performed, we found that several inmates at both state and CoreCivic facilities did not receive a PREA screening within the 72-hour and/or 30-day deadlines set by policy. See **Finding 15**.

7. **Audit Objective:** Did the department ensure inmates received orientation within three days of their arrival at a correctional facility, and that staff signed and completed orientation forms and filed the forms in the inmate institutional files?

Conclusion: From our review of inmate institutional files at the four facilities (state and CoreCivic), we found inmates who did not receive orientation within the required three-day limit, and whose signed orientation forms were not on file. See **Finding 16**.

8. Audit Objective: Did CoreCivic's management correct the prior audit finding by providing inmates with unimpeded access to grievance and sick call forms, information relating to medical care access in living areas, and access to PREA hotline numbers at its correctional facilities?

Conclusion: Based on our walkthroughs of the housing pods at Trousdale Turner Correctional Center, Whiteville Correctional Facility, and Hardeman County Correctional Facility, CoreCivic management corrected the prior audit finding by providing inmates with unimpeded access to grievance and sick call forms.

9. Audit Objective: Did department management provide inmates at its state-run correctional facilities with unimpeded access to grievance and sick call forms, information relating to medical care access in living areas, and access to PREA hotline numbers?

Conclusion: Based on our observations of the housing pods at the state correctional facilities, we noted a few instances where inmates did not have unimpeded access to grievance forms and information relating to access healthcare. See **Observation 8**. We did observe that the facilities posted PREA hotline information in the inmates' living areas.

10. Audit Objective: Did correctional facilities maintain the required documentation for inmates attending classes and assigned to jobs to support the inmates' pay and job responsibilities?

Conclusion: Based on our testwork, we found that state and CoreCivic facilities did not maintain adequate inmate class attendance records to support inmate pay for attending classes or maintain inmate job documentation in accordance with department policy. See **Observation 9**.

11. Audit Objective: Did the correctional facilities perform the required random drug screenings and enter the results into TOMIS as required by policy?

Conclusion: Based on our review, we found that facilities did not comply with the department's policy regarding required random drug screenings and did not enter the results into TOMIS as required. See **Observation 10**.

Finding 15 – State and CoreCivic correctional facility personnel did not consistently administer required inmate screenings that are used to prevent sexual abuse in correctional facilities

Based on testwork performed to determine if correctional facility staff screened inmates upon arrival for sexual abuse risks in accordance with the Prison Rape Elimination Act (PREA) standards, we found that staff at 5 facilities did not complete most initial PREA screenings upon arrival, and staff at all 6 facilities did not complete some 30-day screenings after arrival, as required by department policy. See **Table 42** for results.

**Table 42
Prison Rape Elimination Act Standards' Required Screening Not Performed**

Correctional Facility	Inmate Sample Size	72-Hour Screenings		30-Day Screenings	
		Not Performed Timely	Not Performed At All	Not Performed Timely	Not Performed At All
Northeast	60	16	1	9	–
Northwest	25	11	–	13	3
Turney Center	25	3	–	9	8
Hardeman*	60	3	–	5	5
Whiteville*	60	2	–		1
Trousdale Turner*	60	No Issues		4	2

Source: Inmates' institutional files.

*CoreCivic-managed facilities.

According to Department Policy 502.06.1, "Prison Rape Elimination Act (PREA) Screening, Classification, and Monitoring,"

- All inmates shall be screened, using the PREA Screening Application, upon arrival at a facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. This screening shall ordinarily take place within 72 hours of arrival at the facility.
- Within 30 days of the inmate's arrival at a facility, staff will again screen, using the PREA Screening Application, the inmate for risk of victimization or abusiveness to include any additional relevant information received by the facility since the intake screening.

In our discussion with department management, they stated that they did not dispute the fact that the facilities either did not complete the screenings or completed them late; they believe the issues likely occurred due to staffing shortages or simple human error. Furthermore, management stated that sometimes inmates may be unavailable for the screening due to a court hearing, medical reasons, or a transfer.

The Department of Justice's May 2019 PREA Audit Report on the Northwest facility found similar problems. The report stated that "the initial PREA risk screening was conducted past 72 hours, past 30 days and/or not at all."⁹¹ When the department does not conduct timely and accurate risk screenings, the risk of inmates being abused or abusing others increases.

Recommendation

Management should ensure that all relevant correctional staff tasked with performing PREA screenings perform the screenings within the required timeframes. Management should implement effective controls to ensure compliance with applicable requirements, assign employees to be responsible and accountable for ongoing monitoring of risks and any mitigating controls, and act if deficiencies occur.

Management's Comment

Concur.

PREA compliance is a priority for our Department.

PREA screenings are an important tool to ensure sexual safety at all of our facilities. All offenders are screened as part of the diagnostic process and any risks for sexual victimization are identified and documented as well as any proclivities to act as a sexual aggressor.

In a recent DOJ audit of our diagnostic facility, Bledsoe County Correctional Complex, the DOJ auditor noted that TDOC not only met the standard for initial screenings, but exceeded the

⁹¹ The Department of Justice PREA audits issued from October 2017 through July 2019 on the Turney Center and Northeast facilities found no problems with screenings.

standard because they were conducted immediately upon arrival rather than waiting the allowable 72 hours. The results of these screenings are documented and available for approved users in the Tennessee Offender Management Information System (TOMIS) thereby allowing us to communicate the results statewide.

Prior to housing assignment at any facility, the results of prior screenings are reviewed. In addition to the initial diagnostic screening, an offender should be screened within 72 hours of arrival to each facility in our system and also subsequently screened within 30 days. As the issues with timeliness of screenings were discovered internally, they were corrected prior to the audit. Of the 290 initial screenings reviewed during the audit, 36 were noted to be deficient. Of the 36 noted to be deficient, 35 of them were completed prior to the audit review. Of the 290 thirty-day reviews evaluated during the audit, 59 were noted to be deficient. Of the 59 noted to be deficient, 40 of them had been completed prior to the audit review.

Although the internal process did resolve 93% of the errors, the issues with timeliness of PREA screenings have already been addressed at the facilities noted with a comprehensive agency approach being developed and implemented.

Finding 16 – State and CoreCivic facility personnel did not perform inmate orientation within three days of arrival at the facility or did not consistently maintain a signed Orientation Acknowledgement Form in the inmate institutional file

Department Policy 404.05 states that inmates must receive orientation within three calendar days of arrival, and that the Orientation Acknowledgement Form is the document of record for the completed orientation; the form serves as the department’s record that the correctional facility informed the inmate about the rules of the facility in order to assist the inmate with integration into the new environment. Policy 512.01, “Maintenance and Safeguarding of Inmate Institutional Records,” states that the correctional staff should file the completed form in the inmate’s institutional file. To determine if correctional staff at the 6 facilities we visited obtained Orientation Acknowledgement Forms, we selected a total nonstatistical random sample of 250 inmate files from a total population of 5,232 files.

For the full methodology, including the breakdown of the population and sample sizes by correctional facility we visited, see Appendix F-1 on page 169.

Based on testwork performed during our facility visits, we tested a sample of inmates assigned to the four correctional facilities on and after October 1, 2017. We found that the facilities either did not conduct orientation for their assigned inmates in a timely manner or did not obtain Orientation Acknowledgement Forms as documentation that inmates received orientation.

Table 43
Results of Testwork – Late Orientations and
Missing Orientation Acknowledgement Forms

Correctional Facility	Inmate Sample Size	Number of Orientations Performed Past the 3-Day Limit	Number of Missing Orientation Forms
Northeast	60	8	28
Northwest	24	11	8
Turney Center	60	1	8
Whiteville*	60	2	2

Source: Inmate institutional files.

*CoreCivic-managed facility.

Whiteville and Turney Center personnel could not explain why they conducted orientation late or account for the missing forms. At Northwest, the Director of Compliance explained that, during a U.S. Department of Justice PREA audit in December 2018 and May 2019, the federal auditor requested a random sample of inmate Orientation Acknowledgement Forms as part of the facility’s PREA audit. In both audits, Northwest’s personnel could not provide the auditor with the Orientation Acknowledgement Forms. As a result of this audit, Northwest personnel were retrained on the orientation process. As part of the follow-up corrective action plan for the May 2019 audit, all inmates received orientation again. Northwest personnel did not have these new orientation forms in the files.

According to Northeast personnel, they documented orientation in TOMIS. We found, however, that the TOMIS contact notes stated “to complete the orientation process/paperwork with the Sgt [Sergeant]” and did not indicate that personnel provided orientation within the required three days. Additionally, Northeast personnel could not find the Orientation Acknowledgement Forms for some inmates and could not explain why they conducted the orientations late.

Orientation is designed to make inmates aware of institutional and department policies they are expected to adhere to during their stay. It also provides inmates entering the system with information including, but not limited to, clothing issuance, family visitation and telephone privileges, inmate funds, disciplinary procedures, and access to health and mental health care. Completed and signed Orientation Acknowledgement Forms confirm that offenders received orientation upon arrival at a facility and the information they need to successfully integrate into the correctional environment. Signed, completed forms are proof the inmate acknowledged receipt of orientation materials.

Recommendation

Management should ensure that all correctional staff are conducting inmate orientations and completing and filing the appropriate forms as required by policy and should provide additional training to ensure correctional facilities comply with department policy.

Management's Comment

Concur.

Orientation of inmates is an important step to ensure an individual's successful integration into the period of confinement.

Although inmate orientation could be delayed by a number of factors, the process itself is expected to progress within the allotted timeframe.

We further acknowledge that proper documentation is necessary to create the historical record relevant to an inmate's arrival processing at the receiving facility.

The facility internal review process will be utilized to reinforce this policy requirement by conducting training and enforcing accountability.

Observation 8 – Northwest Correctional Complex and Turney Center Industrial Complex impeded inmates' access to information relating to healthcare, including access to grievance and sick call forms

Based on our observations while touring five housing pods at the correctional facilities we visited, we found that CoreCivic had corrected the issues involving access to grievance and sick call forms and had posted written instructions for inmates to access medical care in inmate living spaces; however, we found that two state-managed facilities—Northwest Correctional Complex and Turney Center Industrial Complex—had actually impeded the inmates' access to forms and healthcare instructions. Specifically, we found the following:

- At Northwest Correctional Complex, in 3 of the 5 pods we visited (60%), facility management placed the grievance and sick call forms in the cages used by the correctional officers. Inmates had to ask a correctional officer for the forms.
- In one of the 10 pods at Turney Center (10%), we found that inmates did not have ready access to grievance forms. Additionally, in one pod, facility management did not post the required information regarding inmates' access to medical care.

According to department staff, correctional officers and housing supervisors⁹² did not promptly replace grievance and sick call forms as needed and did not replace the posted instructions to access medical care that had been removed. We discussed with department staff the location of grievance and sick call forms locked in cages, and staff stated they placed the forms in the cages because the inmates used the forms to draw on or for illicit drug activity or had merely ripped the forms up. While we understand the challenges facilities' staff face in providing full access to these forms, without access to grievance and sick call forms, inmates cannot file a complaint or obtain medical care without assistance from facility staff, which may potentially

⁹² Housing supervisors are correctional officers who supervise the regular correctional officers and inmates in the housing units and pods.

delay an inmate’s grievance resolution or ability to receive medical care promptly. Additionally, without access to the posted information concerning how to obtain medical care, inmates may not fully understand how to obtain the medical care they need.

We recommend management and staff continue to find ways to make the required forms and information readily available to the inmates.

Observation 9 – State and CoreCivic correctional staff did not properly maintain class and job documentation in accordance with department policy

Classes

To determine if correctional staff maintained the required documentation for inmates attending classes, we tested a sample of inmates at six correctional facilities and examined attendance records for 13 randomly selected days for the period, as described in **Appendix F-1** on page 169. Because class instructors did not complete attendance sheets or maintain other clear documentation to support inmate class attendance, we found that staff at each facility could not fully support class attendance for the inmates we tested. We also determined that department management did not ensure that all attendance entries in TOMIS agreed with the correctional facility’s attendance records that were provided. Our testwork results are shown in **Table 44**.

Table 44
Results of Testwork – Inmates with Class Attendance Record Issues

Facility	Attendance Records Not Complete or Clear	Attendance Records Do Not Agree with TOMIS	Attendance Records Not Maintained
Northeast*	11 of 60 (18%)	2 of 60 (3%)	9 of 25 (36%)
Northwest	6 of 25 (24%)	7 of 25 (28%)	9 of 25 (36%)
Turney Center	6 of 25 (24%)	12 of 25 (48%)	9 of 25 (36%)
Whiteville†	1 of 60 (2%)	8 of 60 (13%)	No Issues
Trousdale Turner†	1 of 60 (2%)	4 of 60 (7%)	No Issues

*Due to numerous issues found in the initial sample of 25, we expanded the sample for some testwork to 60.

†CoreCivic-managed facilities.

Source: Department of Correction class attendance records.

According to department management, the issues noted related to oversight and human error. In the instances where instructors at Northeast and Turney Center did not complete attendance records, the inmates in question were in special housing units and were not required to attend class to complete class-related work. The class instructors gave the inmates homework for class credit. However, we could not verify the inmates actually completed the homework or the instructors maintained documentation for inmates they saw on those days. When department and CoreCivic management do not ensure that staff maintain accurate attendance records, the risk increases for improper payments to inmates for attending classes.

Jobs

We found that for five of the six correctional facilities visited, the department and CoreCivic did not have the required documentation, such as the inmates' signed job acknowledgment forms. See **Table 45**. Agreements for job positions and inmate-acknowledged responsibilities provide the department and CoreCivic with transparency and documentation to prevent possible disputes regarding job responsibilities and inmate pay.

Table 45
Results of Testwork - Job Acknowledgment Forms

Facility	No Inmate Acknowledgement Form
Northeast	15 of 25 (60%)
Northwest	16 of 60 (27%)
Turney Center	18 of 60 (30%)
Hardeman*	8 of 25 (32%)
Trousdale Turner*	8 of 60 (13%)

Source: Department of Correction inmate job files.

* CoreCivic-managed facilities.

According to the department, the job acknowledgment forms were likely with the inmates' job supervisors, instead of in the inmates' job files. However, we requested the forms multiple times, and facility staff could not locate them while we were on site.

These job acknowledgement forms are important because they document that the inmate understands the duties of his or her job, the pay rates for the job, and who the job supervisor is. The management and staff of the department and CoreCivic should ensure the job coordinators are aware of the requirement for the job agreements to be signed by the inmates and the need for the signed agreement to be maintained in the job files. The department should continue to work with educators at the facilities to ensure they follow departmental policies for attendance recordkeeping and entry into TOMIS.

Observation 10 – Trousdale Turner Correctional Center did not conduct the minimally required random drug screenings of the inmate population, and Whiteville Correctional Facility, Turney Center Industrial Complex, and Northwest Correctional Complex did not consistently and accurately record screening results in TOMIS

Based on our testwork at the six correctional facilities, we found that four facilities did not conduct the required random drug screenings each month and did not enter the results in TOMIS. Specifically, we found the following:

- The facility personnel at Whiteville Correctional Facility did not record the inmates' random drug screen results in TOMIS for 3 of 60 inmate drug screens we reviewed (5%). Although the staff should have recorded the results in TOMIS, we found that, because the results of all three drug screens were negative, facility personnel did not

need to pursue disciplinary action for these inmates. According to department management, this issue was due to an oversight; staff should have entered the information into TOMIS as negative drug screens.

- Based on our interview with the drug testing coordinator at Trousdale Turner Correctional Center, the coordinator informed us that he did not test the minimally required 2.5% of the inmate population for either March or April 2019. According to the drug testing coordinator, when he was given the responsibility for conducting the drug screenings in March 2019, he received on-the-job training from the former drug testing coordinator. He went on to state that he did not have access to TOMIS at that time and had to attend a critical incident response team class.
- We found that the Turney Center Industrial Complex drug testing coordinator did not enter 3 of 60 screenings (5%) in TOMIS accurately for drug screens conducted in February and March 2019. Specifically, the coordinator did not enter one test result and incorrectly entered information on the remaining two drug screenings. For the two incorrectly entered tests, the inmates refused to take the drug screen, but the coordinator entered in TOMIS that the test results were “Negative”; according to the drug screening coordinator, he mistakenly clicked on the wrong TOMIS prompt. For the drug screen that the coordinator did not enter, the sample tested positive for alcohol and drugs; however, the coordinator stated he missed entering the information.
- Based on discussion with the drug screening coordinator and the disciplinary board sergeant and our review of drug screening documentation, we found that facility personnel at Northwest Correctional Complex were approximately three months behind on holding disciplinary hearings for inmates with positive drug screens and those inmates who refused to take the drug screens. Northwest’s Disciplinary Board Sergeant stated that the relevant policy, TDOC Policies 502.01 and 502.02, states that disciplinary hearings should be performed in a reasonable time.

“No inmate charged with a disciplinary offense should be required to wait more than seven days for his/her disciplinary hearing to be held.”

Source: TDOC Policy 502.01.

By not performing the minimum number of monthly random drug screenings, facility management faces an increased risk that inmate alcohol or drug use could go undetected, creating an environment for increased violent behavior. The department and CoreCivic management should continue to educate and work with the facilities’ drug testing coordinators to ensure the facilities meet the 2.5% random drug testing requirement and that staff enter the drug screening results completely and accurately into TOMIS. By doing so, the department and CoreCivic can better track the number of positive drug results occurring at each facility, allowing them to address facilities with the greatest risk of alcohol and drug abuse. The department and CoreCivic can also offer inmate referrals to the facilities’ substance abuse treatment programs, if the facilities conduct the appropriate screenings and accurately enter the results in TOMIS.

Appendix F Inmate Services and Support

Appendix F-1 Methodologies to Achieve Objectives

To achieve our objectives, we selected a nonstatistical random sample of inmates at the following correctional facilities to determine if they completed the Inmate Admissions Assessment forms.

Correctional Facility	Inmate Population	Inmate Sample Size
Northeast	168	58
Northwest	476	24
Turney Center	246	58
Hardeman*	332	25
Whiteville*	1,496	25
Trousdale Turner*	2,514	25
Total	5,232	215

* CoreCivic-managed facilities.

Source: Department of Correction inmate rosters pulled from INFOPAC reports generated on June 6, 2019 (Northeast), May 15, 2019 (Northwest), May 30, 2019 (Turney Center), May 9, 2019 (Hardeman), April 11, 2019 (Whiteville), and May 2, 2019 (Trousdale Turner).

We reviewed files for inmates assigned to each facility on or after October 1, 2017, which is the beginning of the audit period. We inspected the files to determine if correctional facility personnel consistently checked the Inmate Admissions Assessment form for completeness and filed it as required by policy.

We selected nonstatistical random samples of inmate files assigned the following correctional facilities on or after October 1, 2017, to determine if the inmates received written notice at least 48 hours in advance of any classification panel hearing or if the inmates waived this notice instead.

Correctional Facility	Inmate File Population Size	Inmate File Sample Size for Late Classification Hearings	Inmate File Sample Size for Missing 48-Hour Notifications and Waivers	Inmate File Sample Size for Missing Classification Summaries
Northeast	168	24	25	58
Northwest	476	23	59	24
Turney Center	246	23	58	24
Hardeman*	332	25	25	25
Whiteville*	1,496	60	60	60
Trousdale Turner*	2,514	60	25	60
Total	5,232	215	252	216

*CoreCivic-managed facilities.

Source: Department of Correction inmate rosters pulled from INFOPAC reports generated on June 6, 2019 (Northeast), May 15, 2019 (Northwest), May 30, 2019 (Turney Center), May 9, 2019 (Hardeman), April 11, 2019 (Whiteville), and May 2, 2019 (Trousdale Turner).

In addition, we tested inmate files to determine if the inmates received a classification hearing within 14 days of their arrival for processing at the Bledsoe County Correctional Complex and whether the files contained signed Offender Classification Summaries. We then compared the files to corresponding dates, entries, and contact notes in TOMIS.

We selected a nonstatistical random sample of inmate files assigned to the following correctional facilities on or after October 1, 2017, and we inspected these files to determine if they contained a signed Risk Needs Assessment report.

Correctional Facility	Inmate File Population Size	Inmate File Sample Size
Northeast	168	58
Northwest	476	24
Turney Center	246	24
Hardeman*	332	25
Whiteville*	1,496	25
Trousdale Turner*	2,514	60
Total	5,232	216

*CoreCivic-managed facilities.

Source: Department of Correction inmate rosters pulled from INFOPAC reports generated on June 6, 2019 (Northeast), May 15, 2019 (Northwest), May 30, 2019 (Turney Center), May 9, 2019 (Hardeman), April 11, 2019 (Whiteville), and May 2, 2019 (Trousdale Turner).

We compared the files to corresponding dates, entries, and contact notes in TOMIS.

From the following populations, we selected a nonstatistical random sample of inmates assigned to the following correctional facilities on or after October 1, 2017, to determine if the inmates received the appropriate Prison Rape Elimination Act screenings upon arrival at the facility.

Correctional Facility	Inmate Population Size	Inmate Sample Size
Northeast	168	60
Northwest	476	25
Turney Center	246	25
Hardeman*	332	60
Whiteville*	1,496	60
Trousdale Turner*	2,514	60
Total	5,232	290

*CoreCivic-managed facilities.

Source: Department of Correction inmate rosters pulled from INFOPAC reports generated on June 6, 2019 (Northeast), May 15, 2019 (Northwest), May 30, 2019 (Turney), May 9, 2019 (Hardeman), April 11, 2019 (Whiteville), and May 2, 2019 (Trousdale).

We examined dates listed in TOMIS to determine whether facility staff screened the inmates for a history of aggressive sexual behavior or sexual abuse and victimization within 72 hours after their arrival at the facilities and rescreened inmates within 30 days.

We selected a nonstatistical random sample of inmate files assigned to the following correctional facilities on or after October 1, 2017, to determine if each inmate had a completed and signed Orientation Acknowledgement Form in the inmate's institutional file.

Correctional Facility	Inmate File Population Size	Inmate File Sample Size
Northeast	168	58
Northwest	476	24
Turney Center	246	58
Hardeman*	332	25
Whiteville*	1,496	60
Trousdale Turner*	2,514	25
Total	5,232	250

*CoreCivic-managed facilities.

Source: Department of Correction inmate rosters pulled from INFOPAC reports generated on June 6, 2019 (Northeast), May 15, 2019 (Northwest), May 30, 2019 (Turney Center), May 9, 2019 (Hardeman), April 11, 2019 (Whiteville), and May 2, 2019 (Trousdale Turner).

We compared the files to corresponding dates, entries, and contact notes in TOMIS.

We obtained and reviewed department policies related to grievances and access to healthcare at all six correctional facilities:

- Northeast Correctional Complex (state-managed);
- Northwest Correctional Complex (state-managed);
- Turney Center Industrial Complex (state-managed);
- Hardeman County Correctional Facility (CoreCivic-managed);
- Whiteville Correctional Facility (CoreCivic-managed); and

- Trousdale Turner Correctional Center (CoreCivic-managed).

During each visit we performed walkthrough procedures in five housing pods at each facility, expanding to five additional pods at Turney Center due to issues we found, to determine if department and CoreCivic management provided inmates with unimpeded access to grievance forms and posted instructions for inmates to access medical care and the Prison Rape Elimination Act (PREA) hotline numbers in the pods' living areas.

We reviewed departmental policy related to inmate classes and jobs. We obtained INFOPAC reports from TOMIS related to inmate pay and attendance for different pay periods. At each facility we visited, we selected the following nonstatistical random samples of inmates from the following populations. To test inmate class requirements, we haphazardly selected 13 days for each inmate.

Correctional Facility	Period	Population Size	Maximum Sample Size Tested
Northeast Correctional Complex	April 26-May 25, 2019	1,245 inmates assigned to jobs and 262 inmates assigned to classes	25 inmates assigned to jobs and 60 inmates assigned to classes
Northwest Correctional Complex	March 26-April 25, 2019	1,733 inmates assigned to jobs and 671 inmates assigned to classes	60 inmates assigned to jobs and 25 inmates assigned to classes
Turney Center Industrial Complex	March 26-April 25, 2019	1,770 inmates assigned to jobs and 160 inmates assigned to classes	60 inmates assigned to jobs and 25 inmates assigned to classes
Hardeman County Correctional Facility*	March 26-April 25, 2019	1,600 inmates assigned to jobs and 464 inmates assigned to classes	25 inmates assigned to jobs and 60 inmates assigned to classes
Whiteville Correctional Facility*	February 26-March 25, 2019	1,119 inmates assigned to jobs and 319 inmates assigned to classes	25 inmates assigned to jobs and 60 inmates assigned to classes
Trousdale Turner Correctional Center*	March 26-April 25, 2019	1,745 inmates assigned to jobs and 364 inmates assigned to classes	60 inmates assigned to jobs and 60 inmates assigned to classes
	Total	9,212 inmates assigned to jobs and 2,240 inmates assigned to classes	255 inmates assigned to jobs and 290 inmates assigned to classes

*CoreCivic-managed facilities.

Source: Offender Pay Attendance reports generated from INFOPAC for the periods listed above.

For the inmates sampled, we obtained educational attendance records for each class to determine which inmates attended. We haphazardly sampled 13 days from the pay period⁹³ prior to our facility visit to determine if the inmates' attendance records agreed to the inmates' pay. We obtained the job files for each inmate sampled to determine if the job files contained the required acknowledgment forms signed by the inmates.

We obtained and reviewed the department's policy for required random drug testing. We conducted site visits and performed testwork at the six correctional facilities we visited.

We obtained the department's monthly drug screening listing from each facility's drug testing coordinator for approximately one to two months prior to the date of the site visit. Using the listings, we selected the following nonstatistical random sample from each facility to determine if the facility performed drug screenings on 2.5% of inmates each month. We also determined if the facility entered the drug screening results in TOMIS; for any positive screenings, we determined if the facility initiated disciplinary action, as required by department policy.

Correctional Facility	Site Visit Date	Sample Size Tested
Northeast	June 10-14, 2019	25
Northwest	May 20-24, 2019	25
Turney Center	June 3-7, 2019	60
Hardeman*	May 13-17, 2019	60
Whiteville*	May 15, 2019	60
Trousdale Turner*	May 6-9, 2019	25
Total		255

* CoreCivic-managed facilities.

Source: Samples pulled from population of random drug screenings obtained from each facility's Drug Screening Coordinator for the month(s) prior to visits to correctional facilities.

⁹³ The pay period is the month for which the inmate is paid for working a job or attending a class. The pay periods start on the 26th of one month and end on the 25th of the succeeding month.

DEPARTMENT'S COMMUNITY SUPERVISION RESPONSIBILITIES

CHAPTER CONCLUSIONS

Matter for Legislative Consideration – Single Comprehensive Resource for Offender Arrests (page 175)

Finding 17 – Community supervision supervisors, District Directors, and Correctional Administrators did not always review case records as required by department policy to ensure probation and parole officers performed their required duties (page 179)

Observation 11 – Although department management has worked since 2014 to ensure probation and parole officers performed their required duties, probation and parole officers did not meet supervision requirements for offender case plan reviews (page 182)

DEPARTMENT’S COMMUNITY SUPERVISION RESPONSIBILITIES

MATTER FOR LEGISLATIVE CONSIDERATION – SINGLE COMPREHENSIVE RESOURCE FOR OFFENDER ARRESTS

The Department of Correction and state and local law enforcement agencies could benefit from a single comprehensive resource for looking up offender arrests across the state to more easily monitor offenders’ compliance with supervision requirements. Section 40-28-605, *Tennessee Code Annotated*, requires that probation and parole officers “supervise, investigate and check on the conduct, behavior and progress of parolees and persons placed on probation.” As noted in **Observation 11**, officers are required to determine on a monthly basis whether offenders have new arrests or outstanding warrants; however, to fulfill this requirement, officers must search and ultimately rely on multiple federal, state, local, and third-party sources to determine whether the department’s offenders have new arrests or outstanding warrants. These sources include searching paper arrest logs of local jurisdictions, news sources, the victim notification service,⁹⁴ arrest compilation websites (such as Arrests.gov), the federal National Crime Information Center (NCIC), and third-party free cell phone applications (such as Vinelink or Mobile Patrol). Based on our discussions with department management, the state does not have a centralized (state, local, and federal) electronic database for arrests or warrants.

State law enforcement and department probation and parole officers could benefit from a statewide electronic database for the centralization of arrests, warrants, and other similar actions. A single comprehensive resource would allow law enforcement and probation and parole officers to quickly determine if an individual has been arrested recently anywhere in the state, or if there is any open warrant out for their arrest.

Offender Supervision Process

Probation and parole officers are responsible for supervising parolees and individuals on probation on active supervision status⁹⁵ on a monthly basis to ensure they meet the conditions of their parole or sentence. Specifically, the officers are required to perform the following 11 supervisory requirements:

- perform arrest checks;
- request offender drug screens;
- perform employment verification;
- hold face-to-face meetings with offenders;

⁹⁴ Tennessee’s Victim Notification Service is maintained by the Department of Correction and is used to keep registered victims, survivors, families, and other interested parties informed of an offender’s status, movements, parole hearing dates, release status, and other information.

⁹⁵ The department may also place offenders on administrative offender status who live out of state, have outstanding warrants or are in custody, or have absconded supervision. Of the supervisory requirements, officers are only required to perform arrest checks on administrative status offenders.

- collect monthly probation and parole fees for supervision, diversion, and Criminal Injuries Compensation funds, as well as incidental fees from activities like DNA collection, GPS monitoring, and drug testing;
- perform home visits;
- create or review the offender's case plan, which details risks, needs, and areas of concern, and provides the offender with suggested methods to better their situation and comply with supervision requirements;
- conduct searches of a higher-risk offender's home;
- perform procedures to determine an offender's needs and any significant risks the offender poses that need to be taken into account to properly supervise and reform the offender;
- perform checks to ensure sex offenders are attending required sex offender treatment therapy; and
- perform checks to determine if the offender is complying with any special conditions set by the judge as a condition of their probation or parole.

The offender's supervision level⁹⁶ determines the specific supervisory requirements an officer must perform and their required frequency. For example, officers are required to conduct a face-to-face meeting with minimum-security offenders every six months, with medium-security offenders every three months, and maximum- and enhanced-security offenders every month.

Standards Due Report

A staff person from the Department of Finance and Administration's Strategic Technology Solutions group generates the data needed for the Standards Due Report for use by the Department of Correction. The Department of Correction's administrative staff then use this data to create a tool that contains information on all offenders on probation and parole. Department management distributes the tool twice a week to each probation and parole officer to facilitate their monitoring of offenders. Officers use this tool to complete their supervisory requirements each month, as it highlights each requirement that is due during the current month and any requirements that are overdue, so that officers can prioritize those items to ensure that they are completed.

During the period October 1, 2018, through March 4, 2019, the reports contained data on an average of 40,432⁹⁷ offenders. This data includes the assigned probation and parole officer and the due dates for each of the 11 supervisory requirements for all offenders.

⁹⁶ The most common supervision levels are Intake, Minimum, Medium, Maximum, and Enhanced. Additionally, there are four levels of supervision for sex offenders. These are Transitional, Intermediate, Secondary, and Primary.

⁹⁷ We calculated a six-month average using monthly department supervisory reports we reviewed during the audit.

Supervision of Probation and Parole Officers

Department policy describes community supervision supervisors and managers' review requirements to ensure probation and parole officers continually monitor their assigned offenders and update the offender case records.

Offender Case Record Life Cycle	Review Requirements
Initial Case Record Review	Once the offender enters community supervision, supervisors and/or managers review all initial case records within 60 days of the offender's community supervision start date. This includes reviewing the case file and TOMIS.
Monthly Case Record Review	District supervisors inspect a minimum of 3% of their case files and TOMIS records.
Closing Case Record Review	Supervisors perform a final review of the offender's case file when the court or Board of Parole issued an order of restitution ⁹⁸ prior to the offender's release from community supervision.
Quarterly Case Record Reviews	Community Supervision District Directors review 10% of their district's required 3% monthly case record reviews. Correctional Administrators review 10% of the District Directors' quarterly case record reviews per their assigned regions.

Source: Department of Correction Policy 706.02, "*Supervisory Review of Caseloads*."

To facilitate the monitoring of probation and parole officers' work, the department provides a Supervisor Annual Case Record Review report four times a month to probation and parole supervisors, District Directors, and Correctional Administrators. In the first report, the department randomly selects a sample of offender case records representing 3% of the total active parole and probation offender population as of the beginning of that month. Supervisors must complete their case record reviews listed on the Supervisory Case Record Review report and enter their comments in TOMIS before the end of the month.

By the end of each quarter, District Directors must review 10% of the Supervisory Case Record Review reports run for that quarter and specifically review the supervisors' or managers' work. Correctional Administrators must audit 10% of the District Directors' reviews by the end of that same quarter.

Results of Prior Audits

In the 2012 Performance Audit of the Board of Probation and Parole (TDOC took over all board functions after this audit), we found that probation and parole officers were not completing

⁹⁸ Identified victims, whether individuals or businesses, may be entitled to an order of restitution for certain losses suffered because of the commission of an offense, or losses the offender agrees to repay as part of a plea agreement. The sentencing judge determines the parameters and issues the order of restitution.

all supervision requirements. Management concurred and indicated that the department would ensure that probation and parole officers follow offender supervision guidelines and enter all information appropriately in TOMIS, largely through additional training and equipment upgrades to increase efficiency. We also found that probation and parole officer supervisors did not review approximately half of the cases in our sample. Management concurred and indicated it would use all available tools to ensure the completion of supervisory reviews, and that supervisors discuss the results with officers as policy requires.

In the 2014 Performance Audit of the Department of Correction, we found that while there was improvement in supervision rates since 2012, probation and parole officers were still not completing all supervision requirements. Management concurred and restated its commitment to improving officer performance, citing increased training and improvement of standards, adding a requirement for probation and parole managers to report monthly to their District Directors, and requiring manager and District Director signatures on case file review audit forms. We also found that the department had not used all available tools to ensure the completion of supervisory reviews and did not ensure supervisors discussed reviews with officers as required. Management concurred only in part, stating that they believed their performance to be an improvement over the previous audit. However, they stated they would initiate a policy to clarify review requirements and timeliness. Following the audit fieldwork, management developed additional monitoring methods at the district level to monitor supervisors.

In the department's 2017 performance audit, we reported repeated conditions that probation and parole officers did not always meet offender supervision requirements and supervisors did not always meet oversight requirements. Management concurred with our findings and stated that to improve the monitoring capabilities of officers, they would add by 2018 a compliance rating scale to each standard in the Standards Due Report. This would be the basis of an automatically calculated compliance score for each offender every time the report generated, allowing officers, managers, and other supervisors the ability to quickly review an offender's status. Management also stated that the Standards Due Report allows managers to view their officers' caseloads at a glance, so that they can help the officers manage their work and time. They stated that the Report also allows District Directors to quickly determine their district's compliance level. They were working to implement a Case Management Review process to facilitate improvements in the ability to meet supervisor oversight requirements. Management updated the Standards Due Report to include functionality that alerted probation and parole officers when a supervisory requirement was almost due or was overdue for each offender. This change allowed the department to correct this finding for all supervisory requirements other than reviewing and creating offender case plans.

Audit Results

- 1. Audit Objective:** In response to the prior audit finding, did management ensure that community supervision supervisors and managers meet the requirements for offender case record reviews to ensure the probation and parole officers performed their required duties?

Conclusion: Based on our testwork, we found that the department’s community supervision supervisors did not always perform their required duties for initial and monthly reviews. Furthermore, we noted that the District Directors and Correctional Administrators did not complete their required number of quarterly case reviews. See **Finding 17**.

2. Audit Objective: In response to the prior audit finding, did management ensure that probation and parole officers met all offender supervision standards?

Conclusion: Based on our testwork, although the probation and parole officers used the updated Standards Due Report tool to better perform their duties in a timely manner, we found that the officers did not always complete offender case plan reviews when required. See **Observation 11**.

3. Audit Objective: Do probation and parole officers have a single comprehensive resource for looking up arrests in Tennessee to make their monthly arrests checks?

Conclusion Based on our discussions with agency management during our review of offender supervision, officers do not have a reliable source of arrest information statewide. See **Matter for Legislative Consideration**.

Finding 17 – Community supervision supervisors, District Directors, and Correctional Administrators did not always review case records as required by department policy to ensure probation and parole officers performed their required duties

To determine whether probation and parole supervisors and high-level management met supervisory review responsibilities, we obtained and analyzed 18 monthly Supervisor Annual Case Record Review reports. These reports, in total, included 18,130 offenders who were active from October 1, 2017, through March 31, 2019. In addition, we attempted to obtain documentation relating to District Director and Correctional Administrator reviews.

For the full methodology, see Appendix G-1 on page 184.

Department Policy 706.02, “Supervisory Review of Caseloads,” requires supervisors to ensure parole and probation officers are properly monitoring offenders by

- reviewing all offender case records after completion of the intake process but within 60 days of the offender supervision start date,
- entering a summary of the review into TOMIS as a contact note with a comment outlining the completeness of the offender case record and TOMIS record, and
- reviewing a minimum of 3% of their staff’s offender case records each month using the Monthly Case Record Review.

The policy also requires the District Directors to compile three months of supervisory reviews and inspect 10% of those reviews, including the case records they refer to for deficiencies; and requires Correctional Administrators to review 10% of the District Director's quarterly case records to identify any deficiencies in the reviews.

Initial Case Record Reviews – Repeated Condition

The initial case record review is the first review of an offender case file and TOMIS record performed by a supervisor, meant to ensure that officers completed the intake process for every offender beginning probation or parole. During our testwork, we found that supervisors did not perform initial reviews for 5 of 60 probation and parole offender case records (8%) within the required 60-day period, and 1 of the 60 case records (2%) did not receive the initial review. Additionally, supervisors must enter specific contact notes in TOMIS upon completion of the initial review. For 14 of 60 initial reviews (23%), we determined in our testwork that the supervisor opened the TOMIS record but did not document the review in the contact notes as required.

According to the department, the Community Supervision unit is short staffed, causing supervisors with large workloads to fall behind in their reviews. Department management also stated that the policy which sets the deadline for the initial review may be confusing to some supervisors.

District Director and Correctional Administrator Quarterly Reviews – New Condition

Based on our review, we determined that the department did not track whether District Directors and Correctional Administrators performed the required 10% of supervisor reviews every quarter. According to the Director of Compliance, by the time of our audit, management had not implemented “a formal tracking mechanism to memorialize and preserve a record of the reviews completed by District Directors and Correctional Administrators.” The Director of Compliance and Acting Assistant Commissioner both stated that if the outgoing Assistant Commissioner of Community Supervision who exited during our audit period had a process for tracking District Director and Correctional Administrator reviews, she did not share it with them.

After the completion of our field work and discussion of these findings with department management, the Director of Compliance and Acting Assistant Commissioner created adjustments to department Policy 706.02, stating that the adjustments would be in force no later than November 1, 2019.

The newly adjusted policy now requires that District Directors and Correctional Administrators perform their respective 10% reviews once a month instead of once a quarter. The new policy also establishes a contact code in TOMIS specifically for Correctional Administrator reviews to differentiate them from other supervisor reviews. Finally, the policy clearly defines the period of initial case record review for probation and parole supervisors, requiring them to perform an initial review within 60 days after the initial intake and orientation interview performed by a probation and parole officer.

The Director of Compliance and the Acting Assistant Commissioner also provided evidence to indicate they will receive monthly updates on the numbers of reviews performed by the District Directors and Correctional Administrators. In addition, they provided evidence of new spreadsheets built for internal use that would provide the Acting Assistant Commissioner with a weekly breakdown of both performed and unperformed reviews for a three-month period, as well as the number of reviews of violent and sex offenders performed by region. They stated that the data for these numbers will come from TOMIS.

Overall Effect

When community supervision supervisors and managers do not perform required reviews completely and timely, the department cannot ensure offenders are meeting community supervision requirements and are increasing the risk that offenders will go unmonitored and that the community's safety will be put at risk.

Recommendation

Management should provide appropriate training to community supervision supervisors and managers regarding department policies and procedures. Furthermore, the department should implement appropriate procedures that ensure District Directors and Correctional Administrators are meeting policy requirements for case record reviews.

Management's Comment

Concur in part.

While there is always room for improvement, it is important to recognize that the Community Supervision division completion of both Initial and Annual Supervisory Case File Reviews has consistently met the required 95% or above compliance standard required by the department's internal audit process.

The Department acknowledges that at the manager level some files were not reviewed within the expected time frame; however all reviews were conducted. Focused training on documentation requirements will continue to be delivered to ensure more comprehensive comments are entered by supervisors during the case file review process. To more specifically target the training, we have developed a report to identify insufficient documentation in ZZZI and ZZZA contact notes.

Also, while review of supervision practices by the Correctional Administrators and District Directors takes place through the use of the Standards Due Report practices, not all case file reviews by the District Directors and Correctional Administrators were appropriately documented. The department has since developed and implemented specific procedures for verification of case file reviews completed by District Directors and Correctional Administrators.

The procedure was reviewed and noted as adequate by the Comptroller's auditors prior to the close of the audit. It includes a two-pronged tracking mechanism that provides regular updates

of case file reviews completed throughout the month and an end-of-the-month report-out to ensure the reviews are completed by District Directors and Correctional Administrators in accordance with policy.

The procedure demonstrated with the auditors was implemented in August 2019 and currently reflects all required completed case file reviews by District Directors and Correctional Administrators.

Additionally, Policy 706.02, “Supervisory Review of Caseloads,” has been modified to clarify ambiguity in policy language relative to the specific timeframe in which supervisors should complete initial case file reviews.

Also, the formula for the Standards Due Report has been modified to reflect this policy change. And finally, the Initial Casefile Review Checklist has been modified to further clarify items related to the Case Management Plan, Employment Verification, and other Intake standards of supervision requirements.

Training regarding these modifications has been provided to supervisors.

Observation 11 – Although department management has worked since 2014 to ensure probation and parole officers performed their required duties, probation and parole officers did not meet supervision requirements for offender case plan reviews

We analyzed six monthly Standards Due Reports for the period October 1, 2018, through March 4, 2019, to determine whether probation and parole officers met the 11 key supervisory requirements, and we selected the first report created for each month of the test period. Based on this analysis, we identified 2 of 11 supervisory requirements (18%)—Employment Checks and Offender Case Plan Reviews—that were consistently overdue. We selected a random sample of 25 overdue items for employment checks and 25 overdue items for offender case plan reviews. We reviewed the officers’ TOMIS case activity and notes⁹⁹ to determine if these overdue items were due to an officer failing to perform supervisory requirements.

We found that, for 7 of 25 offender case plan reviews (28%), officers did not document in TOMIS case activity and notes to indicate that they completed these reviews timely. To perform offender case plan reviews, the officer meets face-to-face with offenders to discuss their risks and needs, progress or deficits, and any special conditions, and other areas of concern. The officer then creates or modifies the offender’s case plan,¹⁰⁰ using contact notes that describe the recommendations that the officer believes will help the offender meet the terms of probation or parole.

⁹⁹ Case activity includes all information in TOMIS related to the offender’s community supervision case. This includes all contact notes, supervision level, and location. See the methodology in **Appendix G-1** on page 184 for more information.

¹⁰⁰ In the offender’s case plan, the officer can recommend classes or meetings with case workers or other specialists.

Department Policy 704.01, “Standards of Offender Supervision,” requires officers to create offender case plan reviews for offenders. Policy 704.01 also requires the officer to document within TOMIS all contact and activity that the officer schedules and completes with the offender, including when the officer attempted to contact or complete activities with the offender but was unable to do so. Additionally, Policies 706.01, “Offender Case Record Management,” and 706.03, “Offender Contact Notes,” require officers to record in TOMIS any offender case activity. If officers do not adequately and timely supervise offenders, the risk increases that an offender will violate the terms of probation or parole.

For employment verification, based on our review of the contact notes, we noted that the offenders

- failed to contact the officer,
- did not always provide the required proof, and
- failed to show for scheduled visits.

As a result of the offenders’ actions, the officers could not complete their review as required.

Management should ensure that probation and parole officers conduct all required offender monitoring activities on time and ensure that those activities are documented in accordance with department policy.

Appendix G

Department's Community Supervision Responsibilities

Appendix G-1

Methodologies to Achieve Objectives

To meet our objective, we interviewed the Former Assistant Commissioner of Community Supervision, Acting Assistant Commissioner of Community Supervision, Director of Classification, Director of Community Housing Supervision, Director of Community Supervision Policy, a Data Analyst in Community Supervision, a Business Intelligence specialist with Finance and Administration, a District Director, and the Senior Management Consultant to obtain an understanding of the Community Supervision unit and the procedures management implemented to address the prior audit findings. We also reviewed all relevant laws and department policies and procedures. To determine if probation and parole officers met all offender supervision requirements, we obtained and analyzed¹⁰¹ six Standards Due Reports from October 1, 2018, through March 4, 2019, then

- traced key pieces of offender data from these reports to TOMIS to determine if the reports are accurately obtaining data from the TOMIS database;
- used the original TOMIS data used to create the Standards Due Reports to re-perform calculations of the total amount of supervisory requirements overdue relative to each offender and compared them to the department's calculations;
- compared the number and percentage of overdue requirements from the March 4, 2019, Standards Due Report to the overdue amounts from both the October 1, 2018, Standards Due Report and the prior testwork results from the 2017 performance audit to determine if overall improvement has been made;
- created a trend analysis to determine if the percentage of overdue requirements have improved or worsened over time; and
- performed additional sample testwork (see below) to determine if officers were performing their supervisory requirements or if other factors prevented the officers from completing their duties.

This testwork consisted of selecting a nonstatistical random sample of 25 overdue items for both employment checks (from a population of 2,432 overdue checks) and offender case plan reviews (from a population of 2,278 overdue reviews) and reviewing the TOMIS case notes for the offender to determine if these overdue items were due to an officer failing to perform supervisory requirements.

¹⁰¹ This analysis consisted of two steps. First, we used the raw TOMIS data used to create the Standards Due Reports to build our own report, then reconciled the two reports for all 11 supervisory requirements. We compared the number of offenders each requirement applied to with the number of overdue procedures for that requirement. These procedures were performed for each of the six months in the above testwork period and then reviewed to determine if lateness progressed over the same period.

To determine if an overdue item was caused by the officer failing to perform the supervisory requirements, we reviewed the following information within TOMIS for six months prior to and after the requirement's due date:

- all contact notes for the offender;
- the offender's supervision level; and
- the offender's location.

We noted that officers often created contact notes that described the completion of a supervisory requirement but did not include all contact codes for the requirements described within that note. The Standards Due Report determines if a requirement is late by detecting if an officer entered this code. If the officer described how they performed the supervisory requirement in any note, we did not consider it an error. Additionally, the officer could note that they could not contact the offender; that the offender did not attend a scheduled meeting, was sick, or was in court; or other similar reasons why the requirement could not be completed.

We reviewed the offender's supervision level and location to determine if the offender needed to have the tested supervisory requirements performed. For example, if the offender's previous supervision level was "In Custody," "Warrant," "Residential Treatment Placement," or other similar supervision level, then the officer would not need to perform the supervision requirements. Also, an offender's supervision level may change from "In Custody, etc." to a standard level, such as minimum or medium security. In this case, the Standards Due Report would only see that a supervisory requirement was not previously performed and would flag it as late, not taking into consideration an offender's previous non-active status.

To determine whether probation and parole supervisors, managers, District Directors, and Correctional Administrators were meeting all standards required by policy, we obtained and analyzed 18 monthly Supervisor Annual Case Record Review reports. These 18 reports together totaled 18,130 offenders who were active during the period October 1, 2017, to March 31, 2019. We used this population to

- test a 12-month period for duplicate TOMIS IDs (out of 12,357 TOMIS IDs) in these reports, to ensure the algorithm that creates the report was properly omitting duplicate IDs;
- test two random, nonstatistical samples of offenders listed in the supervisor case record review reports: one sample of 60 (out of 8,422 offender records in TOMIS) for adherence to proper intake review procedures, and one sample of 60 (out of 7,561 offender records) for adherence to proper closing review procedures; and
- test a third random, nonstatistical sample of 60 offenders listed in the supervisor case record review reports (out of 5,111 offender records) to determine whether supervisors followed proper procedures during monthly reviews.

We also tested whether District Directors and Correctional Administrators were reviewing their required number of offender case files and supervisor reviews. To do so, we obtained and

reviewed a list of all probation and parole managers, District Directors, and Correctional Administrators active within our audit period, inspected review forms completed by Directors and Administrators, and analyzed a department spreadsheet that summarized the count of Director and Administrator review forms by probation and parole district. Our conclusions were based on interviews and correspondence with department management; a list of all probation and parole managers, District Directors, and Correctional Administrators active within our audit period; review forms completed by Directors and Administrators that the department provided; and inspection of a department spreadsheet that summarized the count of those forms by probation and parole district.

COMET IMPLEMENTATION

CHAPTER CONCLUSION

Observation 12 – After signing a \$15,347,200 contract, spending three years on development, and facing unforeseen obstacles, the department’s vendor has been unable to implement the new COMET system, and as of September 2019, there is no official “go-live” date (page 188)

COMET IMPLEMENTATION

General Background Information

The Tennessee Department of Correction relies on information systems to support its critical business functions, including managing its inmate/offender population statewide. The department contracts with the Department of Finance and Administration's Strategic Technology Solutions Division (STS) for the department's technology needs, including systems development, operations, and maintenance.

Under a Federal Court Consent Decree in February 1990 (related to the *Grubbs vs. Bradley* lawsuit), the Tennessee Department of Correction hired Andersen Consulting to design, install, and implement the Tennessee Offender Management Information System (TOMIS). Completed in June 1992, TOMIS managed the entire correctional process from sentencing through incarceration to release. TOMIS has served the department well for over 25 years, but in today's technological climate, the state's ability to support the system is diminishing.

TOMIS Replacement Efforts

To address the aging mainframe system, in fiscal year 2013 the department began looking for a replacement to TOMIS. The department contracted with the Department of Finance and Administration's Business Solutions Delivery (BSD)¹⁰² group, which is part of Strategic Technology Solutions, to manage the project and to work with the Department of General Services' Central Procurement Office (CPO) so that the state could find a new IT vendor. Based on their efforts, the state awarded a contract to Abilis Solutions Inc.

Abilis offered a commercial off-the-shelf product that met 80% of the department's needs, but Abilis would have had to customize the remaining 20% to meet the department's needs. According to research gathered during the request for information and request for proposal phase of the project, the approximate time frame for most vendors to implement a new system was three years. However, according to the BSD Domain Director, the department's former Commissioner insisted on rolling out COMET within the first two years of the contract and transitioning to Abilis's hosting of the system for years three through five.

The department's contract with Abilis for the development of the new offender management system, which the department named COMET, began on February 5, 2016, with a termination date of February 4, 2021, and a maximum liability amount of \$15,374,200. Under the contract, Abilis is set to receive a firm fixed-payment amount of \$11,709,904, meaning that the department will only pay Abilis up to this amount regardless of any cost overruns the vendor incurs to complete the project. The remaining contract budget availability of \$3.6 million was set aside to cover STS's costs to pay salaries of contractors and employees who work on the COMET project as well as costs of servers and software development. Based on expenditure data extracted from Edison, the department has paid Abilis approximately \$9 million since project initiation.

¹⁰²Business Solutions Delivery consists of five domain groups assigned to departments: Health and Social Services; Law/Safety/Corrections; Resources and Regulations; General Government; and Business and Community Development.

In an effort to meet the former Commissioner's implementation deadlines, the contract originally identified January 26, 2018,¹⁰³ as the target completion date for COMET to go live. The vendor, however, fell behind schedule, requiring the department and STS to set a late-2020 tentative go-live date. In addition to COMET's implementation delay, the department is continuing to pay approximately \$368,804 per month to keep TOMIS operational.

Audit Results

Audit Objective: What is the current status of the department's \$15.3 million contract with Abilis Solutions to develop COMET, the department's new offender management system?

Conclusion: Due to unanticipated obstacles, the COMET project is over 18 months behind schedule. STS and the department have yet to re-baseline the project schedule and select an official new go-live date. See **Observation 12**.

Observation 12 – After signing a \$15,347,200 contract, spending three years on development, and facing unforeseen obstacles, the department's vendor has been unable to implement the new COMET system, and as of September 2019, there is no official "go-live" date

The department has paid approximately \$9 million to Abilis, COMET's contractor, and COMET's implementation is over 18 months behind schedule. When we spoke with COMET project managers, they indicated that COMET may not be implemented until December 2020. However, the project schedule has not been re-baselined to include an official go-live date as of September 2019.

TDOC, Business Solutions Delivery, and Strategic Technology Solutions Identified COMET Challenges

- **Public Safety Act of 2016¹⁰⁴** – The passage of the Public Safety Act of 2016 (PSA) (Sections 40-28-301 through 306, *Tennessee Code Annotated*) required significant modifications to both TOMIS and COMET. As a result, department and STS subject matter experts shifted from the COMET implementation project to TOMIS system changes to comply with the new statute. Staff devoted an estimated nine months to one year implementing the required changes in TOMIS and departmental policies and procedures in order to comply with the PSA.

Furthermore, because the department signed the contract with Abilis prior to the PSA's passage, staff responsible for changing TOMIS were also required to make system

¹⁰³ This was the deadline to comply with the former Commissioner's two-year completion period.

¹⁰⁴ The Public Safety Act of 2016 aims to reduce crime and address the growing prison and jail population by focusing on key areas driving Tennessee's violent crime rate. To accomplish this, the initiative has four main components: addressing domestic violence, implementing smart changes in sentencing, using a single validated risk and needs assessment across the criminal justice community, and instituting swift, certain, and proportionate sanctions for offenders on community supervision if no new crime has been committed.

changes in COMET to comply with the law. Department management explained that the passage of the PSA ultimately “changed the goal line” for the COMET project.

- **Two-Year Timeline Unrealistic Due to PSA** – The BSD Domain Director indicated that the department’s former Commissioner required all parties to complete the project within two years. Based on the STS project team’s initial research and proposals received, however, the evidence indicated that the vendor needed three years to complete the project. The department’s original expectation, though, was hampered by the passage of the Public Safety Act.
- **Commercial Off-the-Shelf Product Challenges** – When Abilis bid on the project, its proposal stated that it could provide a system that was 80% off-the-shelf and 20% customized to meet the department’s needs. The BSD COMET project managers indicated that COMET is approximately 50% customized, rather than the originally anticipated 20%, because of changes needed due to implementation of the Public Safety Act. Department management stated that they did not originally pursue a custom-built system because of the high cost.
- **Saving the Most Challenging Modules for Last** – The department and BSD COMET project team both indicated that Abilis chose to save development of the two most challenging modules—sentencing and warrants and supervision—until the end of the project. When Abilis designed the offender management system for Virginia, the system required very little customization. Tennessee’s business rules for both sentencing and warrants and supervision, however, are very complex. TDOC and STS both believe that Abilis underestimated the level of difficulty and time required to account for all the business rules for these modules.
- **Abilis Project Management Turnover** – In his opinion, the BSD COMET project manager indicated that Abilis experienced project management turnover, resulting in an unstable project knowledge basis. He added that Abilis constantly brought in new project managers, who had to be educated to understand the department’s business requirements for COMET. The project director position with Abilis has been vacant for over a year.
- **Multiple Parties Involved in Project** – The department developed a new validated risk and needs assessment tool called Strong-R¹⁰⁵ through Vant4ge¹⁰⁶ as a result of the PSA. Vant4ge’s vendor had to work with the department, STS, and Abilis to update the Strong-R application to interface with COMET, requiring all parties to be on the same page. Based on our review of Abilis’ COMET Weekly Status Reports from March through July 2019, all parties are coordinating efforts to identify issues and work on solutions.

¹⁰⁵ Strong R is a program designed to match offenders to programs that are most likely to prevent re-offending.

¹⁰⁶ Vant4ge (Vant4gePoint) is a software application the department uses to perform inmate Risk Needs Assessments to determine if the inmate is at risk of committing another crime. For more information about the Risk Needs Assessment, see the description on page 153.

Remaining Work to Be Completed on COMET

- **Outstanding Change Requests** – As of August 31, 2019, there were eight outstanding change requests (CRs). The department submits change requests to modify COMET’s development. For one outstanding CR relating to community supervision, Abilis misunderstood the difference between probation and parole. The department and Abilis are continuing to discuss acceptable changes to COMET.
- **Data Migration** – The BSD COMET project managers estimated that as of August 2019, data migration from TOMIS to COMET was 80% complete.
- **User Acceptance Testing** – The department has been conducting some testing as of August 2019, but some modules require TDOC subject matter experts to test for functionality. In some areas, tests cannot be done until data migration (moving data from TOMIS to COMET) is complete.
- **End User Training** – The last piece that must be completed before COMET can go live is end-user training. The department plans on utilizing a train-the-trainer model where the department and STS train superusers, and they in-turn train the employees who will use the system daily. The department indicated that it will not conduct training until the change requests, data migration, and functionality testing are completed to reduce the possibility of retraining if COMET changes.

Due to the challenges relating to COMET implementation, the department must continue using TOMIS. The department paid, on average, \$367,104.94 per month in fiscal years 2018 and 2019 to STS to maintain TOMIS and will continue to do so until COMET is implemented. See **Appendix H-1** on page 191 for costs related to TOMIS. Additionally, the department placed a moratorium on making any changes to TOMIS that are not mission critical until COMET goes live. This creates a challenge if the department must make necessary changes, such as updating incident codes, to maintain data integrity. Ultimately though, department management indicated that it is not rushing the project because it is focused on “getting COMET right.”

Appendix H COMET Implementation

Appendix H-1 TOMIS Mainframe and Processing Costs for Fiscal Years 2018 and 2019

FY 2018 TOMIS Mainframe and CPU ¹⁰⁷ Costs			
Month	Mainframe	CPUs	Total
Jul-17 ¹⁰⁸			\$ 0
Aug-17	\$ 242,141.40	\$ 2,292.37	\$ 244,433.77
Sep-17	\$ 201,847.98	\$ 1,932.07	\$ 203,780.05
Oct-17	\$ 205,158.30	\$ 1,939.50	\$ 207,097.80
Nov-17	\$ 247,579.75	\$ 2,190.24	\$ 249,769.99
Dec-17	\$ 190,043.24	\$ 1,743.06	\$ 191,786.30
Jan-18	\$ 193,671.86	\$ 1,683.19	\$ 195,355.05
Feb-18	\$ 639,165.93	\$ 1,817.14	\$ 640,983.07
Mar-18	\$ 692,922.34	\$ 2,385.27	\$ 695,307.61
Apr-18	\$ 623,135.09	\$ 1,938.86	\$ 625,073.95
May-18	\$ 631,536.82	\$ 2,317.85	\$ 633,854.67
Jun-18	\$ 597,216.27	\$ 1,986.55	\$ 599,202.82
FY 18 Monthly Average	\$ 405,856.27	\$ 2,020.55	\$ 407,876.83
Total FY 18	\$4,464,418.98	\$22,226.10	\$4,486,645.08

Source: STS Billing Data for Fiscal Year 2018.

FY 2019 TOMIS Mainframe and CPU Costs			
Month	Mainframe	CPUs	Total
Jul-18	\$ 290,117.38	\$ 3,494.03	\$ 293,611.41
Aug-18	\$ 375,816.60	\$ 4,614.36	\$ 380,430.96
Sep-18	\$ 295,137.23	\$ 3,589.61	\$ 298,726.84
Oct-18	\$ 294,068.91	\$ 3,631.11	\$ 297,700.02
Nov-18	\$ 368,963.11	\$ 4,333.18	\$ 373,296.29
Dec-18	\$ 346,601.56	\$ 4,427.47	\$ 351,029.03
Jan-19	\$ 371,884.53	\$ 4,560.48	\$ 376,445.01
Feb-19	\$ 310,630.35	\$ 3,838.69	\$ 314,469.04
Mar-19	\$ 310,645.50	\$ 3,984.54	\$ 314,630.04
Apr-19	\$ 301,103.43	\$ 3,774.45	\$ 304,877.88
May-19	\$ 333,773.70	\$ 3,955.40	\$ 337,729.10
June-19	\$ 309,243.11	\$ 4,579.79	\$ 313,822.90

¹⁰⁷ CPU costs are STS's costs to process and make copies of TOMIS data.

¹⁰⁸ STS designated July 2017 a "billing holiday." STS did not charge its contracted departments for mainframe services for this month.

FY 2019 TOMIS Mainframe and CPU Costs			
Month	Mainframe	CPUs	Total
FY 19 Monthly Average	\$ 325,657.95	\$ 4,065.26	\$ 329,723.21
Total FY 19	\$3,907,895.41	\$48,783.11	\$3,956,678.52

Source: STS Billing Data for Fiscal Year 2019.

Appendix H-2 Methodologies to Achieve Objectives

To determine the department's and vendor's status to implement COMET, we interviewed the Business Solutions Delivery COMET project managers, TDOC senior management, and staff of Abilis Solutions Inc. We also interviewed state Department of Correction staff in Maine and Virginia to determine their experiences working with Abilis to implement their department's new offender management system. We requested and reviewed monthly COMET progress reports, STS billing data (for the cost of TOMIS upkeep), as well as COMET project expenditures.

PUBLIC RECORDS MANAGEMENT

CHAPTER CONCLUSIONS

Finding 18 – Department management did not ensure its staff and CoreCivic complied with the state’s public records statute and records management standards (page 195)

Observation 13 – Staff at the Turney Center Industrial Complex did not follow the department’s procedure for restoring public records after a minor flood destroyed some Fire and Safety records in spring 2019 (page 198)

PUBLIC RECORDS MANAGEMENT

General Background

The Public Records Commission is required by Section 10-7-302, *Tennessee Code Annotated*, to determine and order the proper disposition of the state's public records and direct the Tennessee Department of State's Records Management Division to initiate any action necessary to establish the regulation of record holding and management in any state agency. Section 10-7-301(6), *Tennessee Code Annotated*, defines public records as

all documents, papers, letters, maps, books, photographs, microfilms, electronic data processing files and output, films, sound recordings, or other material, regardless of physical form or characteristics made or received pursuant to law or ordinance or in connection with the transaction of official business by any governmental agency.

According to Section 10-7-509, *Tennessee Code Annotated*, "the disposition of all state records shall occur only through the process of an approved records disposition authorization."

Based on our review, Department of Correction policy for maintaining footage was in conflict with the department's approved records disposition authorizations.

Public officials are legally responsible for creating and maintaining records that document government business transactions. These records provide evidence of government operations and accountability to citizens. Public officials must maintain records according to established records disposition authorizations (RDAs). According to Section 10-7-509, *Tennessee Code Annotated*,

The disposition of all state records shall occur only through the process of an approved records disposition authorization. Records authorized for destruction shall be disposed of according to the records disposition authorization and shall not be given to any unauthorized person, transferred to another agency, political subdivision, or private or semiprivate institution.

RDAs describe the public record, retention period, and destruction method for each record type under an agency's authority. Agencies must submit a certificate of destruction to the Records Management Division after properly disposing of any public records according to their approved RDAs.

In March 2013, the Records Management Division developed an online application to catalog and maintain RDAs, and the Public Records Commission asked all state agencies to amend or retire their existing RDAs and create new ones for public records still in use. As of March 2012, the Department of Correction had 53 active RDAs. The department has updated, retired, or combined all but one of these RDAs and has created five new RDAs.

Department's Records Management Process

The Department of Correction is unique among state agencies because it operates a central office in Nashville, the Cook Chill Records Warehouse; 14 correctional facilities; and probation

and parole offices. Each of these facilities is responsible for many different types of public records that must be maintained, and each facility must have staff who are properly trained in record retention requirements. Each correctional facility has its own records storage facility or warehouse, as well as its own facility Records Officers and property officers charged with storing, maintaining, and destroying public records created by or transferred to that facility. The department has an agency Records Officer and a central office records management group. Each facility's records management staff takes direction from and submits certificates of records destruction for approval to the department's Records Officer.

Additionally, four of the state's correctional facilities are privately operated by CoreCivic and may have their own records instead of state-created records; however, they must follow applicable state RDAs. According to the department's Records Officer, the department sends each CoreCivic facility updated RDA lists, records management instructions, and other information annually.

The Records Management Division conducted a public records assessment at the department's records warehouse and the central office, as well as the Morgan County Correctional Complex, Tennessee Prison for Women, Turney Center Industrial Complex, and Riverbend Maximum Security Institution.¹⁰⁹ The purpose of the assessment was to

- measure the department's records management process;
- identify the RDAs used and determine if new ones were needed; and
- assess the volume of records for each RDA.

The division issued the assessments on November 21, 2017; December 11, 2017; June 1, 2018; June 28, 2018; July 27, 2018; and August 3, 2018. The division noted 36 recommendations.

Public Records Recovery Process

In September 2018, the department established a procedure for what to do if an original record gets damaged or destroyed. These instructions are in the department's *Records Management Disaster Reference Manual*, which, according to the Records Officer, is distributed to facility record staff during annual training and annual inspections by Records Division staff. In the event of water damage, the manual states that staff should move paper records to a secure area, arrange them individually, and frequently turn them over to increase exposure to the air. It also states not to re-box records until they are completely dry. If there is an outbreak of mold, staff should quarantine and dry the records in a location that vents to the outside. Once the records are dried, then the mold can be removed. According to the department's Records Officer, staff at the facility should perform a preliminary assessment of the damage and report it to the director within 24 hours. A central office records management team would then be dispatched to assist with cleanup and resolution.

¹⁰⁹ The Records Management Division performed six separate records assessments: the department's central office on November 17, 2017; the Morgan County Correctional Complex on December 1, 2017; the Turney Center Industrial Complex on June 1, 2018; the Cook Chill Records Warehouse on June 21, 2018; the Riverbend Maximum Security Institution on July 23, 2018; and the Tennessee Prison for Women on July 27, 2018.

Audit Results

1. Audit Objective: Did department management ensure that the department's RDAs as of March 2013 had been revised or retired?

Conclusion: Management ensured that all but one of the department's existing RDAs were revised or retired. The department's Records Officer is currently working with the Records Management Division to update the remaining RDA.

2. Audit Objective: Did department management implement the recommendations from the Records Management Division's assessments?

Conclusion: Based on our review, the department's Records Officer completed corrective action on 17 of 36 recommendations (47%), partial corrective action on 4 recommendations (11%), and no corrective action on 15 recommendations (42%) as of August 2019. The Records Officer stated that all corrective action should be complete by November 30, 2019.

3. Audit Objective: Did department management ensure that the correctional facilities were following records management requirements?

Conclusion: Based on our testwork, department management did not ensure that the correctional facilities were following records management requirements. See **Finding 18**.

4. Audit Objective: Did staff follow the department's public records recovery procedures after a flood event that damaged records?

Conclusion: Staff did not follow the department's public records recovery process after a minor flood event at the Turney Center Industrial Complex. As a result, paper files were no longer readable and had mold damage. See **Observation 13**.

Finding 18 –Department management did not ensure its staff and CoreCivic complied with the state's public records statute and records management standards

The Department of Correction has a basic responsibility to protect the state's public records and to follow state statute and guidance provided by the Department of State's Records Management Division. Additionally, the Department of Correction should ensure that CoreCivic follows the same requirements.

The department did not have written policies and procedures governing how facility staff and CoreCivic manage public records. Based on our site visit reviews, we found that for four of six correctional facilities, department and CoreCivic management did not ensure that the

department’s public records were properly retained, maintained, and destroyed. Specifically, we noted the following issues during our visits to the correctional facilities:

- **Outdated RDAs:** Facilities did not have up-to-date copies of records disposition authorizations (RDAs) on file because management did not ensure that appropriate staff at each facility had the current list.
- **Destroying Records Without Approved Certificates of Destruction:** Facilities destroyed public records throughout the year without creating certificates of destruction or notifying the department’s Records Officer.
- **Insufficient Record Inventories:** Facilities did not keep detailed inventories of the type, volume, location, or date of destruction of records that were to be destroyed.

Table 46 summarizes the issues we found at four of the six facilities. We did not note any issues pertaining to the retention of records at either the Trousdale Turner Correctional Center or the Turney Center Industrial Complex.

Table 46
Results of Public Records Review

Issue	Correctional Facility*			
	Hardeman	Whiteville	Northeast	Northwest
Outdated RDAs	X	X	X	X
Destroying records without approved certificates of destruction	X	X		X
Insufficient record inventories	X	X		X

*The Hardeman and Whiteville correctional facilities are operated by CoreCivic, while Northeast and Northwest are operated by the Department of Correction.

During our review, we learned that facility staff destroyed large volumes of files they considered old enough and did not prepare the required certificates of destruction. Because of the lack of insufficient record inventories, we were unable to determine if staff maintained the destroyed records in accordance with state statute. Given the problems we identified during our fieldwork, we also reviewed the department’s 2018 annual risk assessment and found that management did not identify any risks related to the state’s public records.

Noncompliance With Video Recordings

Based on our observation at the Northwest Correctional Complex, department management did not ensure security camera footage was retained for the required three months in accordance with RDA 34, “Recordings From Law Enforcement Electronic Devices – Incident Not Identified,” which states that all camera footage must be kept for a minimum of 90 days whether or not an incident was captured. However, according to the facility’s warden, the security camera system sometimes overwrote the footage after two weeks of recording. Furthermore, we noted that the department’s Policy 506.29 states that facilities only need to keep recorded data that may have recorded an incident for 30 days, which conflicts with the statewide RDA. When required

recordings are not available, including footage that may record an incident that is not immediately apparent, valuable evidence is lost.

Based on our discussions with management, the records management issues were caused by a lack of staff training, ineffective communication, or no internal controls to ensure that staff followed records management policies and procedures. Most facility Records Officers or property officers charged with storing and destroying records did not maintain up-to-date copies of RDAs and did not know how to obtain up-to-date RDAs. Additionally, one key member of the records staff did not know the department's central Records Officer or how to contact her to obtain updated information and did not know to submit certificates of destruction for her review. Additionally, we found that staff at one CoreCivic correctional facility did not know to follow state RDA requirements and stated that they only needed to follow their internal policies concerning the retention and destruction of public records.

Overall Effect

Public records ensure a state agency's official business is fair and transparent. Without retaining records in accordance with established RDAs, there is an increased risk that the department cannot effectively conduct its operations and assure the public, legislators, and other stakeholders about management decisions. Not ensuring that the department's public records are properly created, maintained, or retained through RDAs could lead staff to prematurely destroy records and to keep out-of-date or nonessential records. Additionally, without an effective records management system, if records are misplaced, damaged, or not retained, staff may need to spend time locating, restoring, or recreating these records, if possible.

Recommendation

The Commissioner should ensure that all of the department's public records are covered by an RDA and that staff prepare and submit certificates of destruction as required. The Commissioner should ensure that written policies and procedures are prepared and disseminated so the department meets all state records retention requirements. The Records Officer should work with the Records Management Division to resolve the conflict between Statewide RDA 34 and department policy.

The Records Officer should ensure that appropriate management and staff of all correctional facilities, whether managed privately or by the state, are properly trained and understand the process required for properly destroying records. The Records Officer should also ensure all facilities have up-to-date RDAs on file. Department management should create policies and procedures manuals for the CoreCivic-managed correctional facilities to ensure that they understand which records management requirements apply to them and how best to comply with state policies and requirements. The Commissioner should ensure management assesses all significant risks, including the risks noted in this finding, in the department's annual risk assessment.

Management's Comment

Concur.

The Department recognizes the serious nature of record keeping responsibilities and is taking swift action to meet RDA and training expectations.

As to the retention of video from security cameras, most of the Department's fixed security cameras are analog and the analog recorders do not have the capacity to retain three months of video and cannot be upgraded.

Replacement of those cameras/recorders will take some time and funding, but will be studied. In the budget submitted to the governor, there is a capital project for upgrading security electronics for 1 million dollars. If approved, approximately \$600,000 of those funds would be utilized this next year to purchase digital encoders for the analog cameras and larger digital records which would provide the required 90 days of storage for all cameras in the prisons.

After purchasing the equipment, approximately 6 months would be required to upgrade the equipment by ITS staff.

In the meantime, the Department will consult with the Records Management Division concerning the feasibility of an RDA specifically for the Department's security video that is within current capacity.

Observation 13 – Staff at the Turney Center Industrial Complex did not follow the department's procedure for restoring public records after a minor flood destroyed some Fire and Safety records in spring 2019

During our visit to the Turney Center Industrial Complex in June 2019, we learned that a minor flood in March 2019 had damaged some records in the Fire and Safety Officer's office. Fire and Safety Officers are responsible for ensuring the safety of buildings, equipment, and hazardous chemicals. Their primary responsibilities include routine inspections of fire alarms, smoke detectors, sprinkler systems, fire extinguishers, and emergency breathing apparatuses. They also conduct inventories of hazardous materials, inspect the facilities for any safety concerns, and compile statistics on employee and offender injuries that occur within the facilities.

We accompanied Turney Center Industrial Complex's Fire and Safety Officer to a storage room at the water treatment plant, where the officer had moved the damaged records after the flood. We observed three boxes full of originals and copies of Fire and Safety records. Copies included meeting minutes from monthly Fire and Safety meetings; Accident/Incident/Traumatic Injury Reports; and maintenance work orders. The following items were original records that were in conditions ranging from wrinkled to covered in mold:

- Hazardous Material Inventory Sheets;
- Weekly Fire/Safety Inspection Checklists;

- Hazardous Materials Bin Cards; and
- Self-Contained Breathing Apparatus (SCBA) and Emergency Escape Breathing Apparatus (EEBA) Inspection and Data Sheets.

The records in the boxes included documentation from 2014, 2015, and 2017.

Department of Correction staff must follow three records disposition authorizations (RDAs) in regard to the records mentioned above:

- **RDA 2275, “Tennessee Occupational Safety & Health Association Inspection Reports”:** This RDA includes, but is not limited to, copies of inspection reports completed by the Department of Labor and Workforce Development to monitor safety at all Department of Correction buildings and institutions. These records are required to be maintained for five years before they can be destroyed.
- **RDA 2392, “Work Place Chemicals and Hazardous Materials Records”:** This RDA includes, but is not limited to, all required documents pertaining to hazardous chemicals and materials used or stored in the workplace. This includes workplace chemicals, hazardous material bin cards, hazardous material inventory, and material safety data sheets. These records are required to be maintained for 30 years after the hazardous materials or chemicals are no longer used or stored onsite.
- **RDA 11085, “Department of Correction Administrative Records”:** This RDA includes, but is not limited to, records pertaining to administrative functions. This includes facility maintenance records and fire, safety, and sanitation inspection reports. These records are to be maintained for five years before they can be destroyed. These items were previously listed under retired RDA 1773, which is still referenced at the bottom of some of the related forms.

The department’s *Records Management Disaster Reference Manual* outlines the procedures for recovering and protecting records that cannot be reproduced. This process requires that wet records be moved to a secure location, arranged individually, and turned over frequently to increase exposure to the air. The process also requires staff to notify facility management and the department’s Records Officer; however, the manual does not state how soon the Records Officer should be notified.

The department’s Director of Compliance informed us that due to lack of training, the Fire and Safety Officer was unaware of the official process to prevent the records from further destruction.¹¹⁰ He did not place the records out individually to dry or notify anyone that the records were damaged. The director stated that management at the Turney Center Industrial Complex should have been notified immediately so that the recovery process could be initiated.

Failure to ensure that records are restored after a natural disaster could lead to costly restoration services or the permanent loss of critical institutional documentation. The department should ensure that all facility operations staff, not just records personnel, are informed and follow

¹¹⁰ The Fire and Safety Officer, hired in January 2017, no longer works for the department.

the department's records management disaster recovery process. The department should include specific language in its *Records Management Disaster Reference Manual* that facility operations personnel should immediately contact the department's Records Officer to obtain assistance after a disaster.

Appendix I Public Records Management

Appendix I-1 Methodologies to Achieve Objectives

To gain an understanding of the records management process, we interviewed the department's Records Officer and facility staff and management, and we reviewed the Secretary of State's *Records Management Best Practices and Procedures, Tennessee Code Annotated*, the *Rules of Public Records Commission*, and internal policies and procedures. We reviewed the department's RDAs and statewide RDAs to ensure compliance with statewide records management procedures and requirements. We reviewed the Secretary of State's records management assessments of the department and performed procedures to determine if the department adequately responded to these assessments. To determine if the department properly assessed risks related to records management, we reviewed the department's risk assessment included in its 2018 Financial Integrity Report. We visited six correctional facilities to determine their records management procedures, appropriateness of storage facilities, and knowledge of staff and management.

To determine whether staff followed recovery procedures after the minor flood event, we interviewed the Fire and Safety Officer at the Turney Center Industrial Complex and spoke with the department's Director of Compliance. We also viewed the damaged records and documented the various types of records that were destroyed.

RECIDIVISM RATES FOR THE DEPARTMENT'S EDUCATIONAL AND VOCATIONAL PROGRAMS

CHAPTER CONCLUSION

**Matter for Legislative Consideration – Recidivism Rates for the Department's Education
and Vocational Programs (page 203)**

RECIDIVISM RATES FOR THE DEPARTMENT'S EDUCATIONAL AND VOCATIONAL PROGRAMS

Background

As described under State's Recidivism Rates on page 6 of this report, the department defines recidivism in Tennessee as the percentage of felony inmates who are reincarcerated within three years of their release. See page 6 for more information about the department's calculation of recidivism rates. The department publishes recidivism rates for felons annually on OpenMaps.tn.gov; however, it does not publish recidivism rates for inmates who participated in specific educational or vocational programs as required by Section 41-21-238 et seq., *Tennessee Code Annotated*, which requires the Department of Correction, in conjunction with the Department of Education, the University of Tennessee, and the Tennessee Board of Regents, to develop a plan to increase the education and vocational opportunities available to inmates in the custody of the Department of Correction.

This statute further specifies that the results of the monitoring of the plan should be reported annually to the state and local government committee of the senate, the state government committee of the house of representatives, the education committee of the senate, and the education administration and planning committee of the house of representatives.

According to the department's Legislative Liaison, the department used to present recidivism rates for educational and vocational programs to the Corrections Oversight Committee; however, that committee dissolved in 2010.

Audit Results

Audit Objective: Did the department report to the appropriate legislative committees the recidivism rates for inmates who participated in educational and/or vocational programs?

Conclusion: Based on inquiries with management, the department has not reported recidivism rates for educational and vocational programs since 2011 because the Select Oversight Committee on Corrections was dissolved in 2011. The department believes there are other important education-related statistics like program participation rates, graduation rates, and completed certifications that are better measures of the success of educational and vocational programs than recidivism rates. As such, the General Assembly may wish to consider amending state statute to reflect current measures. See the **Matter for Legislative Consideration**.

MATTER FOR LEGISLATIVE CONSIDERATION – RECIDIVISM RATES FOR THE DEPARTMENT'S EDUCATION AND VOCATIONAL PROGRAMS

As previously noted, the passage of Section 41-21-238 et seq., *Tennessee Code Annotated*, in 1994 required the Commissioner of Education, with the assistance of the Commissioner of

Correction, the Board of Regents,¹¹¹ and the University of Tennessee system, to develop a plan to increase the educational and vocational opportunities available to inmates in the department's custody. This statute requires the Department of Correction to monitor and document the effectiveness of this plan; part of the documentation includes calculating the recidivism rate of inmates who participate in the plan. The department is required to submit the results of the monitoring of the plan to select legislative committees annually.

During our audit, the department's management indicated that they routinely present educational and vocational program information to the General Assembly; however, they do not include recidivism rates of inmates in educational and vocational programs because the department believes there are other measures like participation and completion rates that are better indicators of success. According to management, the plan referenced in this statute is outdated given the shift in educational focus over the last 25 years. As a result, the General Assembly may wish to consider amending the statute to reflect the department's current approach towards educational and vocational programming.

¹¹¹ The General Assembly may also wish to amend Section 41-21-238 et seq., to include the six locally governed institutions, which are no longer part of the Tennessee Board of Regents.

Appendix J Recidivism Rates for Educational and Vocational Programs

Appendix J-1 Methodologies to Achieve Objective

To achieve our objective, we interviewed the Commissioner, Assistant Commissioner of Rehabilitative Services, Director and Assistant Director of the department's Decision Support: Research and Planning Division, and the department's Legislative Liaison to gain an understanding of the department's responsibility to report to the appropriate legislative committees recidivism rates for inmates who participate in educational and vocational programs. We obtained recidivism rate calculations made by the department's Research and Planning Division to determine whether the department calculates recidivism rates for inmates who participated in specific educational or vocational programs and reviewed recorded legislative hearings to determine if the department presented such recidivism rates.

APPENDICES

Appendix K-1 Edison Business Units

329.00	Correction
329.01	Administration
329.04	State Prosecutions
329.06	Correction Academy
329.13	Tennessee Prison for Women
329.14	Turney Center Industrial Complex
329.16	Mark Luttrell Transition Center
329.17	Charles B. Bass Correctional Complex
329.18	Bledsoe County Correctional Complex
329.21	Hardeman County Incarceration Agreement
329.22	Hardeman County Incarceration Agreement - Whiteville
329.23	Trousdale Incarceration Agreement
329.28	Correction Release Centers
329.32	Major Maintenance
329.41	West Tennessee State Penitentiary
329.41	Northeast Correctional Complex
329.42	Riverbend Maximum Security Institution
329.43	Northeast Correctional Complex
329.44	South Central Correctional Facility
329.45	Northwest Correctional Facility
329.46	Lois M. DeBerry Special Needs Facility
329.47	Morgan County Correctional Complex
329.48	Office of Investigations and Compliance
329.50	Sex Offender Treatment Program
329.51	Probation and Parole Field Supervision
329.52	Community Corrections
329.99	Sentencing Act of 1985

Appendix K-2
Department of Correction
Expenditure and Revenue Information by Fiscal Year
UNAUDITED INFORMATION

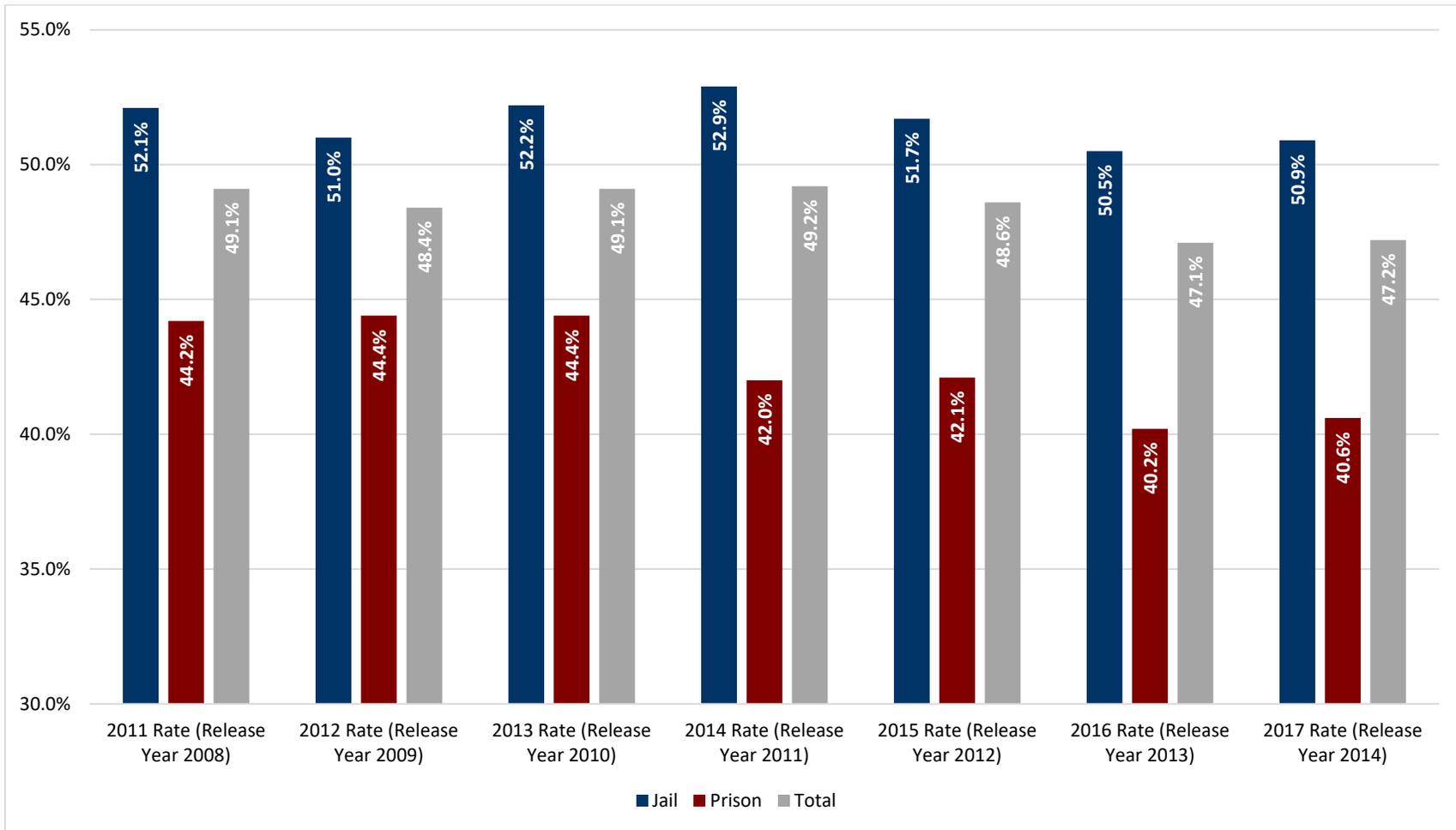
Description	Fiscal Year	
	2018	2019†
Regular Salaries	\$ 215,331,413.84	\$ 210,729,428.28
Longevity	6,363,521.70	7,720,056.94
Overtime	22,213,556.89	27,221,724.24
Benefits	110,935,363.11	105,067,632.30
Subtotal Personnel	\$ 354,843,855.54	\$ 350,738,841.76
Travel	\$ 2,685,730.08	\$ 3,010,491.69
Printing and Duplicating	70,656.03	78,510.91
Utilities and Fuel	19,479,155.12	18,947,119.62
Communications	799,624.00	755,890.52
Maintenance, Repairs, and Service	7,373,433.28	7,561,963.10
Professional Services Third Party	177,096,916.67	176,213,534.53
Supplies and Materials	50,237,860.22	44,985,247.37
Rentals and Insurance	1,772,360.46	2,002,696.24
Motor Vehicle Operations	558,645.77	578,467.70
Awards and Indemnities	4,978,227.65	5,496,853.80
Grants and Subsidies	284,980,270.00	257,524,501.29
Unclassified	3,600.00	27,570.15
Stores for Resale/Reissue/Mfg.	10,050,181.82	9,522,275.60
Equipment	926,147.75	844,116.15
Land	0.00	0.00
Buildings	32,032.00	14,877.00
Discounts Lost	0.00	0.00
Highway Construction	0.00	0.00
Training	374,021.43	333,918.64
Data Processing	5,815,937.61	4,496,498.19
Professional Services State Agencies	51,969,511.94	47,396,374.04
Retirement of Debt	0.00	0.00
Interest on Debt	0.00	0.00
Trustee Fees	0.00	0.00
Depreciation	0.00	0.00
Loss on Disposal of Equipment	0.00	0.00
Reallocations Plant Work Order	0.00	0.00
Subtotal Operations	\$ 619,204,311.83	\$ 579,790,906.54
Total Expenditures	\$ 974,048,167.37	\$ 930,529,748.30
† - This information runs through June 20, 2019.		

Source: Edison.

Description	Fiscal Year	
	2018	2019†
Reserve - Unencumbered Bal	\$ 13,781,501.39	\$ 3,847,297.64
Reserve - Capital Outlay	1,309,502.75	0.00
Reserves	4,322,342.71	2,601,874.30
State Appropriations	977,254,100.00	996,651,619.28
Total Appropriation	\$ 996,667,446.85	\$ 1,003,100,791.22
Federal Revenue	\$ 324,795.74	\$ 583,608.60
Federal Capital Grants	0.00	0.00
Refund Prior Year Federal Expense	0.00	0.00
Total Federal	\$ 324,795.74	\$ 583,608.60
Counties	\$ -	\$ -
Refund of Prior Year Local Expense	0.00	0.00
Cities	0.00	0.00
Non-Governmental	0.00	30,505.31
Other State	0.00	0.00
Current Services	14,404,266.25	14,850,100.19
Interest Income	613.90	971.75
Inter-Departmental	1,886,689.71	2,692,633.28
Interdepartmental - CU	2,087.59	1,256.12
Current Services - Licenses	0.00	0.00
Current Services - Fines	0.00	0.00
Subtotal Other Revenue	\$ 16,293,657.45	\$ 17,575,466.65
Total Funding	\$ 1,013,285,900.04	\$ 1,021,259,866.47
† - This information runs through June 20, 2019.		

Source: Edison.

**Appendix K-3
State's Recidivism Rates
Calendar Years 2011 to 2017**



Source: OpenMaps.TN.Gov.

**Appendix K-4
Title VI Information**

Pursuant to state statute, the Tennessee Human Rights Commission is responsible for verifying that state governmental entities receiving federal financial assistance comply with the requirements of Title VI of the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, and national origin in federally funded programs and activities. The commission serves as the central coordinating agency for executive-branch departments and agencies and provides technical assistance, consultation, and resources to encourage and assist departments and agencies with compliance.

By October 1 of each year, state departments and agencies receiving federal funds must submit Title VI implementation plans to the commission describing how they will meet Title VI requirements. The commission staff perform reviews of all implementation plans each year to ensure the plans include limited English proficiency (LEP) policies and procedures, data collection procedures, subrecipient monitoring, and whether departments provide sufficient Title VI training to staff. The commission staff also perform detailed on-site compliance reviews of a select number of state agencies each year to ensure that agencies are following the implementation plans.

The commission issues the report *Tennessee Title VI Compliance Program* (available on its website: <https://www.tn.gov/humanrights.html>), which covers the status of Title VI compliance for the State of Tennessee. The report describes the implementation plan review process, the results of compliance reviews completed, and details of federal dollars received by state agencies, Title VI complaints received, and Title VI implementation plan submission dates.

According to the commission’s fiscal year 2017-2018 report (the most recent report available as of July 2019), the Department of Correction’s Title VI implementation plan was submitted on time. In addition, the commission’s implementation plan review of the Department of Correction’s 2017-18 Title VI implementation plan resulted in no findings. See the charts for a breakdown of the department’s employee gender and ethnicity as of July 19, 2019.

Employees by Gender	
Gender	Number of Employees
Male	3,077
Female	2,522

Employees by Ethnicity	
Gender	Number of Employees
White	3,965
Black or African American	1,455
Hispanic or Latino	77
Asian	20
American Indian or Alaska Native	19
Other	38
Two or More Ethnicities	15
Native Hawaiian or Other Pacific Islander	1
Unknown	9



**STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY**



DEPARTMENT OF CORRECTION

Performance Audit Report

November 2017

Justin P. Wilson, Comptroller



**Division of State Audit
Sunset Performance Section**

DEBORAH V. LOVELESS, CPA, CGFM, CGMA
Director

JOSEPH SCHUSSLER, CPA, CGFM
Assistant Director

DENA W. WINNINGHAM, CGFM
Audit Manager

Vincent Finamore, CFE
David Wright, CFE
In-Charge Auditors

Fonda Douglas
Greg Spradley
Jafar Ware
Staff Auditors

Amy Brack
Editor

Amanda Adams
Assistant Editor

Comptroller of the Treasury, Division of State Audit
Suite 1500, James K. Polk State Office Building
505 Deaderick St.
Nashville, TN 37243-1402
(615) 401-7897

Reports are available at
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STATE OF TENNESSEE
COMPTROLLER OF THE TREASURY
DEPARTMENT OF AUDIT
DIVISION OF STATE AUDIT

PHONE (615) 401-7897
FAX (615) 532-2765

SUITE 1500, JAMES K. POLK STATE OFFICE BUILDING
505 DEADERICK STREET
NASHVILLE, TENNESSEE 37243-1402

November 3, 2017

The Honorable Randy McNally
Speaker of the Senate
The Honorable Beth Harwell
Speaker of the House of Representatives
The Honorable Mike Bell, Chair
Senate Committee on Government Operations
The Honorable Jeremy Faison, Chair
House Committee on Government Operations
and
Members of the General Assembly
State Capitol
Nashville, Tennessee 37243
and
The Honorable Tony Parker, Commissioner
Tennessee Department of Correction
320 Sixth Avenue North
Nashville, Tennessee 37243-0465

Ladies and Gentlemen:

Transmitted herewith is the sunset performance audit of the Department of Correction. This audit was conducted pursuant to the requirements of the Tennessee Governmental Entity Review Law, Section 4-29-111, *Tennessee Code Annotated*.

This report is intended to aid the Joint Government Operations Committee in its review to determine whether the department should be continued, restructured, or terminated.

Sincerely,

Deborah V. Loveless, CPA
Director

17275

State of Tennessee

Audit Highlights

Comptroller of the Treasury

Division of State Audit

Performance Audit
Department of Correction
November 2017

FINDINGS

Trousdale Turner Correctional Center and Whiteville Correctional Facility, managed by Core Civic, operated with fewer than approved correctional officer staff, did not have all staffing rosters, did not follow staffing pattern guidelines, and one left critical posts unstaffed Shortages in correctional officer staff may have prevented two Core Civic facilities (Trousdale Turner Correctional Center and Whiteville Correctional Facility) from meeting staffing obligations and may have limited their ability to effectively manage the inmate populations assigned to them. Correctional officer staffing was often less than operationally planned, and Trousdale Turner had unstaffed critical posts on several days. Both facilities had rosters that did not match state-approved staffing patterns, and both facilities were consistently short-staffed (page 7).

Core Civic staffing reports for two facilities (Trousdale Turner Correctional Center and Hardeman County Correctional Center) contained numerous errors, so information about hires, terminations, and vacancies may not be reliable

Our review of staffing reports revealed inconsistencies regarding hires, terminations, and vacancies for two of the four Core Civic facilities. We found the following reporting issues for Trousdale Turner Correctional Center and Hardeman County Correctional Center: missing position numbers for vacancies; vacancies carrying over to subsequent months without additional vacant days; vacancies listed with more than 30 days not listed for the previous month; different job titles with the same position number; the number of hires and terminations not reconciling to the number of vacancies; and reports missing the number of filled positions, inmate population, and officer-to-inmate ratio (page 15).

Trousdale Turner Correctional Center management's continued noncompliance with contract requirements and department policies challenges the department's ability to effectively monitor the private prison

After nearly two years in operation, Trousdale Turner Correctional Center still did not comply with some of the Department of Correction's policies and contract requirements. While the department's contract monitoring efforts regularly report the facility's shortcomings, cuts in monitoring staff may have reduced the department's ability to effectively monitor key contract

requirements. This lack of effective monitoring has resulted in situations that may undermine the department's ability to achieve its stated mission and could result in harm to inmates (page 22).

Probation and parole officers did not always meet supervision requirements

As noted in the 2012 and 2014 performance audits, probation and parole officers did not always meet supervision standards. We determined that the department has not fully corrected probation and parole issues identified in the previous two performance audits and must continue to improve its monitoring capabilities (page 26).

Probation and parole supervisors did not always meet oversight requirements

As noted in the 2012 and 2014 performance audits, supervisors did not always meet the requirements for reviewing the work of probation officers. We found that 2 of the 5 case files had been reviewed by a supervisor within 60 days, while 2 did not contain the required initial case file review code indicating the date when the file had been reviewed, and 1 was not performed within the required time frame (page 28).

OBSERVATION

The audit also discusses the following issue: the department should annually publish the correctional officer turnover rate and clearly identify which classifications are included in its annually published correctional officer series turnover rate (page 18).

Performance Audit Department of Correction

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Performance Audit Department of Correction

INTRODUCTION

PURPOSE AND AUTHORITY FOR THE AUDIT

This performance audit of the Department of Correction was conducted pursuant to the Tennessee Governmental Entity Review Law, Title 4, Chapter 29, *Tennessee Code Annotated*. Under Section 4-29-239(a)(13), the department is scheduled to terminate June 30, 2018. The Comptroller of the Treasury is authorized under Section 4-29-111 to conduct a limited program review audit of the department and to report to the Joint Government Operations Committee of the General Assembly. This audit is intended to aid the committee in determining whether the Department of Correction should be continued, restructured, or terminated.

ORGANIZATION AND STATUTORY RESPONSIBILITIES

The Department of Correction was established in 1923 under Title 4, Chapter 3, Part 6, *Tennessee Code Annotated*, to operate the correctional system for the State of Tennessee (Section 41-1-102). The department's mission is to operate safe and secure prisons and provide effective community supervision in order to enhance public safety. In July 2012, duties including probation and parole supervision and community correction grant program functions were transferred to the department from the Board of Parole.

The department houses nearly 21,000 inmates at 10 adult prisons; contracts with a private prison management company for the operation of one prison; and contracts with several counties for the operation of three other private correctional facilities that are owned and operated by private contractor Core Civic (formerly known as Corrections Corporation of America). All facilities housing Department of Correction prisoners are located on the map on page 5. The Tennessee Prison for Women and the Women's Therapeutic Residential Center (located at the West Tennessee State Penitentiary site) exclusively house female offenders, and the Bledsoe County Correctional Complex houses both male and female offenders. The other 11 facilities house only male offenders. The department's Community Supervision unit supervises nearly 78,000 offenders on probation, on parole, or in a community correction program. Table 1 illustrates the offender population under the department's jurisdiction as of July 2017.

Table 1
Number of Offenders Under Department of Correction Oversight
July 2017

Type of Oversight	Number of Offenders
Incarcerated Felons	30,185
Probation and Community Corrections	66,148
Parole	11,553
Total Population	107,886

Source: Tennessee Felon Population Update, July 2017.

The department employs more than 6,500 staff members at the correctional facilities, at administrative offices in Nashville, and at Community Supervision offices throughout the state. The department trains staff members and criminal justice professionals from other government agencies at the Tennessee Correction Academy in Tullahoma.

The department's Commissioner is supported by a Deputy Commissioner/Chief of Staff, who also oversees Title VI and Grant Management; a Deputy Commissioner Administration/General Counsel; four Assistant Commissioners (Operational Support, Prisons, Community Supervision, and Rehabilitative Services); and the Chief Financial Officer. Executive Operations, also under the Commissioner's purview, includes the Office of Investigations and Compliance; Legal Services; Communications; Decision Support; Research and Planning; and the department's Legislative Liaison. The department recently added a Chief Interdiction Officer who answers directly to the Commissioner and focuses on combatting the introduction of prohibited items (drugs, cell phones, etc.) into correctional facilities. Various divisions operate under each Deputy and Assistant Commissioner, as follows:

Deputy Commissioner of Administration/General Counsel

Staff Attorneys; the Policy Development Manager; Human Resources; Offender Administration (including Offender Sentence Management and Offender Records Management); and Talent Management operate under the supervision of the Deputy Commissioner of Administration/General Counsel.

Assistant Commissioner of Operational Support

Support divisions under this Deputy Commissioner include Facilities Planning and Construction; Facilities Management and Maintenance; Mission Support; and Statewide Training, which oversees the Tennessee Correction Academy.

Assistant Commissioner of Prisons

Under the Assistant Commissioner of Prisons, the correctional administrators in the East, Middle, and West regions oversee the operation of all state-owned and operated correctional facilities, while one correctional administrator for Core Civic facilities oversees contract monitors

at the four Core Civic facilities housing prisoners. The Assistant Commissioner of Prisons also oversees the Local Jails Resource Office, Transportation, Classification, and Inmate Grievances.

Assistant Commissioner of Community Supervision

The Assistant Commissioner of Community Supervision supervises three Field Services Administrators, who in turn oversee correctional administrators in charge of probation, parole, and specialized caseload operations in the East, Middle, and West regions of the state. This unit also oversees the department's Community Correction Programs and the Criminal Conviction Records unit.

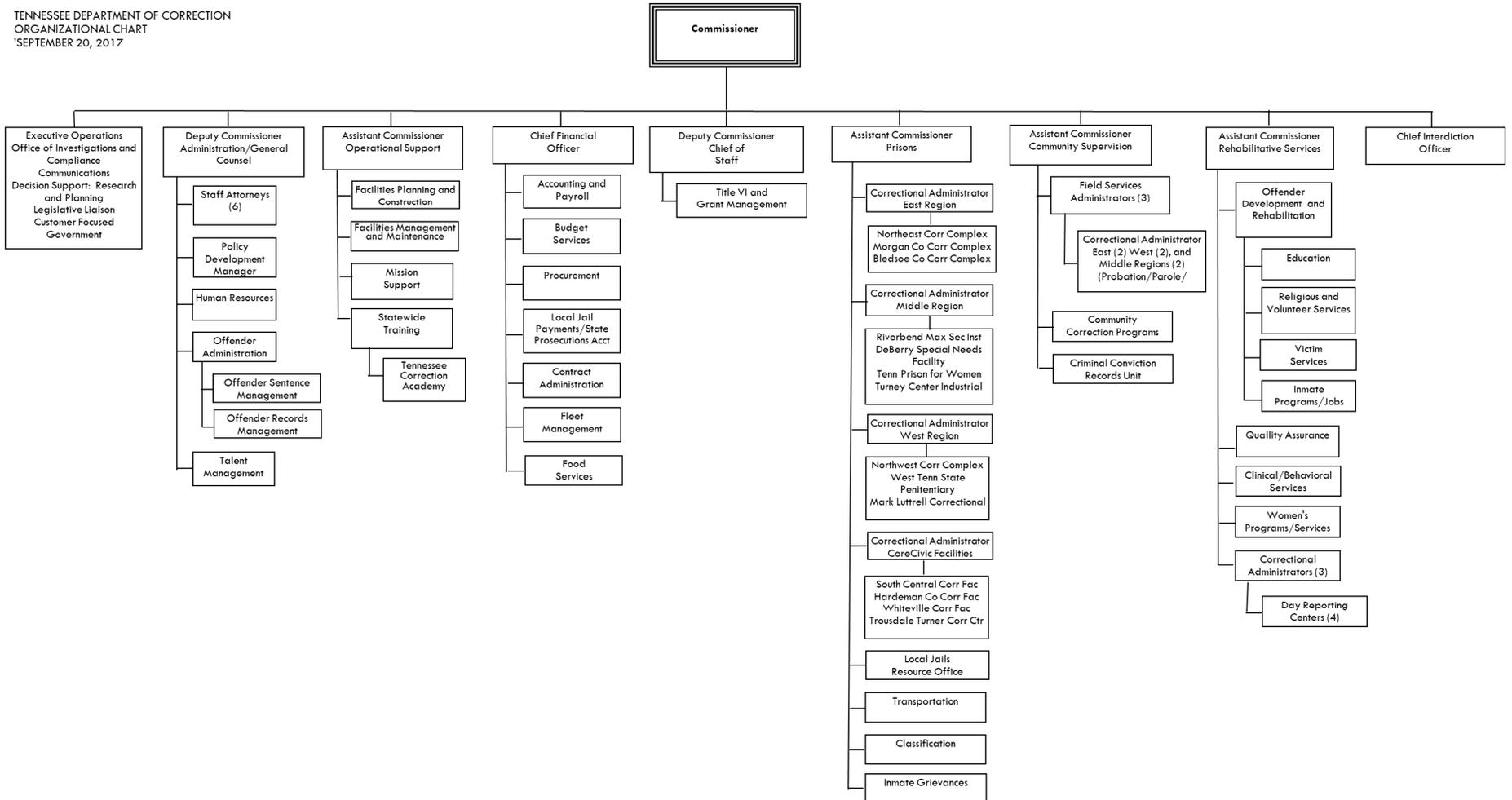
Assistant Commissioner of Rehabilitative Services

This Assistant Commissioner oversees Offender Development and Rehabilitation; Quality Assurance; Clinical/Behavioral Services; Women's Programs/Services; and four Day Reporting Centers.

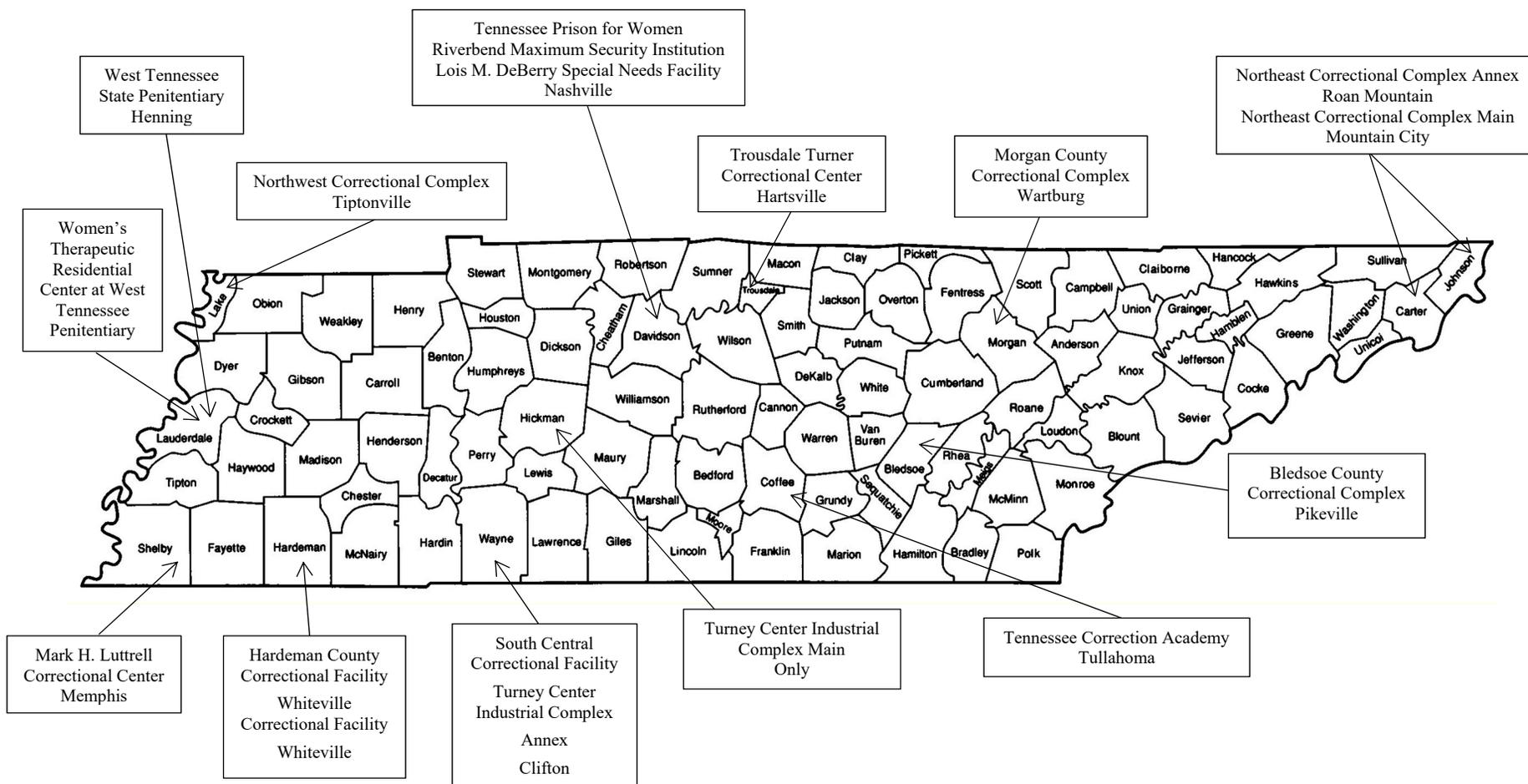
Chief Financial Officer

Accounting and Payroll; Budget Services; Procurement; Local Jail Payments/State Prosecutions Accountant; Contract Administration; and Fleet Management operate under the Chief Financial Officer.

The department's organizational chart is presented on the next page.



Tennessee Department of Correction Facility Locations



Source: Information provided by the Department of Correction.

AUDIT SCOPE

We audited the Department of Correction's activities for the period July 1, 2014, through August 31, 2017. Our audit scope included a review of internal controls and compliance with laws, regulations, and provisions of contracts or grant agreements that are significant within the context of the audit objectives. Management of the department is responsible for establishing and maintaining effective internal controls and for complying with applicable laws, regulations, and provisions of contracts and grant agreements.

For our sample design, we used nonstatistical audit sampling, which was the most appropriate and cost-effective method for concluding on our audit objectives. Based on our professional judgment, review of authoritative sampling guidance, and careful consideration of underlying statistical concepts, we believe that nonstatistical sampling provides sufficient, appropriate audit evidence to support the conclusions in our report. Although our sample results provide reasonable bases for drawing conclusions, the errors identified in these samples cannot be used to make statistically valid projections. We present more detailed information about our methodologies in the individual report sections.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

OBJECTIVES, METHODOLOGIES, AND CONCLUSIONS

STAFFING LEVELS—PRIVATE PRISON REVIEW

Background Information

Core Civic (formerly Corrections Corporation of America) is a private prison contractor based in Tennessee and operates four prisons in the state (Hardeman County Correctional Center, South Central Correctional Center, Trousdale Turner Correctional Center, and Whiteville Correctional Facility). South Central is owned by the state and is operated under direct contract with the state; the other three are subcontracted through the counties in which they are located. Trousdale Turner began accepting state prisoners on January 4, 2016, with an assigned capacity of 2,512 inmates; as of July 5, 2017, it housed 2,483 inmates, which is 99% of capacity. Whiteville began accepting state prisoners in 2002, with an assigned capacity of 1,505 inmates; as of July 5, 2017, it housed 1,497 inmates, which is 99% of capacity.

Objective and Methodology for Staffing Review (Finding 1)

The contracts for the Trousdale Turner, Whiteville, and Hardeman County facilities require each facility to submit an operations plan, subject to the state's approval, that addresses all areas of the contract, including but not limited to the following:

- *Staffing patterns* list the designated posts and the number of officers the contractor will use per shift per post. The department approves the contractor's proposed staffing pattern.
- *Staffing rosters* are daily shift logs that show the active officer posts, the officers scheduled per post, and the officer attendance.
- *Critical posts* are shown in bold on the staffing rosters and are based on what facility management determines to be critical to its operations. According to the department's Policy 506.22, critical posts must be staffed regardless of institutional circumstances; if the posts were left unstaffed, it would jeopardize the security or safety of the facility, staff, offenders, or community.

These operations plans establish the policies and procedures the facilities are required to follow in all areas covered by the contract. The terms also state that the "plan shall not be altered, amended, modified, revised or supplemented without the prior written approval by the State."

We analyzed correctional officer staffing by comparing a sample of daily facility staffing rosters to the currently approved staffing patterns.

We randomly selected 3 days per month over the 9-month period between October 2016 and June 2017, for a total of 27 days. We selected a separate sample of days for each facility and asked facility staff for copies of the completed daily staffing rosters for the selected days. We also reviewed the department's contract monitoring reports and monitoring tools related to the evaluation of staffing patterns and rosters for both the Trousdale Turner and Whiteville facilities.

Finding

- 1. Trousdale Turner Correctional Center and Whiteville Correctional Facility, managed by Core Civic, operated with fewer than approved correctional officer staff, did not have all staffing rosters, did not follow staffing pattern guidelines, and one left critical posts unstaffed**

Shortages in correctional officer staff may have prevented two Core Civic facilities (Trousdale Turner Correctional Center and Whiteville Correctional Facility) from meeting staffing obligations and may have limited their ability to effectively manage the inmate populations assigned to them. Correctional officer staffing was often less than operationally planned, and Trousdale Turner had unstaffed critical posts on several days. Both facilities had rosters that did not match state-approved staffing patterns, and both facilities were consistently short-staffed.

Sample Collection Results

The number of staffing rosters we expected to receive varied for the facilities, depending on the number of shifts per day during the time under review. For Trousdale Turner, we expected a total of 72 signed rosters and for Whiteville, a total of 54 signed rosters. We received only 51% of the requested signed rosters from Trousdale Turner, but we received 100% from Whiteville (see Table 2).

Table 2
Daily Shift Rosters Requested From Core Civic Facilities
October 2016 – June 2017

Facility	Number of Rosters Expected	Percentage Received
Trousdale Turner	72*	51%
Whiteville	54**	100%

* Between October 2016 and March 2017, Trousdale Turner operated on three 8-hour shifts, so we expected to receive 54 staffing rosters ([3 rosters per day x 3 sampled days per month] x 6 months). Between April and June, the facility operated two 12-hour shifts per day. For this period, we expected to receive 18 staffing rosters ([2 rosters per day x 3 sampled days per month] x 3 months). In total, we expected 72 (54 + 18) staffing rosters.

** Whiteville operated with two 12-hour shifts during the entire sampled period, so we expected to receive 54 staffing rosters ([2 shifts per month x 3 sampled days per month] x 9 months).

Shift Rosters Not Received

We received blank rosters from Trousdale Turner for each shift in both October and November 2016.

From the rosters, we judgmentally chose to review 16 officer posts for Trousdale Turner and 17 posts for Whiteville. The selected posts consisted of housing units; segregation; recreation; transportation; central control; perimeter; medical; and utility, search, and escort. The majority of the posts were designated as critical on the rosters.

Trousdale Turner Correctional Center Review

Trousdale Turner operated with less than the number of security staff listed on the approved staffing pattern. Our analysis revealed instances of officers working consecutive shifts (16 hours in a row); critical and non-critical posts closed because officers were moved to cover other posts; and posts designated as closed on the roster with no staff assigned when the staffing pattern indicated the posts should be staffed. On April 1, 2017, Trousdale Turner management implemented a new staffing pattern that changed the number of critical posts and the number of shifts for security staff; however, the department did not approve the new plan until June 2017. The new staffing pattern changed certain security and unit management posts from three 8-hour shifts to two 12-hour shifts and reduced the total number of correctional officer staff needed to cover operations. See Table 3.

Table 3
Trousdale Turner Correctional Center's Staffing Patterns

Date of Staffing Pattern	Required Officers	Officer-to-Inmate Ratio
October 2016 to March 2017	196	1:13
April 1, 2017, and onward	183	1:14

Source: TTCC TDOC approved staffing patterns provided by TDOC.

Between the months of December 2016 and March 2017, some correctional officers worked extended hours because of staffing shortages, which may have motivated the staffing pattern change. The rosters show that on one day in March, 11 officers worked 16-hour shifts to cover posts.

A sample of 3 different days in 3 months revealed 44 critical posts unstaffed. We might have identified more unstaffed posts, but our review was limited by the blank staffing rosters. We received only 10 of the 18 rosters we expected between April and June 2017 ([2 rosters per day x 3 sampled days] x 3 months). See Table 4.

Table 4
Trousdale Turner Correctional Center's Critical Posts Unstaffed
Three Selected Days in Each Month
April – June 2017

Month	Sampled Days			Total
	Day 1	Day 2	Day 3	
April	Blank Rosters	7	11	18
May	12	Blank Rosters	6	18
June	Blank Rosters	Blank Rosters	8	8
Review Period Total				44

Source: Daily rosters provided by Trousdale Turner Correctional Center.

Critical Posts Unstaffed

Although there were 8 blank rosters (2 shifts per day x 4 days), we still identified 44 unstaffed critical posts.

Whiteville Correctional Facility Review

Whiteville operated with fewer staff than allowed by the approved staffing pattern. According to our analysis of 17 correctional officer positions, the staffing pattern's combined shift total need for the positions reviewed was 79 officers. We observed, on average, a shift total of 57 officers, a difference of 21 officers. Most critical posts were staffed on the sampled days, but 1 critical post (the front gate) was often unstaffed for approximately 6 hours out of the 12-hour second shift.

Recreation and Transportation Posts

In some cases, staffing rosters for both facilities had fewer posts than the approved staffing patterns required. Recreation and transportation posts were consistently under-staffed, under-posted, and closed. These positions are designated as non-critical; however, if these positions are

not properly manned, the facilities may not be able to properly provide offenders with programming and services like yard time or transportation to and from medical appointments.

The Trousdale Turner staffing pattern requires 5 recreation posts to be manned for 8 hours during the 1st and 2nd shifts, 5 days a week. The Whiteville staffing pattern requires 5 recreation posts to be manned for 12 hours during the 1st shift, 7 days a week. For the sampled days in April through June 2017, Trousdale Turner’s rosters only list 3 posts and the Whiteville rosters only list 4 posts, instead of 5 as in the staffing pattern. Neither facility’s roster showed that the posts were manned to the level the staffing patterns require. (See Tables 5 and 6.)

Table 5
Trousdale Turner Correctional Center – Recreation Posts Filled (April – June 2017)

Note: 1st Shift | 2nd Shift
Staffing Pattern = 5 | 5, 5 Days per Week

Month	Posts per Shift	Sample Day			
Staffing Pattern	5 5	Day 1	Day 2	Day 3	Total
April Rosters	3 3	- -*	- -*	0 0	0
May Rosters	3 3	0 0	Blank Roster	0 0	0
June Rosters	3 3	Blank Roster	- -*	1 1	2
Period Total					2

* Weekend.

Summary: Trousdale Turner lists only 3 of the 5 required posts on the daily rosters. In our sample, 34 out of 36 roster posts were unfilled. The staffing pattern recommends 60 posts.

Table 6
Whiteville Correctional Facility – Recreational Posts Filled (April – June 2017)

Note: 1st Shift | 2nd Shift
Staffing Pattern = 5 | 0, 7 Days per Week

Month	Posts per Shift	Sample Day			
Staffing Pattern	5 0	Day 1	Day 2	Day 3	Total
April Rosters	4 0	1 0	3 0	4 0	8
May Rosters	4 0	1 0	2 0	0 0	3
June Rosters	4 0	1 0	0 0	2 0	3
Period Total					14

Summary: Whiteville lists only 4 of 5 required posts on the daily rosters. In our sample, 22 out of 36 roster posts were unfilled. The staffing pattern recommends 45 posts.

Table 7
Trousdale Turner Correctional Center – Transportation Posts Filled (April – June 2017)

Note: 1st Shift | 2nd Shift
 Staffing Pattern = 3 | 1, 5 Days per Week

Month	Posts per Shift	Sample Day			
Staffing Pattern	3 1	Day 1	Day 2	Day 3	Total
April Rosters	4 0	- -*	- -*	4 0	4
May Rosters	4 0	4 0	Blank Roster	1 0	5
June Rosters	4 0	Blank Roster	- -*	1** 0	1
Period Total					10

*Weekend.

**Posts without staff assigned 3 of the 4.

Summary: Trousdale Turner lists 4 posts on 1st shift and 0 on 2nd shift. Rosters show 1st-shift posts are 8 hours, from 7:00 a.m. to 3:00 p.m. In our sample, 10 out of 24 posts were unfilled. The staffing pattern recommends 24 posts; however, 6 of these are to be on 2nd shift.

Whiteville did not have designated transportation posts on its roster. The staffing pattern provides that there should be 2 posts on the 1st shift for 8 hours, 5 days a week.

Department of Correction Monitoring

We reviewed Whiteville’s April, May, and June monitoring reports; its March, May, and June noncompliance summaries; and its April and August noncompliance reports. For Trousdale Turner, we reviewed its June noncompliance report, as well as its April and June monitoring report. In these reports, the department did not cite unstaffed posts or staffing pattern inconsistencies for these two prisons for the reviewed period. The department’s annual inspections for Whiteville and Trousdale Turner did not address these areas either. The staffing reports we reviewed indicated compliance with staffing rosters and staffing levels. We found, however, that the rosters did not match the approved staffing patterns, and both facilities were experiencing problems filling posts consistently.

The contract monitor for Trousdale Turner did include unstaffed critical posts in the most recent noncompliance report dated August 11, 2017, we feel in part due to the observations we shared. As a result of the noncompliance report, Trousdale Turner created a plan of action to address these issues.

We visited both Trousdale Turner and Whiteville facilities and spoke with the wardens and other facility staff, as well as the contract monitors. Historically, staffing has been a concern for correctional facilities statewide. According to Trousdale Turner management, they continue to recruit new officers and have increased correctional officer salaries (see Table 8). The newly appointed warden (as of July 1, 2017) informed us that they conduct pre-service training for new recruits every two weeks.

**Table 8
Trousdale Turner Correctional Center
Correctional Officer Salary**

2015	6/12/2016	12/11/2016	6/25/2017
\$11.75	\$13.75	\$15.75	\$16.50

Source: The Human Resources Director at the Trousdale Turner Correctional Center.

The facilities have changed their training programs by emphasizing more on-the-job training within the facilities, including exposing new recruits to inmates earlier in the curriculum. Whiteville management mentioned that providing exposure upfront helps new officers to more quickly determine if the job will be a fit for them or not. Whiteville has also increased salaries for its officers, as shown in Table 9.

**Table 9
Whiteville Correctional Facility
Correctional Officer Salary**

2015	6/12/2016	12/11/2016	6/25/2017
\$11.75	\$11.75	\$12.50	\$13.25

Source: The Human Resources Manager at the Whiteville Correctional Facility.

Whiteville management mentioned during our visit that the overall nature of inmates and the characteristics of newly hired correctional officers create new challenges for recruiting and keeping correctional officers. The younger inmates are more disrespectful and less cooperative. Young correctional officers no longer view the position as a career, but rather as a temporary paycheck on the path to a different job, or perhaps to earn money while in school. Management stated that younger officers take less pride in the job, but, more importantly, they lack the required human interaction skills to properly interact with the inmates.

Facilities that fail to maintain consistent staffing levels of correctional officers can be limited in their ability to provide staff and inmates with a safe environment and to meet inmate needs like recreation and transportation. A March 2017 article, "Impacts of Understaffing," published by the American Correctional Officer Intelligence Network, states, "Staffing is arguably the most crucial element to safety inside our prisons" and "the total interaction between staff and inmates is what determines the level of safety within the facility." Staffing rosters and staffing patterns are strong indicators of operational performance, and they should be analyzed routinely. Not following approved staffing patterns can undermine

"Staffing is arguably the most crucial element to safety inside our prisons" and "the total interaction between staff and inmates is what determines the level of safety within the facility."

—American Correctional Officer Intelligence Network, "Impacts of Understaffing"



the department's ability to provide a safe prison environment and to reduce recidivism. It can also lead to increased violence, escapes, forced overtime, staff sick leave, staff turnover, and cases of post-traumatic stress disorder.

Recommendation

To ensure critical posts are staffed, the department's contract monitors should identify unstaffed critical posts, write noncompliance reports documenting these contract violations, document when staffing levels are below the approved staffing requirements, and document the actions Core Civic management takes to address staff shortages. The contract monitors also should ensure that department management approve any staffing change before it is implemented. Core Civic should ensure that facilities are operating with enough staff to provide necessary services and should complete staffing reports for all shifts.

Management's Comment

We concur in part with the finding. The Department of Correction has issued multiple noncompliance reports to Core Civic for understaffing at both Trousdale Turner Correctional Center (TTCC) and Whiteville Correctional Facility (WCFA). Both facilities have submitted corrective action plans and have been proactive with regard to recruitment and retention, as illustrated by significantly increasing staff pay. For instance, TTCC has increased their officer pay by more than \$4.00 per hour and is also providing an additional \$1.00 to \$2.00 per hour for any correctional staff with previous years of correctional experience. Immediate signing bonuses and relocation bonuses are also being offered by Core Civic as a means of resolving staff vacancies.

We do not concur in part with the finding. The Department of Correction works daily with Core Civic to support consistent staffing patterns and gives thoughtful consideration to any proposed staffing changes. As a point of clarification, approved staffing patterns list how many people are required to be working at the facility based on their inmate population. However, this is not the amount of people required to be at the facility on a shift by shift basis. Various shifts across a twenty-four hour period are characterized by staff being distributed differentially based upon the movement (or lack of movement) associated with inmate activities. For instance, the pattern of staff placement overnight is not identical to staff placement during the daytime. Similarly, most facilities remove the front gate officer after traffic stops in the area. And finally, some posts by function are only necessary when offenders are present, such as a utility/yard officer position that is required if inmates are on the yard, but these officers are frequently redirected to other functions when inmates are no longer present in that area.

Objective and Methodology for Staffing Reports (Finding 2)

We obtained staffing reports from each of the four Core Civic facilities for January through June 2017 to determine if staffing information (new hires, terminations, and vacancies) was accurately communicated. Contract terms require the state to develop reporting requirements for staff turnover and vacancies and that each month each contracted facility submit a report to the contract monitor. The report must include names and position numbers for employees hired, the name of each employee terminated including the reason for termination, and any vacant positions on the staffing pattern including the number of days vacant. Department contract monitors located on-site at each contracted facility use these reports to monitor staffing and identify contract violations, such as when a position is vacant for more than 45 days.

Contract monitors provided the audit team staffing reports that are in the form of a memo, except for the Whiteville Correctional Facility, which provided a Staffing Legend spreadsheet. The memos are divided into three sections:

1. Total Number of Employees Hired for Reporting Period,
2. Total Number of Employees Terminated for Reporting Period, and
3. Vacant Positions in Staffing Pattern.

In each section of the memo, the number of items in the list should equal the total number at the top of the list.

For section 1, Employees Hired, the employee name and position title are provided; for section 2, Employees Terminated, the employee name, position title, and reason for termination are provided; for section 3, Vacant Positions, the position title, position number, and number of days vacant are provided. The Staffing Legend provided by Whiteville is a spreadsheet which lists each position in the facility and provides detailed information concerning position numbers, employee names, hiring dates, termination dates, and vacancy designations.



MEMORANDUM

TO: TDOC Contract Monitor Brun

FROM: Warden Blair Leibach

DATE: 05/10/2017

RE: Monthly Staffing for Trousdale Turner Correctional Center
Reporting Period April 2017

1. Total Number of Employees Hired for Reporting Period: 32

	New Employee Name	Position
1		Correctional Officer
2		Correctional Officer
3		Correctional Officer
4		Correctional Officer
5		Correctional Officer
6		Correctional Officer
7		Correctional Officer
8		Correctional Officer

2. Total Number of Employees Terminated for Reporting Period: 23

	Terminated Employee Name	Position	Reason for Termination
1		CORRECTIONAL OFFICER	Job Abandonment-No Rehire
2		CORRECTIONAL OFFICER	Job Abandonment - No Rehire
3		CORRECTIONAL OFFICER	Job Abandonment - No Rehire
4		CORRECTIONAL OFFICER	Job Abandonment - No Rehire
5		ACADEMIC INSTRUCTOR	Job Abandonment - No Rehire

3. Vacant Positions in Staffing Pattern:

	Position Title	Position Number	Days Vacant
1	Sr. Correctional Officer	9 positions	18 days
2	Warehouse/Commissary Worker	4717156	15
3	Vocational Instructor - Carpentry	4714385	182
4	Vocational Instructor - Plumbing	4714326	182
5	Vocational Instructor - Computers	4714351	57
6	Vocational Instructor - CMS	4714254	39
7	Academic Instructor	4714094	69
8	Academic Instructor	4714131	52

Finding

2. Core Civic staffing reports for two facilities (Trousdale Turner Correctional Center and Hardeman County Correctional Center) contained numerous errors, so information about hires, terminations, and vacancies may not be reliable

Our review of staffing reports revealed inconsistencies regarding hires, terminations, and vacancies for two of the four Core Civic facilities. We found the following reporting issues for Turner Trousdale Correctional Center and Hardeman County Correctional Center:

- missing position numbers for vacancies;
- vacancies carrying over to subsequent months without additional vacant days;
- vacancies listed with more than 30 days not listed for the previous month;
- different job titles with the same position number;
- the number of hires and terminations not reconciling to the number of vacancies; and
- reports missing the number of filled positions, inmate population, and officer-to-inmate ratio.

We elaborate on two of the more significant problems below.

Not Providing Position Numbers

In the April, May, and June 2017 staffing reports, staff at Trousdale Turner listed “Correctional Officer, 64 Positions” and “Senior Correctional Officer, 9 positions” as vacancies (see Exhibit 1). Without position numbers for each unique position, the contract monitor has a limited ability to track positions over time and the report does not meet contract requirements. We also observed that reports we reviewed did not include position numbers with the lists of hires and terminations, but did include this information for vacancies. This means monitors could not easily compare lists and locate discrepancies.

Exhibit 1
Vacant Positions in Staffing Pattern for Trowsdale Turner Correctional Center

3. Vacant Positions in Staffing Pattern:

	Position Title	Position Number	Days Vacant
1	Sr. Correctional Officer	9 positions	18 days
2	Warehouse/Commissary Worker	4717156	15
3	Vocational Instructor - Carpentry	4714385	182
4	Vocational Instructor - Plumbing	4714326	182
5	Vocational Instructor - Computers	4714351	57
6	Vocational Instructor - CMS	4714254	39
7	Academic Instructor	4714094	69
8	Academic Instructor	4714131	52
9	Academic Instructor	4714289	37
10	Administrative Clerk	4714668	77
11	Administrative Clerk	4714625	3
12	Administrative Clerk	4714561	55
13	Maintenance Worker	4714924	68
14	Correctional Officer	64 positions	30

Carrying Over Recurring Vacancies Without Adding Additional Vacant Days

We found that the department did not cite at least two 45-day violations at Trowsdale Turner because of not verifying the staffing report information. The contract monitor issued a noncompliance report for March 2017 that cited Trowsdale Turner for having 2 positions vacant for more than 45 days. These positions both showed 152 days vacant. We identified 3 additional positions that could have also needed citing (at least 2 should have been cited). Trowsdale Turner reported 2 of these positions in the March 2017 staffing report as 24 and 29 days vacant, with another reported as 41 days vacant. However, these same positions were listed in the January and February reports as 24 and 29 days vacant, and the third as 8 days vacant. Because the positions had carried over 2 months without additional vacant days added (31 days between the January and February report + 25 days between the February and March report), they appeared on the March report as under the 45-day threshold (see Exhibit 2). Positions 4714351 and 4714131 should have been cited in February with 60 days and 55 days vacant; and in March, with 85 days and 80 days vacant. Because 4714094 is listed in March as having 41 days, it was likely filled during the month, which is why 41 days vacant is listed. Without positions numbers in the Hires section of the report, it is difficult to confirm.

Exhibit 2
Trousdale Turner Correctional Center's Staffing Reports
January Through March 2017

January 2017 Staffing Report

	Position Title	Position Number	Days Vacant
3	Vocational Instructor - Carpentry	4714385	152
4	Vocational Instructor - Plumbing	4714326	152
5	Vocational Instructor - Computers	4714351	29
7	Academic Instructor	4714094	8
8	Academic Instructor	4714131	24

February 2017 Staffing Report

	Position Title	Position Number	Days Vacant
3	Vocational Instructor - Carpentry	4714385	152
4	Vocational Instructor - Plumbing	4714326	152
5	Vocational Instructor - Computers	4714351	29
7	Academic Instructor	4714094	8
8	Academic Instructor	4714131	24

March 2017 Staffing Report

	Position Title	Position Number	Days Vacant
3	Vocational Instructor - Carpentry	4714385	152
4	Vocational Instructor - Plumbing	4714326	152
5	Vocational Instructor - Computers	4714351	29
7	Academic Instructor	4714094	41
8	Academic Instructor	4714131	24

Recommendation

The department's monitoring staff should ensure that the information they receive from Core Civic is complete and accurate, and they should verify information, including vacancies and the length of time positions are vacant. If the reports are not accurate, monitors should cite this in noncompliance reports until the issues are corrected. Additionally, the department may wish to require the number of filled positions and inmate population to be included in each report, so it can better determine the officer-to-inmate ratio, staff turnover rates, and vacancy rates.

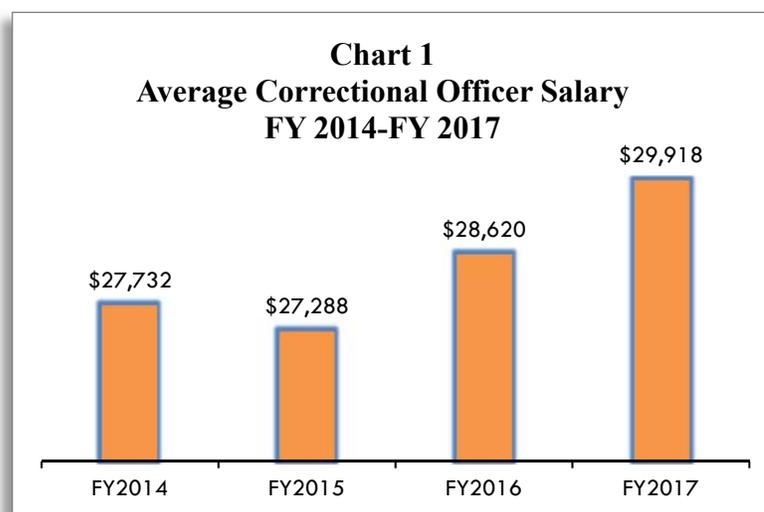
Management's Comment

We concur with the finding. Trousdale Turner Correctional Center (TTCC) has been instructed to use the format identified by the Comptroller's Office audit staff as the best mechanism for reporting vacancies. Using the suggested format will improve the accuracy of information being provided to the monitor and more readily reveal any noncompliance.

Observation

1. **The department should annually publish the correctional officer turnover rate and clearly identify which classifications are included in its annually published correctional officer series turnover rate**

Department of Correction management acknowledges that the turnover rate for correctional officers is high in state-operated correctional facilities. The department operates 10 correctional facilities, and the average correctional officer salary was \$28,389.61 between fiscal years 2014 and 2017 (see Chart 1).



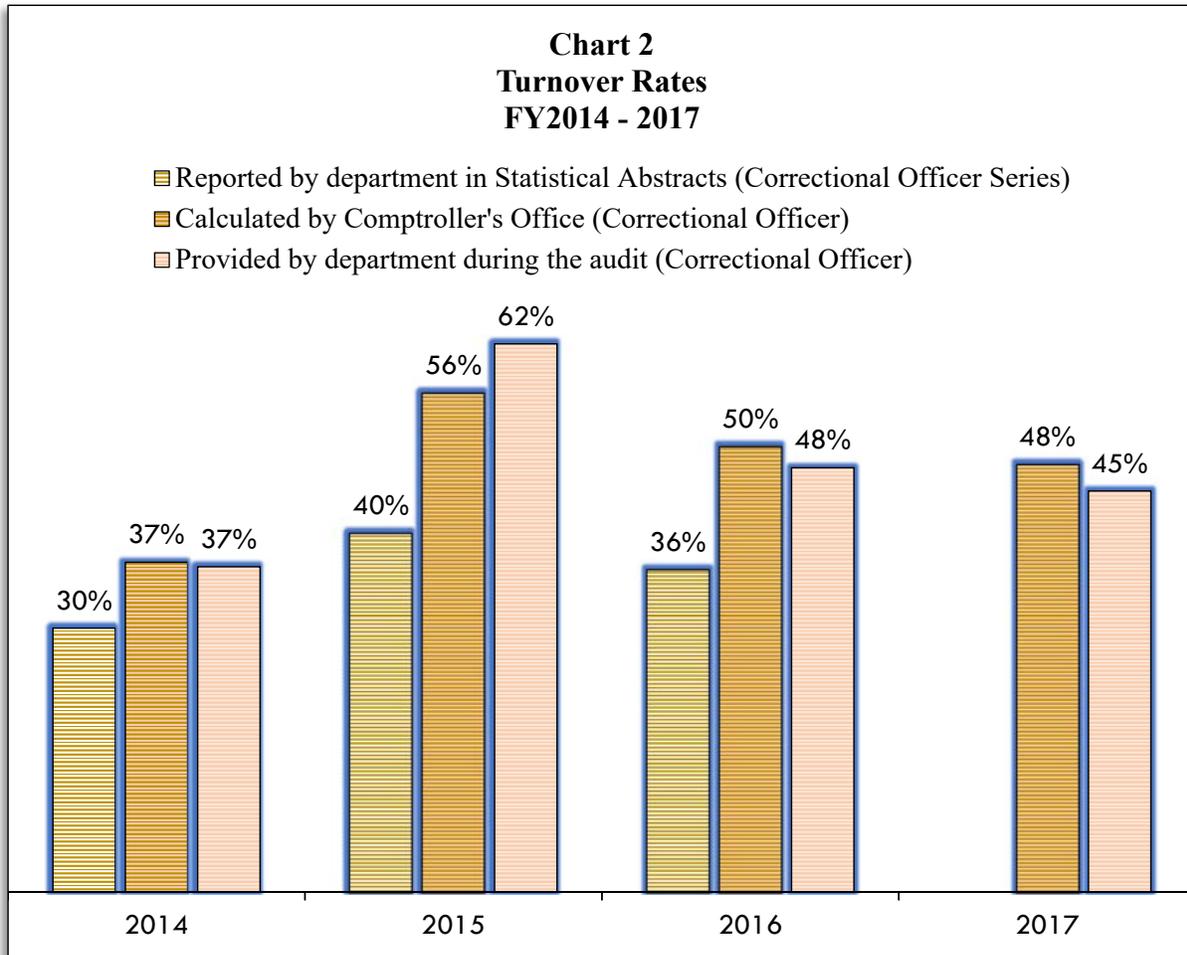
Source: State of Tennessee’s employment management system, EDISON. We obtained Correctional Officer employee data for each fiscal year and averaged the salaries.

Department Correctional Officer Turnover Rate

As the department does not annually publish the correctional officer turnover rate, when we asked them to provide the rates, the department’s human resources management said it would take some time to calculate the turnover rate to provide to us. Furthermore, the department’s human resources management was unable to provide us with a standardized method for calculating the correctional officer turnover rate. The turnover rate for correctional officers eventually provided to us is higher than the turnover rate the department published in its annual statistical abstract reports for fiscal years 2013 through 2016.

We calculated correctional officer turnover rates, because this is an entry-level position whose adequate staffing is critical to the security of correctional facilities. We calculated officer rates for fiscal years 2014, 2015, 2016, and 2017. Our calculated correctional officer turnover rate and the department’s human resources management-provided turnover rate are similar. Chart 2 illustrates that both of the calculated turnover rates for correctional officers (only) are higher than

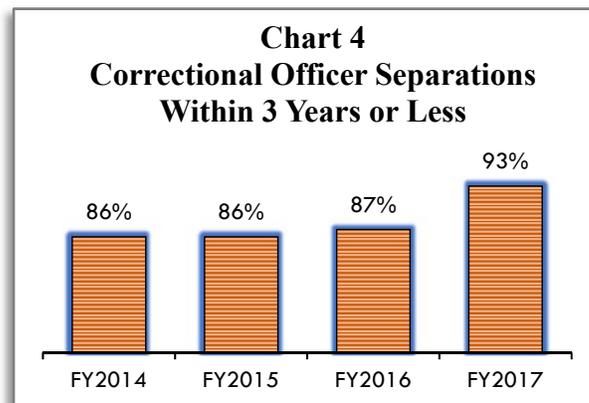
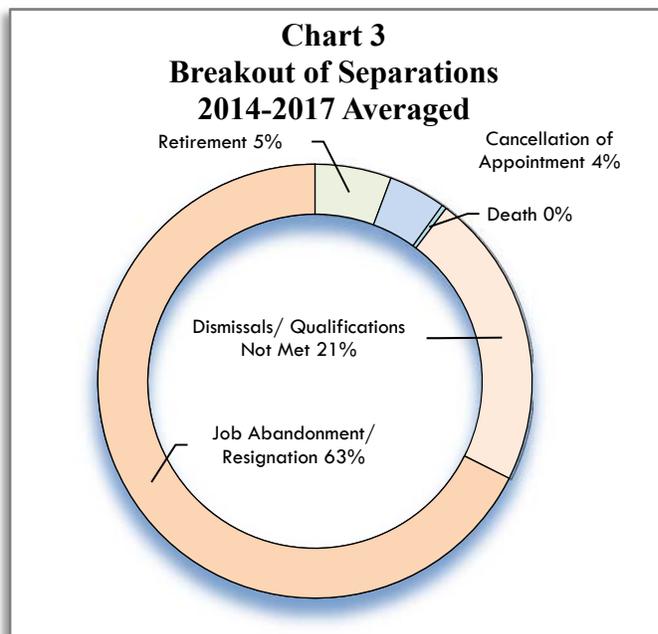
the correctional officer series turnover rates published in the department's statistical abstract reports. This shows the mitigating effects of including supervisory and managerial classifications in the calculation of turnover, instead of reporting the officer rate independently.



Not publishing the correctional officer turnover rate may provide stakeholders with incomplete data. We recommend that the department publish the correctional officer turnover rate in its statistical abstracts in addition to the series rate. The department should also clearly communicate which positions are included in the series rate it publishes and the rationale for providing a combined series rate.

Staffing Concerns

The percentage of correctional officer separations in the first three years of employment has increased to 93% from an average 86% for the prior three fiscal years. On average, the bulk of these separations are a combination of job abandonments and resignations (63%), which is 3 times higher than the next category (dismissals or qualifications not met). See Charts 3 and 4.



To better prepare new correctional officers for the position, the department has recently modified its training to include two weeks of on-site training at state-operated correctional facilities.

Overtime Policy

In 2014, the department adopted a 28-day period for staff scheduling, citing advantages such as improved departmental communication and flexibility in scheduling. However, (1) the length of time between working and being paid for overtime, and (2) not accruing overtime pay (time and a half) until after working 171.1 hours in those 28 days may be factors in the increase in turnover between 2014 and 2015. The American Correctional Association recommended, in its October 2015 report, that the department change the work period from 28 days to 14 days. In 2017, the department moved to implement the 14-day work period.

According to the department, for the 14-day period to be successful, correctional officers will be required to work 12-hour shifts, which will reportedly allow for complete shift coverage in the state-operated facilities. In addition, the 12-hour shift, the department says, will allow correctional officers to be off every 4th day. However, according to facility staffing, some correctional officers may still be required to work a schedule outside of the 12-hour shift, 14-day work period schedule, but this is a facility choice.

Under the 14-day period, the department pays correctional officers premium overtime pay after 80 hours worked within the 14 days. The department cites advantages for correctional officers such as a reduced amount of time between working and being paid for overtime; not being required to work more than three days in a row; and getting a three-day weekend every other week, via a rotating schedule.

The department will pilot the new scheduling system beginning in September 2017 at Bledsoe County Correctional Complex, Turney Center Industrial Complex, and West Tennessee

State Penitentiary, and in late November or early December 2017 at the other seven state-operated correctional facilities. Once the new system is fully implemented at all state-operated correctional facilities, the department will be the only state agency utilizing the 12-hour shift, 14-day work period scheduling system.

PRIVATE PRISON MONITORING

Objective and Methodology

Our objective was to evaluate the Department of Correction's monitoring of the state's private prisons. To accomplish that, we conducted inspections and file reviews at two Core Civic facilities housing Tennessee inmates. We identified several of the department's operational policies, and facility standards, and contract requirements and tested each facility's compliance with these and with records management. Our work at each facility included observing, reviewing paper files, and checking records in the Tennessee Offender Management Information System (TOMIS). For the file reviews and record checks, we generated a random sample of inmates from each of the facilities' roster reports and reviewed information for those selected. For Trousdale Turner Correctional Center, we randomly selected 248 inmates from a roster of 2,483. Once on-site, we determined that after a review of 93 inmate files and 87 medical files, we had a sufficient understanding of the identified problems and would not benefit from further review. Based on our experience at Trousdale Turner, we randomly selected 50 inmates from 1,497 at the Whiteville Correctional Facility. We reviewed all 50 inmate and medical files. Our sampling methodology is nonstatistical; therefore, our conclusions are not statistically generalizable to the entire population. We decided that 50 files from Whiteville would be sufficient to identify if the same types of issues found at Trousdale Turner were also occurring at Whiteville.

We reviewed compliance with facility standards, including unimpeded inmate access to sick call and grievance forms; instructions for obtaining health care posted in housing units; grievance procedures accessible in the facility's library; locked depositories for collection of grievance forms; sign-in sheets to record attendance at classes or jobs within the facility; and secure storage of incident reports and video recordings that are clearly labeled to match written reports.

We also examined a sample of inmate files and medical files for items required by departmental policy, including documentation of inmate health screenings upon arrival at each facility and inmate-signed facility orientation forms, which communicate instructions for obtaining medical care. We also reviewed charge sheets, which inmates are required to sign when disciplined, or their refusal to sign must be noted.

Finally, we checked TOMIS records for documentation of inmate activities, analyzing whether disciplinary investigations had been completed within seven days of the incident; whether appropriate fines were assessed against inmates guilty of disciplinary infractions; whether documentation of disciplinary reports was signed by both the inmate (or their refusal noted) and the reporting staff member; and whether inmate grievances were documented and resolved within appropriate time periods. Our work resulted in the following finding.

Finding

3. Trousdale Turner Correctional Center management's continued noncompliance with contract requirements and department policies challenges the department's ability to effectively monitor the private prison

After nearly two years in operation, Trousdale Turner Correctional Center still did not comply with some of the Department of Correction's policies, facility standards, and contract requirements. While the department's contract monitoring efforts regularly report the facility's shortcomings, cuts in monitoring staff may have reduced the department's ability to effectively monitor key contract requirements. This lack of effective monitoring has resulted in situations that may undermine the department's ability to achieve its stated mission, and could result in harm to inmates.

Our facility visits and file reviews (see the above Objectives and Methodology section for sampling information) revealed multiple instances of noncompliance at Trousdale Turner. One issue, unimpeded access to sick call and grievance forms, appeared to be an issue at both Trousdale Turner and Whiteville. Issues of noncompliance identified during our tour at Trousdale included the following:

- One housing pod did not have grievance forms in the unit, and two pods did not have sick call request forms. Inmates were required to request these forms from the correctional officer on duty. The officer in one of those units reported being out of sick call forms for approximately four hours and waiting for copies. Access to grievance forms, according to the department's Policy 501.01, is required to be "unimpeded." Access to health care is governed by the department's policies and terms of the contract.
- Only one pod out of four had instructions for obtaining medical care posted in the pod. Facility management reported that inmates often tore down items posted in pods or tore off small pieces to write notes, eventually destroying the posted item. Facility managers reported that they were planning to install closed-circuit television screens high on the walls of the pods, with rotating screens displaying information inmates need to know.

Impeded access to sick call forms may reduce inmates' ability to receive timely medical examinations and treatment. Impeded access to grievance forms may reduce inmates' willingness to file grievances against the same staff members they have to ask to provide them with grievance forms.

We did not find issues with locked depositories at housing units, available grievance handbooks, appropriate sign-in sheets at inmate job locations, classrooms with assigned inmate signatures, proper segregation unit records, and properly stored incident report records and videos.

Departmental policies also require certain paperwork to be included in inmate files or inmate medical files. Inmates must sign a form indicating they received facility orientation and instructions for obtaining medical care. Below are the results of our file reviews for Trousdale Turner:

- Of 87 medical files, 11 (13%) did not include documentation of a health screening conducted upon arrival at the facility.
- Of 93 inmate files, 27 (29%) did not include documentation that inmates had been instructed on how to obtain medical care.

We also checked the sampled files for appropriate notations in TOMIS regarding grievances, fines assessed to inmates found guilty of disciplinary infractions, and attendance at assigned jobs or classes. Results of our review at Trousdale Turner include the following:

- Of 29 inmates with grievances noted in TOMIS, 1 (3%) had a grievance that was not logged in TOMIS.
- Of 80 inmates assigned to either a job or class, 20 (25%) had no attendance recorded. Of those 20, 18 were assigned to classes, not jobs.
- Of 80 inmates assigned to either a job or class, 16 (20%) had inaccurate information recorded. Inaccuracies included long periods of time where no attendance was recorded; instances of an inmate assigned to one job or class, but attendance recorded for something different; or an inmate assigned to a class, but attendance at a job recorded. Supervisors of facility school staff are responsible for entering inmate attendance. The department monitor noted problems with verifications of class attendance in the March 2017 internal compliance audit.

These issues at Trousdale Turner could have been caused by relatively new staff members and a lack of experience and training on TOMIS data entry, or by the inmates not attending assigned classes. Notably, from the sampled files at Trousdale Turner, we found no instances of fines not assessed for inmates found guilty of disciplinary infractions.

Reduction in Department Monitoring Staff

We found that the department reduced its monitoring staff and increased the responsibilities of contract monitors at private prisons. Contract provisions include both a contract monitor and a liaison from the department located on-site, with their salaries reimbursed by the private contractor. In July 2015, as a part of the state's Voluntary Buyout Program (VBP), the department eliminated the liaison positions at all private facilities, leaving one contract monitor at each facility to do both jobs. The department also created a single correctional administrator position to oversee monitoring and to provide a layer of administrative oversight for the four private facilities. According to TDOC's justification for this restructuring, this additional layer of administrative oversight would both increase accountability and ensure consistency in operational policies and procedures. However, the liaison's duties were to be absorbed by the contract monitors, adding such additional duties as attending disciplinary and grievance hearings, approving inmate segregation, and being available 24/7 to receive incident reports from the prisons. Contract monitors' original task was to ensure facilities complied with policies, contract provisions, and the Commissioner's directives in all areas of facility operation. Under the structure in place after the VBP, contract monitors are not only responsible for the liaison duties described above, but also for completing each of the monitoring instruments below on a quarterly basis:

Commissary	Counts
Disciplinary Procedures	Drug Testing
Facility and Property	Grievances
Inmate Jobs	Personal Property
Policies and Procedures	Records and Reports
Safety	Searches
Security Equipment	Special Management Inmates
Staffing (monthly)	Use of Force

Having only one individual responsible for both monitoring and (former) liaison duties at Trousdale Turner may have contributed to that facility’s continued noncompliance. Other possible significant factors are the following:

- Trousdale Turner is a relatively new facility.
- Instability in leadership could be a factor—during our review, the facility was on its third warden in two years.
- A mix of inmates transferred from other prisons into Trousdale Turner, a newly established correctional setting and population. For example, wardens at other facilities asked to transfer inmates to Trousdale Turner might move those with disciplinary issues, inmate compatibility issues, or security threat group (gang) affiliation.
- Compared to Whiteville, which we found to be largely in compliance with policies and contract provisions, Trousdale Turner is significantly larger, housing 2,483 inmates compared to 1,497 at Whiteville at the time we visited. A larger facility, with nearly 1,000 more inmates, would likely also have more disciplinary problems, grievances, incidents, and staffing challenges. When we visited Trousdale Turner, the department was in the process of transferring approximately 40 inmates per day in and out of the facility to reduce the percentage of confirmed gang-affiliated inmates at the facility.
- A larger facility adds to the responsibilities of the single on-site contract monitor, likely reducing the overall effectiveness of monitoring to enforce compliance.

The conditions identified in this finding could undermine the department’s ability to prepare offenders for successful reentry into society. Not enforcing class attendance; inaccurate recordkeeping; limited access to grievance, medical, and sick call forms; and unperformed health screenings may prevent the facility from meeting the department’s goal of providing a successful correction system.

Recommendation

The department should address any monitoring deficiency resulting from its decision to eliminate the department liaison position from private prison contract monitoring staff. The department and Core Civic should ensure that staff properly record class attendance and job assignments in TOMIS and should ensure inmates attend their assignments. The department and Core Civic should provide inmates with unimpeded access to grievance and sick call forms. The

department should enforce compliance with policies, standards, directives, and contract terms, and should consider imposing civil monetary penalties allowed in the contract.

Management's Comment

We concur with the finding. Aptly noted by the Comptroller's Office auditors, Trousdale Turner Correctional Center (TTCC) is a relatively new facility that has been operating for less than two years. As such, considerable oversight has been required at the Correctional Administrator level. Many noncompliance issues have been documented on the contract monitoring reports, annual audits, and quarterly medical and mental health audits.

At the direction of the Correctional Administrator, the facility Contract Monitor has submitted 36 noncompliance reports in the last 18 months that relate to nearly every area of the facility. This past March, the annual audit contained 66 deficiencies and resulted in the decision to double the number of audits being conducted at TTCC to ensure continuous forward progress in meeting compliance expectations. The department has also submitted a breach of contract requesting liquidated damages due to continued noncompliance on a critical operational issue.

COMMUNITY SUPERVISION DIVISION

The Community Supervision Division monitors offenders placed on either parole or probation. Offenders on parole have been incarcerated and released to the community. Offenders on probation have been found guilty of a crime but have not been imprisoned. Parole and probation officers monitor offenders to ensure compliance with supervision requirements specified by the offender's assigned supervision level.

The 2012 performance audit and the 2014 follow-up audit identified two findings, one regarding offender supervision by parole and probation officers, and the other pertaining to supervisory review. To determine whether the department resolved the two findings, we tested a sample of 60 probation and parole offenders from the 70,438 offenders the department is responsible for monitoring. The sample consisted of

- 12 offenders (6 on parole and 6 on probation) who were assigned to Interactive Offender Tracking for noncompliance with the conditions of their supervision;
- 12 offenders (6 on parole and 6 on probation) who were placed on Global Positioning System (GPS) monitoring due to a sex offense conviction or having attributes of a violent nature; and
- 36 regular offenders (18 on parole, and 18 on probation).

We reviewed both TOMIS records and paper files over a six-month period, November 2016 to April 2017, to assess the department's compliance. We used this sample for both Findings 4 and 5.

Finding

4. Probation and parole officers did not always meet supervision requirements

As noted in the 2012 and 2014 performance audits, probation and parole officers did not always meet supervision standards. We noted the following problems during our current review:

- 3 of 48 required arrest checks (6%) were not performed and 1 (2%) was not performed within the required time frame;
- 1 of 48 required drug tests (2%) was not performed within the required time frame;
- 1 of 12 Vermont Assessment of Sex Offender Risk checks (8%) was not performed within the required time frame;
- 3 of 48 offenders tested (6%) did not have matching addresses in TOMIS and the paper file;
- 1 of 12 offenders (8%) was missing sex offender treatment monitoring checks;
- 4 of 48 offenders (8%) were missing required face-to-face checks; and
- 7 of 48 special condition monitoring checks (15%) were not conducted in the required time frame.

We determined that the department has not fully corrected probation and parole issues identified in the previous two performance audits and must continue to improve its monitoring capabilities.

Recommendation

We recommend that the department ensures probation and parole officers conduct all required monitoring activities and enter all information into TOMIS.

Management's Comment

We concur with the finding. The Department of Correction has significantly changed how offenders are being managed in the community since assuming responsibility for them in 2012. The goals for the transfer of community supervision included the creation of a seamless supervision model that would foster consistency in how offenders were being managed, focus on increased accountability for offenders, provide cohesive, assessment driven prevention and intervention strategies, and streamline services that would enhance public safety.

To date, the agency has

- Updated the Probation Parole Standards of Supervision to better align with best practices;
- Established felony offender individualized case management plans;
- Implemented a validated risk /needs assessment that is utilized throughout the criminal justice community;
- Effectively enacted a swift, certain and proportionate system of graduated sanctions to hold offenders on community supervision accountable;
- Successfully leveraged partnerships that support enforcement both within and outside the agency;
- Invested heavily in staffing, training, and equipping Probation/Parole Officers to improve felon risk management in the community;
- Expanded transitional programming and treatment availability across the state;
- Focused on workforce development and employable skills training through the opening of the Mark Luttrell Transition Center in Shelby County;
- Partnered with the Department of Safety and Homeland Security to issue drivers licenses to offenders preparing for release to the community; and
- Achieved ACA accreditation of the Community Supervision division.

These accomplishments have resulted in a more robust system of accountability in both how offenders are being supervised in the community and the overall level of offender compliance with conditions of supervision. Given these improvements, it is safe to say that, despite the occasional human error, the day-to-day supervision of more than 78,000 offenders is better managed now than at any previous time.

As it relates to the specific audit finding, the department continues to seek improvements in the monitoring capabilities of parole and probation officers tasked with ensuring that offenders in the community are meeting supervision requirements. One example of enhancing officer monitoring capabilities involves recent changes to the *Standards Due Report* that have been made since the audit follow-up period concluded. The report is a weekly summary of supervision standard compliance requirements and the frequency of the requirement for each offender under parole or probation supervision. Using the new *Standards Due Report* has enhanced the ability of our community supervision officers and managers to monitor the timeliness of completion of compliance standards, such as arrest checks, drug screens, and special conditions checks, throughout the month (rather than at the end of the month).

To further strengthen offender monitoring, by 2018 a compliance rating scale will be assigned to each standard in the *Standard Due Report*. The result will be a compliance score automatically calculated for each offender every time the report is generated. This modification will allow officers, managers and other members of leadership to quickly review the compliance requirements and status for each offender under supervision in the community.

Finding

5. Probation and parole supervisors did not always meet oversight requirements

As noted in the 2012 and 2014 performance audits, supervisors did not meet the requirements for reviewing the work of probation officers.

According to the department's Policy 706.02, "Supervisory Review of Caseloads,"

- supervisors shall review all offender case records within 60 days of the offender's supervision start date, and
- closing case records reviews shall occur no later than 90 days prior to the offender's projected expiration date.

To determine if supervisors reviewed the files within the required time frames, we tested 60 probation and parole files. Within the sample of 60 case files, we identified 5 files initiated after November 1, 2016, thus requiring review by the officer's supervisor within 60 days. We found that 2 of the 5 case files had been reviewed by a supervisor within 60 days, while 2 did not contain the required initial case file review code indicating the date when the file had been reviewed, and 1 was not performed within the required time frame.

Closing Reviews

Supervisors are required to review case files no later than 90 days prior to an offender's projected expiration date. Within the same sample of 60 offender files reviewed, we identified 47 cases closed or projected to close after November 1, 2016. Of these cases, 37 had expiration dates beyond the time frame where we could assess compliance with six of these cases having lifetime supervision because they were sex offenders. Of the remaining case files, 3 did not have a closure review, 4 cases with closure reviews were conducted after the expiration date, and 3 complied with the criteria.

Annual Reviews

To determine if case files were annually reviewed as required, we tested a sample of 10 active case files out of the 961 cases TOMIS selected for supervisory review in April 2017. We found that 6 of the 10 sampled files had an initial case review code, indicating that they had been reviewed in April as required. Three of the 10 case files had not been reviewed. The 10th file had a supervisor closing code for the month reviewed.

We determined that the department has not fully corrected the issues and must continue to improve its supervisory review of parole and probation officers.

Recommendation

The department should ensure probation and parole officers and supervisors complete case file reviews as required.

Management's Comment

We concur with the finding. The department is currently implementing a Case Management Review (CMR) process to facilitate improvements in probation and parole managers' ability to meet oversight requirements. The goal is to support effective and efficient use of time and assets to ensure the completion of mandatory case records reviews while maintaining a robust role in supervising probation and parole officers. An integral part of the CMR process is the *Standards Due Report* discussed in Management's Comment for Finding 4.

Access to the weekly *Standards Due Report* is now providing managers with information that allows them to quickly assess the status and compliance for each officer's caseload and promptly work with officers to appropriately schedule and manage their outstanding requirements for the month. In addition, the district directors can easily discern their district's compliance at any given time during the month and follow up as appropriate with managers.

Quicker assessments of caseload status and the ability to streamline the management of outstanding caseload requirements increase the time available to perform the mandatory case records reviews. However, even a successful time saving process isn't a sufficient substitute for much needed staff increases. Consider this example. Caseload sizes are high (frequently more than 100 offenders) and managers supervising 8 or more officers may have review responsibilities for almost 1,000 offenders. The 3% casefile review protocol means that a manager is expected to complete about 360 case records reviews per year while actively managing their parole and probation officers. This is in addition to the required initial case records reviews and all closing case records reviews.

https://www.wsmv.com/news/woman-says-she-paid-off-gangs-to-keep-son-safe-in-prison/article_a4e670ea-78be-5087-86e5-a65ecd485475.html

Woman says she paid off gangs to keep son safe in prison

REPORTED BY DEMETRIA KALODIMOS

POSTED OCT 5, 2017



Trousdale Turner Correctional Facility. (WSMV file photo)

The News 4 I-Team has heard from several families of inmates housed at Trousdale Turner Correctional Center who say they routinely pay “protection money” to make sure gang members don’t kill their loved ones.

One woman had receipts for the hundreds of dollars she said she has been paying regularly to keep her son safe from gangs.

She also claims to have someone inside “erase infractions” on his prison record.



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began calling almost immediately after arriving, claiming gangs had marked him as a target. The only thing that could keep him safe was money.

“I had to stop and pull over and send \$50 through Western Union today on my way here,” the woman told the I-Team. “Last week it was \$200, and that was supposed to be for protection from the other gangs beating him up. It just goes on and on.”

The mother said gang members appear to control everything, including movement to and from the showers. If protection isn’t paid, inmates are liable to be beaten, stabbed or worse. It’s called “shower security.”

James Middleton, who was recently released from Trousdale Turner, confirmed it and explained it.

“When an inmate comes up and whispers in your ear, ‘Me and my brothers are going to get you if you ever do this again,’ you don’t do it,” Middleton said.

Several times a week, sometimes several times a day, the mother has been sending money through Western Union to Memphis, Cordova and Nashville, often to the same names.

Sometimes anyone can pick it up without showing an ID. All they have to do is recite a pre-arranged question and answer.

It has pushed the woman to the financial and emotional breaking point.

“I can’t. I’m a disabled widow, and I actually have gone for Advance Financial, and that’s crazy. And now I have two full credit cards,” she said. “I don’t know who to call or who to get help from. You can hear the fear in his voice.”

But could it be more than just the gangs profiting from others?

The I-Team listened on the telephone as the woman's son described what needed to happen one day. Before 3 p.m., \$300 would allegedly get behavioral write-ups wiped off his record on the prison computer.

"Are we going to get it in time so they can pull it off the computer?" the woman asked.

An inmate liaison claimed he had made arrangements to pay someone on the CoreCivic staff to do it.

"There's a lot of write-ups, you know," the woman's son said. "If they get 10 people to pay them, then they're making money on it."

"How many times have you been beaten up by these people?" his mother asked.

"Four," her son replied.

The I-Team has spoken to several CoreCivic correctional officers who have questioned why write-ups they've submitted later seem to have disappeared from the official computer record.

They said even some perpetual troublemakers seem to have missing disciplinary write-ups when they pull up the computer data.

"I've had no hot water all summer. I've been taking cold showers," the mother said.

The woman said she will not take the chance that her son might die in prison, so she continues to pay regularly.

"I cried my eyes out for this last \$50," she said. "I just can't. I have to pay my bills this month."

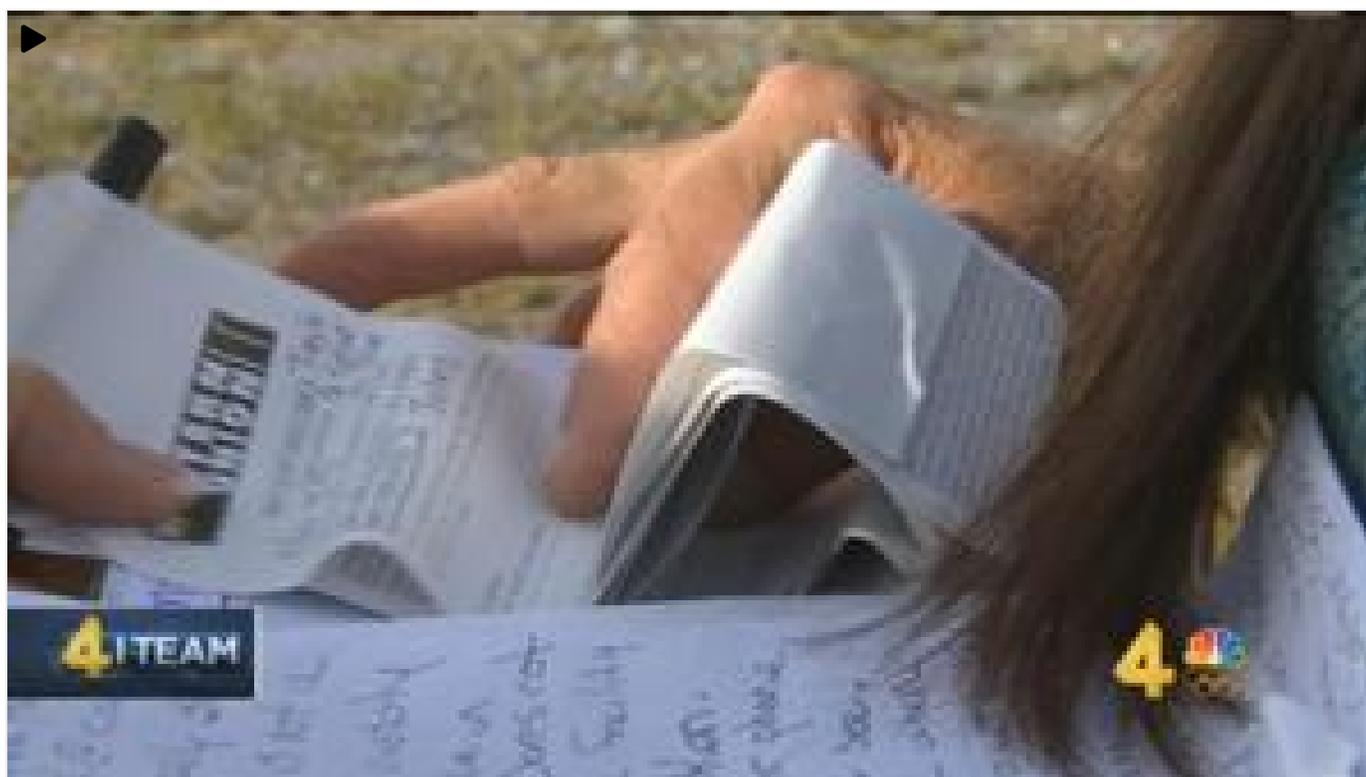
Days ago, the I-Team was contacted by another woman whose husband had died and left her with an insurance policy. She said gangs have now found out her son has an inheritance and are ordering her to send money through Walmart's cash delivery system.

The Tennessee Department of Correction issued the following statement concerning this report: Based on the information you provided which does not include any identifying factors, the Department of Correction is unable to confirm an investigation into the allegations. A key part of the Department of Correction's non-negotiable mission is to operate safe and secure prisons. The

Department encourages anyone with information about criminal activity involving our prisons to call our 24-hour tip line at 1-844-TDC-Find. All tips are investigated by the Department's Office of Investigation and Compliance and if criminal wrongdoing is found the information is forwarded to the District Attorney for prosecution. CoreCivic also issued a statement chastising News 4, despite the fact that we went straight to law enforcement: We weren't aware of these allegations. Although there are multiple means of anonymous and confidential reporting available to our employees, inmates and the public, we have no record of these issues being raised.

It's really unfortunate, too, because if we had known only a few details—details you don't even include below, we could have investigated this and, as needed, protected the affected individuals. If the person(s) who told you didn't feel comfortable coming to us, we wish that he/she/they had gone to TDOC. They have anonymous and confidential reporting systems, too. What you're describing, if true, suggests real people are in danger. Our not knowing more, and the state's not knowing more, prolonged and likely escalated any potential dangers. The I-Team shared names, confirmation numbers and currency transactions with the TBI. We have yet to hear what, if anything, has happened.

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NEWS

Woman says she paid off gangs to keep son safe in prison

Posted Oct 5, 2017

Case 3:22-cv-00093 Document 1-6 Filed 02/11/22 Page 4 of 141 PageID #: 404

Over 1,200 staff, inmates test positive for COVID-19 at Trousdale Turner Correctional Center

JOSEPH WENZEL, DIGITAL CONTENT MANAGER

POSTED MAY 1, 2020



Trousdale Turner Correctional Center in Hartsville, TN, is operated by CoreCivic. (WSMV)

NASHVILLE, TN (WSMV) – More than 1,200 inmates and staff have tested positive for COVID-19 at Trousdale Turner Correctional Center, according to the Department of Correction.

TDOC confirmed 1,246 COVID-19 positive cases out of 2,450 total tests at the correctional center in Trousdale County. These positive tests come after a targeted testing event at the facility that started on April 28.

Following Friday's announcement, Gov. Bill Lee said there will be mass testing starting next week for all Tennessee Department of Correction staff and the inmates.

"Knowing the extent of the virus's spread within our correctional facilities is critical as incarcerated individuals remain one of the most vulnerable populations during this pandemic," Lee said in a statement on Friday. "Thanks to our increased capacity, we'll test all inmates and staff statewide in order to take appropriate actions to safeguard the health of these vulnerable individuals."

Unified Command Group Director Stuart McWhorter said they have been "in close coordination with TDOC" after the targeted testing of inmates and staff in early April.

"Given the increases in positive cases at the Bledsoe County and Trousdale Turner correctional facilities, despite the vast majority being asymptomatic, we are going to take the next steps in partnership with TDOC, Tennessee Department of Health, and Tennessee National Guard to support a broader testing strategy to promote the health and safety of staff and inmates. We will also coordinate plans with our local jails to assist them in safeguarding the health of their populations in the coming days," McWhorter said in a statement on Friday.

The analysis of those inmates and staff tested confirmed that 98 percent are asymptomatic.

Unified Command Group will work with the Tennessee Department of Health on the testing at the other 10 state-run facilities. Testing was done at Bledsoe County and Northwest Correctional Complexes on April 10, and at the Turney Center Industrial Complex on April 19.

Health officials said there were 583 positive staff and inmate cases out of the 2,322 tested. There were 40 positive cases out of 902 staff and inmates tested at Northwest. There were also 40 positive cases out of 313 staff and inmates tested at Turney Center.

Location	Number Tested	Number Positive	Number Negative	Pending
Bledsoe County Correctional Complex	2,322	583	1,703	36
Morgan County Correctional Complex	0	0	0	0
Northeast Correctional Complex	1	0	1	0
Lois M. DeBerry Special Needs Facility	5	0	5	0
Riverbend Maximum Security Institution	2	1	1	0
Tennessee Prison for Woman	5	0	4	1
Turney Center Industrial Complex	275	38	237	0
Turney Center Industrial Complex-Annex	38	2	36	1
Mart Luttrell Transition Center	2	1	1	0

Northwest Correctional Complex	902	40	843	19
West Tennessee State Penitentiary	1	0	1	0
Women's Therapeutic Residential Center	2	0	2	0
Contract & Private Managed prisons				
Hardeman County Correctional Facility	3	0	2	1
South Central Correctional Facility	2	0	1	1
Trousdale Turner Correctional Center	2,272	1,224	1,034	14
Whiteville Correctional Facility	2	0	2	0
Total	5,834	1,889	3,873	73

“The Department of Correction is taking a proactive approach to ensure all staff and the entire inmate population is tested for COVID-19,” TDOC Commissioner Tony Parker said in a statement on Friday. “Our sixth round of mass testing will begin early next week with the remaining 10 facilities conducting testing. With the support and leadership of Governor Lee, Tennessee is leading the nation in our approach to widespread mass testing.”

After positive COVID-19 tests, corrections officials said they follow with contact tracing for potential exposure.

The Department of Correction also delivered more than 93,000 masks for staff, inmates, county jails, and health care workers.

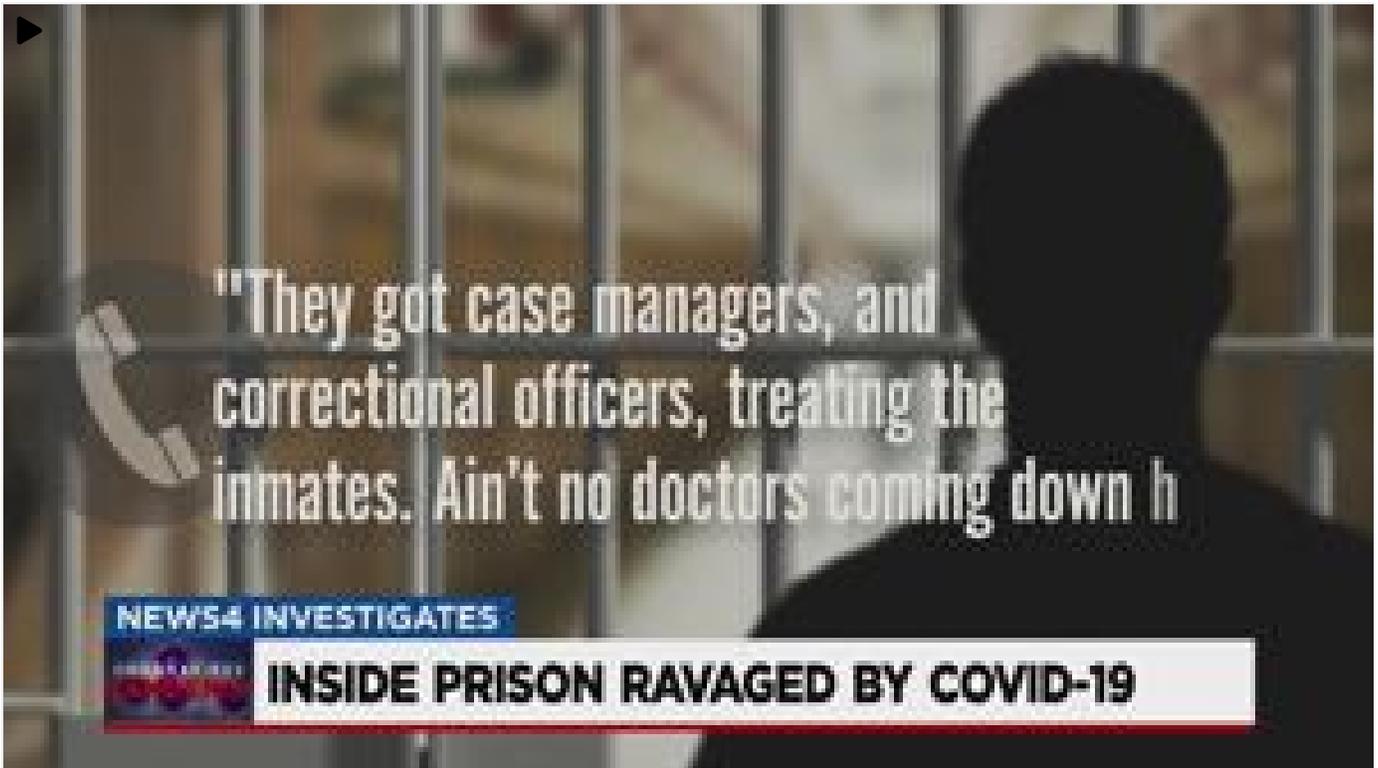
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Inmate at Trowsdale Turner dies after testing positive for COVID-19



Recorded conversations reveal life inside prison ravaged by COVID-19



Almost 60 inmates positive for COVID-19 at Trowsdale Turner after second round of testing

MORE INFORMATION



580 inmates with COVID-19 at Bledsoe prison completed isolation

Joe Wenzel
Digital Content Manager

NEWS

Tennessee prison inmate dies after fight at Trousdale Turner

Adam Tamburin Nashville Tennessean

Published 9:41 a.m. CT Jan. 26, 2020 | Updated 4:45 p.m. CT Jan. 26, 2020

A Tennessee prison inmate died Saturday after a fight at Trousdale Turner Correctional Center in Hartsville.

Staff found inmate Frank Lundy injured "at the entrance to the housing unit" at about 12:45 p.m., according to a prison spokesperson. Lundy was taken to an area hospital where he was pronounced dead at 1:30 p.m.

Trousdale Turner remained on lock down Sunday, and officials with the Tennessee Department of Correction and the Tennessee Bureau of Investigation are looking into the death.

The alleged attacker, who the spokesperson would not identify, is in state custody and will be held in "restricted housing."

Lundy, 34, is listed on the state sex offender registry. Records show an offense of child molestation was logged against him in 2002.

Trousdale Turner is a state prison managed by private contractor CoreCivic. The troubled prison has been roiled by safety and staffing concerns since it opened in 2016.

A recent audit of state prisons found pervasive problems with staffing, training and oversight in Tennessee's public and privately run prisons.

Reach Adam Tamburin at 615-726-5986 and atamburin@tennessean.com. Follow him on Twitter [@tamburintweets](https://twitter.com/tamburintweets).

NEWS

New Tennessee CCA prison stops taking inmates amid 'serious issues'

Dave Boucher USA TODAY NETWORK - Tennessee

Published 3:59 p.m. CT May 24, 2016 | Updated 3:26 p.m. CT May 26, 2016

The newest private prison in Tennessee, set to eventually become the largest prison in the state, has abruptly stopped accepting inmates amid concerns about "serious issues" ranging from inadequate staffing and solitary confinement problems to allegations of excessive force.

Corrections Corporation of America spokesman Steve Owen confirmed Tuesday that CCA and the Tennessee Department of Correction agreed to "pause the ramp-up" at Trousdale Turner Correctional Center in Hartsville. The decision was made in early May, said department spokeswoman Alison Randgaard.

Although Owen made no reference as to why the decision was made, a report from The Associated Press cited a memo Tuesday that outlines concerns about understaffing that led to questions about whether officers were in control of their units.

In the memo, also obtained by The Tennessean, Correctional Administrator Tony Howerton says there are "serious issues" with leadership at the facility. He goes on to state officers were not in control of the housing units and put inmates in solitary confinement for no reason.

He also says he saw video that, in his opinion, shows officers using excessive force when trying to subdue an inmate.

"The inmate in my opinion was already compliant with the officers but he was sprayed with (pepper spray) and then struck three times with the pepper ball gun," Howerton writes.

Howerton says he contacted the department's internal affairs unit and requested an investigation. An investigator told Howerton an investigation would begin March 18.

"In my opinion it is at a minimum of unnecessary force but could be classified as excessive force."

In her statement, Randgaard said "growing pains are to be expected" at any new prison.

"Our partnership with CCA remains strong and we will continue to work together as we fulfill our non-negotiable mission of operating safe and secure prisons," Randgaard said.

CCA swaps wardens in Nashville, new state prison

In a statement to The Tennessean, Owen said as of Tuesday there are 319 employees at Trousdale Turner. That includes officers and all other CCA employees in addition to contracted medical and food services workers. However, on Thursday, Owen said the actual number of total employees at the prison is 281.

When the facility started accepting inmates in January, there were 157 employees, Owen said. In January, the prison initially housed 507 inmates, according to the department. As of April 30, the most recent count, the prison housed 1,706 inmates. Owen said the number of inmates has gone down since CCA stopped accepting new prisoners, due to inmates being released.

"We continue to work closely with our government partner on the timing and pace of further ramp-up of Trousdale. The top priorities guiding these decisions, for both the department and CCA, is safety and security. To that end, we are in the process of increasing staffing levels and conducting training necessary to support additional transfers of inmates to the facility," Owen said in a statement to The Tennessean.

For weeks, family members of inmates at Trousdale Turner have contacted The Tennessean with concerns about how their loved ones have been treated. Those family members have noted understaffing, saying their loved ones have been on "lockdown" — kept in their cells for up to 23 hours a day — for days on end. They've also complained about the solitary confinement practices and about inadequate medical treatment.

Shinar Hurd-Smith says her husband is incarcerated at the facility. She's said for weeks he's received inferior care for his respiratory issues.

"Overall I would like him to get his inhaler and any other medications in a timely manner. I would like for them to be correct as if they are not correct it can mean life or death for him with his severe asthma," Hurd-Smith said in an email Tuesday to The Tennessean.

Tennessee prison assaults soar under new definitions

Smith's concerns are some of many heard repeatedly by No Exceptions Prison Collective, an

Exceptions, said she hoped the decision to stop accepting inmates at Trousdale Turner would serve as a wake-up call to state lawmakers.

"For the past year employees and residents of Tennessee prisons have begged that something be done about current policies that are creating unsafe destabilized environments in Tennessee prisons, and about the inexcusable lack of medical care, programs, jobs, and lack of professionally trained security staff. At some point one has to seriously begin to question if an environment is intentionally being created to provoke riots," Alexander said in an email Tuesday to The Tennessean.

Within 90 days of opening the prison, then-warden Todd Thomas was removed from his position and sent to lead the Metro Nashville Detention Facility, the CCA jail operated on behalf of Metro. Then-jail warden Blair Leibach was sent to take over at Trousdale. CCA spokesman Jonathan Burns said at the time it was a logistical decision made in conjunction with "longer-term planning."

CCA has a five-year, \$276 million contract to operate the facility. Although state law essentially allows for only one private prison, the department is using Trousdale County as something of a pass-through: Trousdale pays the money to CCA after receiving the money from the state.

Reach Dave Boucher at 615-259-8892 and on Twitter @Dave_Boucher1.

This is a developing story. Check Tennessean.com for more information as it becomes available.

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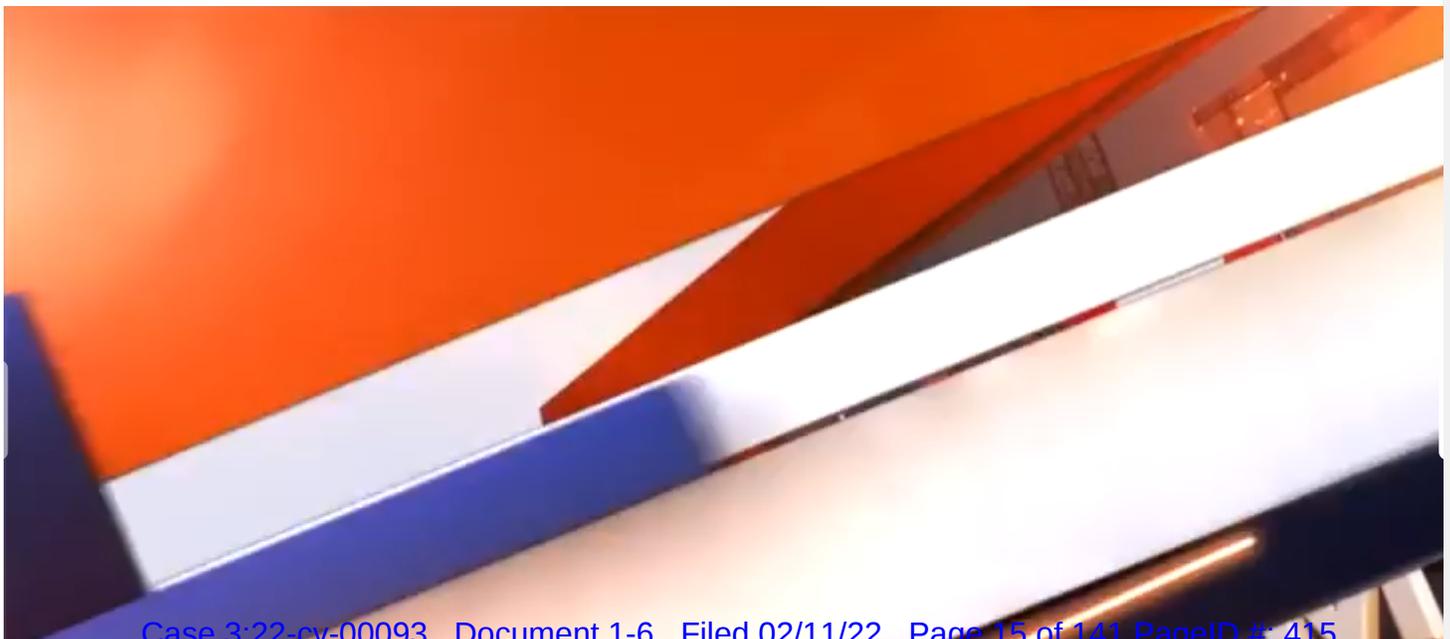
Metro Schools to begin phase-in schedule for in-person learning Feb. 4

LONGFORM



Prisons for profit: Concerns mount about Trousdale Turner Correctional Center, operator CoreCivic

Posted: 1:53 PM, Jun 13, 2019 Updated: 3:56 PM, Jun 14, 2019





After spending more than a year inside Trousdale Turner Correctional Center in Hartsville, Tennessee, one inmate is speaking about the horror he says goes on behind the walls of this private, for-profit prison.



HARTSVILLE, Tenn. (WTVF) — Edwin Steakley has never denied he was guilty. From the moment he was first arrested on an aggravated robbery charge in 2012, Edwin knew he would end up paying the price.

But after spending more than a year inside Trousdale Turner Correctional Center in Hartsville, Tennessee, this 39-year-old man is speaking about the horror he says goes on behind the walls of this private, for-profit prison.

“When I close my eyes, I see a lot of pain. I have trouble sleeping, trouble eating. There’s just a lot of pain,” Edwin said, pausing between long deep breathes.

The deep anxiety this man was feeling, was evident with every word he struggled to speak.

“I was looked upon as a number, as a paycheck, that’s how I feel,” he said.



Edwin Steakley

Management of Trousdale is outsourced to the Nashville-based privately-run company CoreCivic. Of the 14 prisons the Tennessee Department of Corrections owns across the state only four are managed by CoreCivic.

Through a series of interviews with prisoners and family members of former prisoners, NewsChannel 5 spent months documenting why some state lawmakers say prisons for profit in Tennessee are not working.

Prior to his arrival at Trousdale Turner, Steakley was first housed in Morgan County. While there, he found out his mother had breast cancer and requested a transfer to Trousdale County, the same county he grew up in. From the time he arrived at the prison, he says he was preyed upon because of his Jewish faith.

“It was an atmosphere of a lot of tension. You’re constantly on lockdown 24/7. They would be understaffed, and guards would often have to work two shifts,” Steakley said.

That statement was largely substantiated by a [2017 audit performed by the Tennessee State Comptroller](#). The audit found Trousdale Turner had “unstaffed critical posts on several days,” detailed numerous instances when CoreCivic was in “noncompliance with contract requirements,” which impacted, “the department’s ability to effectively monitor the private prison.”

In a statement, emailed to NewsChannel 5, CoreCivic said they have addressed those concerns.

“Staffing was a challenge for several reasons,” spokeswoman Amanda Gilchrist said via email. “First, the Middle Tennessee labor market was very competitive, which made hiring a challenge for public and private facilities alike...In response, we strengthened our employee recruiting efforts at Trousdale Turner by significantly increasing wages and bonuses, which has already led to a 24% reduction in staff turnover from 2017.”

Edwin Steakley does not need a state audit to tell him about the issues at the CoreCivic facility.

He lived them first hand.

“My cellmate started making sexual remarks toward me, so I wrote out, I told case managers, the Sergeant on duty, I even told my mental health therapist and she said, ‘that’s how men talk,’” Steakley said as the color seemed to drain from his face.

Documents submitted to the Tennessee Department of Corrections show Steakley first reported his concerns about being raped on January 20, 2018. Then again on January 21, 22, 23 and 24 – no action was taken by either CoreCivic or TDOC officials.

Less than a month later, in the middle of the night on February 20th, Edwin Steakley was raped by his cellmate. Documents submitted to CoreCivic detail a horrifying rape in which Steakley was forced to perform oral sex on another man in the middle of the night, as a shank was held to his throat and his life was threatened.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

EDWIN STEAKLEY,)
Plaintiff,)
v.) **CASE NO. 3:19-mc-9999**
CORECIVIC, INC., formerly known as)
Corrections Corporation of America;)
JEFFERY REEVES; RUSSELL WASHBURN,)
in his individual and in his official capacity)
as warden of Trousdale Turner)
Correctional Facility; KEITH HUGGINS,)
in his individual and in his official capacity)
as chief of security of Trousdale Turner)
Correctional Facility; HARLEY SILCOX,)
in her individual and in her official)
capacity as correctional sergeant at)
Trousdale Turner Correctional Facility)
Defendants.)

COMPLAINT

1. Plaintiff Edwin Steakley, by and through counsel Daniel Ayoade Yoon, files this complaint under 42 U.S.C. 1983 and all other applicable state and federal law, naming as defendants CoreCivic, Inc., Jeffery Reeves, Warden Russell Washburn, Chief of Security Keith Huggins, and Sergeant Haley Silcox as violating his constitutional rights and for inflicting tortious injuries.

PARTIES

2. Plaintiff Edwin Steakley is a living, natural person and resident of Trousdale County, Tennessee.
3. Defendant CoreCivic, Inc., is a real estate investment trust, a Maryland corporation

“Do you know how that’ll make a person feel? To wake up to that?” Steakley said, breaking down into tears.

“He said, ‘suck my d--- or die.’ ” At this point, Edwin got up from the chair he as sitting in, unable to catch his breath. When he sat back down and composed himself, he continued, “Do you know how much courage it took for me to stand up? To even come forward and admit something like that?”

“Yeah, we all committed a crime, we’re all guilty...We’re still human, we still breathe the same air you breathe, we still have a heart that beats,” he said, barely containing his tears.

While CoreCivic denied requests for an interview, they did address Steakley’s alleged sexual assault:

“CoreCivic examined all reports of sexual abuse filed at Trousdale Turner while he was incarcerated there,” Gilchrist said. “Mr. Steakley was found to have made one report, which was investigated, and the allegations were found to be unsubstantiated. No other reports of sexual abuse were filed by Mr. Steakley during his incarceration at Trousdale Turner.”

Documents provided to NewsChannel 5 by Steakley’s attorney, though, show he filed multiple grievances over the course of a month.

Steakley currently has a lawsuit pending against CoreCivic.

Attachment
3

Att: Warden Wash Burn: Htt

page 5 of 12



TENNESSEE DEPARTMENT OF CORRECTION
INMATE INQUIRY - INFORMATION REQUEST

TTC
INSTITUTION

Edwin Steakley
INMATE NAME (Please Print)

312255
INMATE NUMBER

UNIT: FA ROOM / BED: 102 DATE: 1-23-18

ROUTED TO: Unit Manager Inmate Relations Coordinator (IRC) Counselor Job Coordinator

1. Inmate Inquiry/Request:

Sie I have wrote C/M Jones and spoke with him, SGT S: Icar wrote her and spoke to her, wrote my counselor, and nothing has been done about my cellie making sexual remarks and reaching like he is going to rub his pruts, the hole time telling me he is going to mate me such it.

2. Action by Counselor/IRC:

COUNSELOR/IRC SIGNATURE

DATE

3. Action by Record Office:

RECORD'S OFFICE STAFF SIGNATURE

DATE

4. Sentence Management Service (SMS) Response:

Paying the ultimate price

It is hard to escape the sadness that seems to hang over the Anderson family home just outside of Chattanooga, Tennessee. Bill and Teresa Anderson have dealt with more than their fair share of grief over the last few years. Heartache, they say, that is only compounded because some of Tennessee's prisons are run for profit.

“It is morally and ethically wrong to be making a profit off of people in prison,” Teresa Anderson said.

All along the walls of Anderson's home are pictures of with picture of her children, including her son Ross Anderson. Ross ended up at Trousdale Turner Correctional Center back in 2017 after being convicted of killing his Rachael Johnson and her 5-year-old son Colton.



Bill, Ross, and Teresa Anderson

The horrific murder occurred just a few doors down from Ross's childhood home where his parents still live. “We will forever be the parents of a murder, forever, and there's no erasing that,” Teresa said as she clutched a picture of her son in her hands.

For years, the Anderson's say their son was dealing with a multitude of mental health issues from schizophrenia to severe depression. They do not make any excuses for the crimes their son committed nor are they looking for any kind of pity.

But what they do want, is to bring awareness to what they say are unsafe conditions inside of Trowsdale Turner.

“There was no mental health care there, there was nothing. Our son is the face of everything that is wrong with the mental health system in this state and the prison system in this state,” Teresa said passionately.

Deep down, this mother says she knew that once her son was convicted and sent to prison, he was not going to make it out alive.

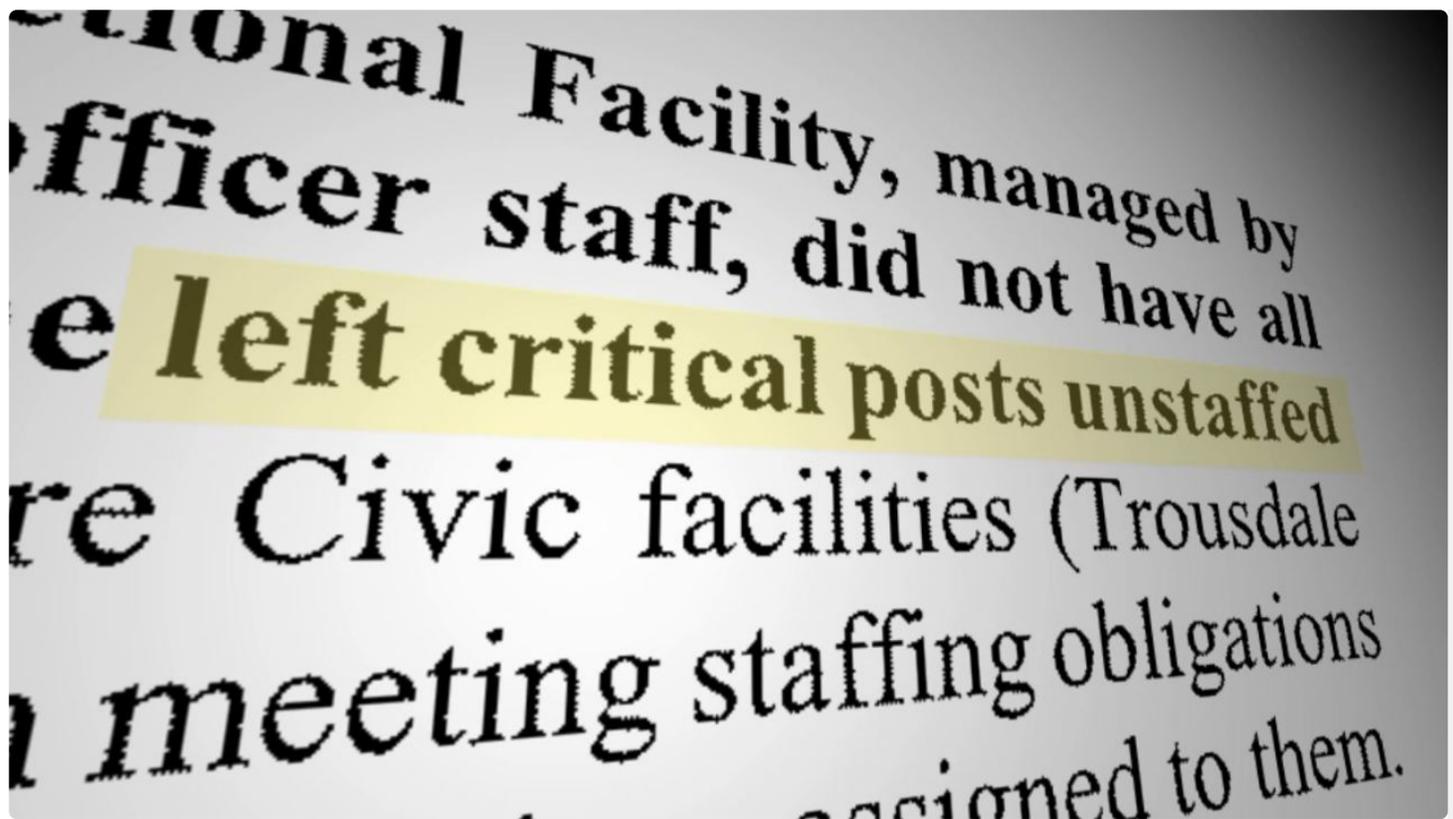
She was right. On December 6, 2018, inside of his cell at Trowsdale Turner Correctional Center, Ross Anderson committed suicide. It was the third anniversary of his girlfriend’s murder.

The 34-year-old had hung himself with a pair of jeans.

“It happened on their watch. That’s what bothers me the most. I can’t stand my own thoughts some days, thinking about him dying in a place like that, alone where no one loved him or cared about it,” she said as teared rolled across her cheeks.

Both Teresa and Bill Anderson though say they believe their son would still likely be alive if Trowsdale Turner was not managed by CoreCivic, a company which last year reported a total revenue of \$482 million dollars. “How can it be okay to make a profit off other people’s misery and mistakes?” Teresa said. "It’s immoral and unethical. "

In response to Ross Anderson’s suicide, CoreCivic’s spokeswoman said, “When an incarcerated person takes their own life, the sense of loss reverberates through family members, fellow inmates and facility staff. Our government partners are immediately notified, and there is a full investigation of the circumstances surrounding the incident.”



A 2017 audit of Trousdale Turner Correctional Center found critical posts were left unstaffed among numerous other instances when CoreCivic was in "noncompliance with contract requirements"

Lawmakers question contract with CoreCivic

That 2017 audit found that the Trousdale facility had 66 documented incidents of noncompliance that resulted in CoreCivic being fined more than \$2.5 million. This year, the number was 26.

CoreCivic says they are constantly working to address issues at all four of their prisons in Tennessee.

"We've taken the challenges at Trousdale Turner very seriously, and we've worked hard to address them. The fact that the facility earned a 95% score on its most recent TDOC audit is a testament to that effort," Gilchrist said in response to questions submitted by NewsChannel 5.

Still though some lawmakers question why the state continues to pay CoreCivic millions of dollars a year when their track record is less than perfect.

The issue of resigning another contract with CoreCivic came to a tipping point at the state Capitol in December 2018. When asked whether the contract with CoreCivic should be ended, TDOC Commissioner Tony Parker said, “I have found the vendor, CoreCivic, they work well with us to try to correct these issues.”

Still, some lawmakers at that hearing seemed dissatisfied with the progress the company is making.

“We have to step up in my opinion,” Janice Bowling, a Republican Senator from Tullahoma, said.

Both Teresa and Bill Anderson were present at the hearing. Bill Anderson testified, detailing his son's suicide. Three minutes into that testimony, was cut off by Republican Chairman Mike Bell.

Bo Mitchell, a Democrat from Nashville, quickly shot back. “I’m done until someone in this committee wants to step up! We’re always in a hurry. We do nothing again, and again, and again, and we send these people home!” Rep. Mitchell said, his voiced raised nearly to the point of yelling.

In the end, CoreCivic’s contract was resigned. They will continue to manage four state facilities including Trousdale for the foreseeable future.

Read CoreCivic's full response to NewsChannel 5 below:

As we've acknowledged previously, there were challenges with bringing the Trousdale Turner Correctional Center up to full speed after its opening. Following the release of the Comptroller's performance audit in November 2017, CoreCivic worked closely with the Tennessee Department of Correction to address all findings through a comprehensive action plan. As a result:

- We improved performance on the 2018 follow up TDOC audit, with Trousdale Turner facility earning a 95 percent score – up significantly from 2017.
- Trousdale Turner also received 100 percent mandatory and 98.6 percent non-mandatory scores on our independent American Correctional Association (ACA) audit.

We appreciate the strong oversight by our government partners and remain committed to operating safe, secure facilities with high-quality reentry programming.

During the 2017 audit it was found the facility didn't have adequate staffing, I know that has been addressed, but why was that the case back then?

Staffing was a challenge for several reasons. First, the Middle Tennessee labor market was very competitive, which made hiring a challenge for public and private facilities alike. The local unemployment rate in Trousdale County was below 3%, which means we were trying to hire from a much tighter labor market than anticipated. Additionally, there was a significant lack of housing around the facility, forcing a number of our correctional officers to commute several hours to and from work and spend a significant amount of their income on gas.

In response, we strengthened our employee recruiting efforts at Trousdale Turner by significantly increasing wages and bonuses, which has already led to a 24% reduction in staff turnover from 2017. Trousdale Turner now has the highest correctional officer starting salary in the state – public or private. We also partnered with a local developer to incentivize the construction of housing options in Hartsville in order to expand the available pool of affordable, local units for Trousdale Turner employees.

We will continue to monitor and adjust recruitment and retention efforts as needed to ensure we remain an attractive option for job-seekers.

Do inmates receive any kind of mental or psychiatric care while at Turner?

A team of seven mental health professionals provide a full range of diagnostic and therapeutic services to the inmates at Trousdale Turner. When specific needs arise, additional outside professionals are used to augment the care given by the professionals in the facility. In addition to providing regularly scheduled mental health services, members of the team are on-call 24/7 to respond to mental health emergencies, including situations requiring an inmate to be placed on suicide watch.

Is CoreCivic doing anything to address the suicide of Ross Anderson?

When an incarcerated person takes their own life, the sense of loss reverberates through family members, fellow inmates and facility staff. Our government partners are immediately notified, and there is a full investigation of the circumstances surrounding the incident. In Mr. Anderson's



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NEWS



Scathing state audit slams Tennessee prisons, CoreCivic for staffing, sexual assaults, and deaths in jails

State audit reveals alarming details in TN prisons

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Civic prisons across the state of Tennessee are still running at minimal staffing levels, in many cases leaving inmates susceptible to sexual assault.



Posted at 12:36 PM, Jan 10, 2020 and last updated 7:19 PM, Jan 10, 2020

NASHVILLE, Tenn. (WTVF) — A scathing state audit released on Friday found that CoreCivic prisons across the state of Tennessee are still running at minimal staffing levels, in many cases meaning inmates suffering mental health issues aren't getting the help they need and creating questions surrounding the nearly 200 inmates who have died in state custody since 2017.

Every year the state pays the privately owned company millions of dollars to manage four prisons across the state of Tennessee.

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ment of Corrections was released on Friday and tracked the department's performance from October 1, 2017 though July 31, 2019. In the last two years the audit found that 171 inmates have died while in state custody. 12 of those deaths were ruled suicide.

[Read the full 210-page audit here](#)

Over the course of the last two years the audit found that TDOC leadership failed to provide adequate oversight of correctional facilities which resulted in a failure to operate, "safe and secure prisons." In many cases CoreCivic officials were also blasted for not properly reporting vital data related to inmate deaths, inmate assaults, correction officer's use of force and facility lockdowns.

In recent years prisoner inside of CoreCivic run prisons owned by the state have come forward saying incidents of sexual assault were either ignored or not dealt with appropriately. In 2019 [NewsChannel 5 interviewed one inmate](#) who said he was raped inside of his jail cell because he was Jewish. Documents show that inmate reported his concerns to officials both prior to the incident happening and after it occurred, yet his claims was found to be unfounded.

Yet that audit said "Three of the eight allegations, correctional facility staff

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An entire section of the audit is related to procedures that apparently aren't investigating sexual abuse and harassment. Inmates do not report being sexually assaulted, or because they do not believe that it will change.

at state prisons where showers were not available. It also found that 171 inmates have died while in state custody. 12 of those deaths were ruled suicide.

Most alarming for families who have lost inmates to suicide inside of state facilities, the findings detail numerous incidents where correctional officials did not perform mental health checks in a timely manner.

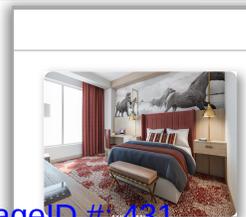
Regularly, the audit found, inmates were walking away with their medications without waiting for a nurse to watch them swallow their pills even though state policy requires "face-to-face observation and monitoring by a qualified health professional of an inmate taking their medication."

The audit contained in all 18 findings that they say needed addressed. They identified several as "key findings"

- TDOC's leadership must improve its oversight in order to ensure compliance with laws, regulations and policies; provide safe and secure facilities; and reduce the risk to public safety.
- TDOC's annual inspection percentage scores of facilities do not provide a

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- TDOC should ensure that staff follow policies and procedures for harassment allegations.
al and mental health contractors met
allowed contractors to offset assessed
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rate that inmates are receiving sufficient
ices.
inue efforts to ensure adequate staffing in
e facilities. CoreCivic must also continue
making progress on the accuracy of its monthly staffing reports.
- Management must ensure staff perform inmate screenings within required timeframes. Management must also be sure inmates are aware of information and services the department provides.
- Although there has been improvement, the department has still not ensured adequate monitoring of individuals placed on parole or probation.
- The department has had difficulties in replacing its outdated information management system for offender data.
- Department management did not ensure that its staff and CoreCivic complied with public records regulations, resulting in lost records as well as potential evidence.
- The department has not reported recidivism rates for inmates who participated in educational and vocational programs, as required by statute.

These issues will be presented to the Joint Government Operations Subcommittee on Judiciary and Government on January 13th at 9 a.m.

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reentry programming, comprehensive healthcare, faith-based support and
ue to work closely with our partners at the
n to ensure our administrative processes are
insparency into our operations.

there were challenges with bringing the
er up to full speed after its opening. We've
ges we've faced, and while we still have work
to do, we are making progress.

For example, we significantly increased pay to attract and retain employees,
with the starting salary at Trousdale now more than \$16.50 per hour, which is
the highest in the state for public or private facilities. We also offer immediate
signing bonuses and relocation bonuses to make sure we're an attractive option
in a competitive Tennessee labor market.

PREA Investigations

We are committed to the safety and dignity of every person entrusted to our
care. We have a zero-tolerance policy for all forms of sexual abuse and sexual
harassment. To ensure we are in full compliance with the Prison Rape
Elimination Act (PREA), all staff receive pre-service and in-service education
and training, and all inmates receive PREA education beginning at initial
reception and continuing while they are with us. Anyone can report an
allegation or suspected incident of sexual abuse or harassment, including
inmates, staff or third parties. There are multiple options to report allegations
including (but not limited to) calling the National Sexual Assault Hotline.

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All allegations of sexual misconduct are promptly, thoroughly and objectively investigated. They are tracked through an incident reporting database and reviewed within 72 hours. Allegations of sexual abuse that are criminal in nature are referred to the appropriate law enforcement agency (Tennessee Department of Correction's Office of Investigations and Compliance) for investigation and potential prosecution. All substantiated allegations of sexual abuse or sexual harassment result in the appropriate disciplinary actions and, where appropriate, referral for prosecution.

You can read more about CoreCivic's efforts to combat sexual abuse and harassment, including our annual PREA reports, here:

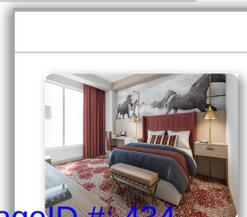
<http://www.corecivic.com/the-prison-rape-elimination-act-of-2003-prea>.

TDOC's commissioner gave the following statement:

The Department of Correction appreciates the work of the Comptroller's Office audit staff and the thoroughness of the report. We have already addressed, or are in the process of addressing the issues raised in the report which includes,

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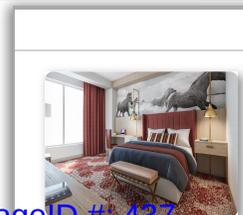
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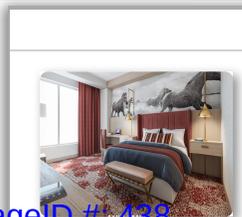
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CoreCivic shareholders gain class action status in securities fraud lawsuit against private prisons company

Jamie McGee The Tennessean

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A federal judge has granted class action status to shareholders suing Nashville-based CoreCivic for securities fraud in a lawsuit that reveals new details about the company's operations and staffing issues.

The lawsuit, filed in August 2016 against the company and four executives, alleges CoreCivic, formerly named Corrections Corp. of America, made false and misleading statements about its operations related to safety, security and effectiveness and committed securities fraud violations.

In an order filed Tuesday in U.S. District Court of Middle Tennessee, Judge Aleta Trauger granted the lawsuit class action status. Trauger had denied the status in January, and the plaintiffs subsequently filed a motion for reconsideration and submitted new evidence.

Among the executives named in the lawsuit are CEO Damon Hininger, David Garfinkle, Todd Millenger and Harley Lappin.

CoreCivic said it does not comment on active litigation.

The lawsuit concerns an announcement made Aug. 18, 2016, that the U.S. Department of Justice would phase out contracts with private prison operators. Then-Deputy Attorney General Sally Q. Yates had instructed the Bureau of Prisons to end or reduce contracts with privately run prisons and cited concerns about safety and security in privately run facilities outlined in a separate report from the Office of the Inspector General.

The OIG report said that privately run prisons had more safety and security incidents per capita than those run by the bureau of prisons and that CoreCivic prisons had the highest rates of fights and inmate-on-inmate assaults.

After Yates' announcement, CoreCivic shares tumbled by 39 percent, and shareholders suffered financial losses because of the company's acts and omissions, the shareholders allege.

Hininger in March 2016 told shareholders that its facilities "meets the needs of our government partners" and that the company has a "strong record of operational excellence," according to the new order. The order also referred to other company reports in which the company claimed to be compliant with government standards.

The order says the BOP regularly notified CoreCivic about "inadequate staffing and its failure to provide sufficient medical services to its inmates." In 2015, the BOP said unless conditions related to health services are cured, the government may terminate its contract.

In October 2015, according to the order, a CoreCivic executive wrote in an email to Hininger, "apparently we had a bad day today with BOP medical audit at Cibola," a detention center in New Mexico. Another email said the matter "is going to kill us at both Cibola and Eden," a facility in Texas. In June 2016, as the BOP reviewed medical services at Cibola County Correctional Center, an executive wrote, "We're dead."

That same month, Hininger said at an investor forum, "We have operationally made sure that we are providing high quality and standard and consistent services to our partners."

When CoreCivic employees were given an advance version of the 2016 OIG report, an executive wrote, "What I'm shocked over is they totally overlooked the consequences of our staff vacancies. They mentioned staffing at the end but could have been much more critical," according to the order.

In a separate order filed in December 2017 that denies CoreCivic's motion to dismiss, an affidavit by a correctional officer describes a 2012 incident that resulted in the death of another employee at a CoreCivic prison in Mississippi. The correctional officer said she was instructed to climb onto a roof after being warned about inmates planning "something big" and to eventually deploy gas canisters at inmates climbing a ladder to the roof, according to the court filing, citing the affidavit. The inmates threw the canisters back at two staff members, along with garbage cans and rocks before beating a staff member with a metal pan and food tray. That correctional officer said after she gained consciousness, she saw the other staff member lying motionless on the roof.

She and her coworkers had told Corecivic officials on numerous occasions that they lacked the staff needed to control inmates and the shortage created a dangerous environment. She

said she was told to “put my big girl panties on and get back to work,” according to the order, citing the affidavit.

The BOP sent CoreCivic several notices about staffing shortages and health services deficiencies at the Mississippi facility and a separate facility, Cibola, in New Mexico, according to the 2017 court filing. "Unsatisfactory" reviews were given to both sites. The company's Eden Detention Center in Texas received notices related to health services deficiencies and the BOP said its response to tuberculosis had been "inadequate."

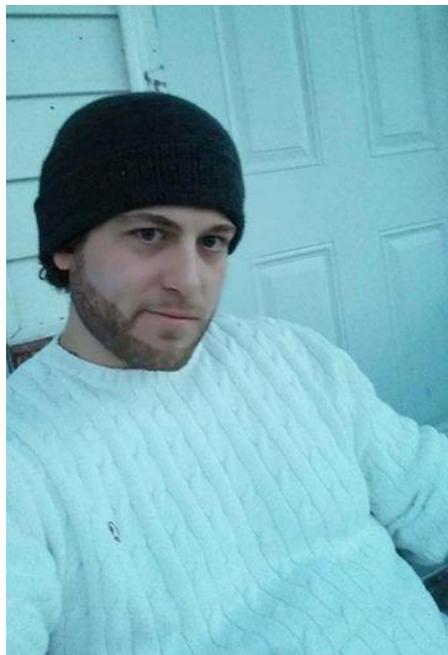
Reach Jamie McGee at 615-259-8071 and on Twitter @JamieMcGee_.

https://www.lebanondemocrat.com/hartsville/family-seeks-answers-in-loved-ones-death-at-trousdale-prison/article_1ffe90f7-0e9f-5021-bb94-9ec1b4d23139.html

Family seeks answers in loved one's death at Trousdale prison

By Chris Gregory cgregory@hartsvillevidette.com

Jan 2, 2021



Aaron Blayke Adams

Submitted

Family members of an inmate at Trousdale Turner Correctional Center are demanding an investigation into what they called a murder inside the facility last month.

CoreCivic, which owns the Hartsville prison, confirmed the death in a press statement by Public Affairs Manager Ryan Gustin.

"At approximately 2:07 a.m. (CST) on Thursday, December 17, Trousdale Turner Correctional Center staff discovered an unresponsive inmate. Staff immediately called a medical emergency. Facility medical staff immediately responded and begin administering emergency first aid and life-saving procedures. EMS responded to the facility, but the inmate passed away prior to being transported.

"Facility administrators notified the Tennessee Department of Correction's (TDOC) Office of Investigations and Conduct (OIC). A full investigation of the incident by the TDOC OIC is underway, and Trousdale Turner staff are cooperating fully," the statement read.

CoreCivic declined to identify the inmate, citing privacy requirements and referred all other inquiries to TDOC. A letter sent to media outlets, TTCC Warden Raymond Byrd, TDOC offices and to the District Attorney's office by the inmate's family identified him as Aaron Blayke Adams, 29. Tennessee's TOMIS inmate identification system also lists Adams as 'deceased.'

"He was murdered at Trousdale Turner," Deborah Henson, Adams' grandmother, said. "He was in protective custody because he was due to be released."

CoreCivic would not confirm whether Adams had been in protective custody or was scheduled for release.

The letter claims that Adams "obtained broken bones and blunt force trauma, to his face and head, along with multiple bruising throughout his body," and Henson added that the funeral home had to reconstruct Adams' head while preparing the body for memorial services.

"It has been devastating to know that he was beaten so badly they had to recap his head and build up his lower jaw just so we could have an open casket," she said.

The family's letter alleges that Adams was killed by "a menace to society... who was already serving time for murdering his own father."

"CoreCivic had a duty but failed to protect our beloved Blayke," the letter states. "Every inmate in their care should be treated humanely and safely secured while in their care. Blayke was not safe, and lost his life, due to the gross negligence of this facility."

CoreCivic declined to identify the alleged party responsible for the death and the claim could not be confirmed at press time. The District Attorney's office was closed for the New Year holiday and also could not be reached for comment at press time.

Inmates at CoreCivic prisons say they sometimes go months without medical care

REPORTED BY DEMETRIA KALODIMOS

POSTED JUN 22, 2017



Department of Corrections officials are reporting another death at Trousdale Turner Correctional Facility after an inmate has tested positive for COVID-19.

Octavious Taylor has a painful and incurable disease. It's a bad combination when you're locked up in prison.

Taylor's fiancée, Larita Dowlen, said when he was transferred from a state-run facility to the privately run Trousdale Turner Correctional Center, he stopped getting his medicine for sickle cell anemia.

“He catches infections really easily. It gets to the point sometimes where he can’t even get out of bed. Excruciating pain,” Dowlen said.

Taylor documented a recent health crisis minute-by-minute in a grievance report.

Over a 24-hour period, Taylor claims he repeatedly asked to see a medical professional for pain. The report says he was refused more than once, told the staff was too busy, and told “unless he was bleeding or dying, it was not a medical emergency.”

When he finally saw a nurse 24 hours later, he got hot compresses and ibuprofen, nothing more.

“I’m actually afraid he’s going to die one day in that prison because they don’t give him the medical help he needs,” Dowlen said.

“No, it doesn’t surprise me,” said Jeannie Alexander, an advocate with No Exceptions. “I mean we’ve received stories of broken bones that are never set, stories of individuals with sickle cell, patients who can’t get their medication. Of course with Trousdale, we have the recent suit brought by prisoners with diabetes who can’t get their insulin shot.

The suit demands that all diabetics be transferred at once to a non-CoreCivic prison in Tennessee with adequate medical staff.

“Why do you want to spend money on health care? The point is to spend as little as possible to confine these people, and that’s the name of the game,” Alexander said.

But what happened at another CoreCivic prison in Tennessee may up the ante altogether.

The details are spelled out in two separate, but similar, letters from inmates. One of them also called Channel 4.

“I wrote you about Chris, you know, about him cutting his testicles off?” the inmate said.

The letter said that on the night of March 21, 2017, Christopher Hall decided the pain he was suffering was so unbearable, he had to do something of his own.

“He kept for four months trying to get medical treatment for them, and he showed them to me,” the caller said. “They had swelled up, looked like a softball, and they was blue.

“He was just in so much pain. And like I said, they was swelled up like 10 times bigger than they should have been,” he added.

The letter says, “Mr. Hall decided he couldn’t bear the pain any longer.”

Hall told the Channel 4 I-Team what he did and why.

“I asked him how long to see a doctor. They told me a couple weeks,” Hall said. “I put in a sick call. They never called me. I wait and I wait and I wait. This is the last straw, I’m hurting so bad in my belly.

“I’ve been trying to see a doctor for over five months. I just broke me a razor out, went up there and got me some thread, went in the shower, shaved a little bit and popped her out,” Hall said.

“He cut his testicles out, put them in a cup, and then took them to the nurse and handed them to her and told her, ‘Here you go. Now you ain’t got to worry about doing nothing,” the caller said.

Hall was bleeding so bad they couldn’t get the bleeding to stop.

“And they took him to Nashville and everything, but they was trying to keep it quiet here and everything,” the inmate said.

“They had me on psych ward lockdown. ... They thought I was crazy, I hurt myself. I said I didn’t hurt myself, I relieved myself. I’ve been trying to see a doctor for five months,” Hall said.

“And they was saying he was suicidal and all that is what they’re blaming it on. Anybody’s going to kill themselves, you know, they’re not going to do that,” the inmate said.

This happened at South Central Correctional Facility.

“What the hell is going on?” Alexander asked. “There will be a time when this state will be ashamed at what’s happened behind prison walls.

“Let journalists in. Let politicians in. Let people go inside and freely speak. Believe your staff. Believe the prisoners who are housed in your facility. Start paying attention,” she added.

“This is the problem with the privatization of prisons, because no longer are you dealing with human lives. The humanitarian issue doesn’t matter, because who does the fiduciary duty run to? The stockholders, not the state, not the communities, not the citizens, not the staff. It’s stockholders.”

After learning of this incident, the I-Team reached out to CoreCivic. Our specific inquiry about this mutilation, made months ago, has yet to be addressed.

Many families have asked the I-Team what they can do to bring their complaints and concerns to light.

CoreCivic is under contract by the state. Taxpayers are sending millions to the firm to provide services to incarcerated Tennesseans. The governor and lawmakers approved the deal.

CoreCivic’s contract in Trousdale County isn’t set to expire until 2018.

WSMV-TV Channel 4, Nashville

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NEWS

Inmates at CoreCivic prisons say they sometimes go months without medical care

Posted Jun 22, 2017

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✿ (</subscribe/digital/>) Incorrect Cause of Tennessee Prisoner's Death Reported by CoreCivic Employees

Loaded on JUNE 7, 2018 published in Prison Legal News June, 2018 (</news/issue/29/6/>), page 34

Filed under: Corrections Corporation of America/CoreCivic (/search/?selected_facets=tags:Corrections%20Corporation%20of%20America/CoreCivic), Contractor Misconduct (/search/?selected_facets=tags:Contractor%20Misconduct), Drug Overdose (/search/?selected_facets=tags:Drug%20Overdose), Statistics/Trends (/search/?selected_facets=tags:Statistics/Trends), Wrongful Death (/search/?selected_facets=tags:Wrongful%20Death). Location: Tennessee (/search/?selected_facets=locations:1517).

selected_facets=tags:Corrections%20Corporation%20of%20America/CoreCivic), Contractor Misconduct (/search/?selected_facets=tags:Contractor%20Misconduct), Drug Overdose (/search/?selected_facets=tags:Drug%20Overdose), Statistics/Trends (/search/?selected_facets=tags:Statistics/Trends), Wrongful Death (/search/?selected_facets=tags:Wrongful%20Death). Location: Tennessee (/search/?selected_facets=locations:1517).

According to the Tennessee Department of Correction (TDOC), state prisoner Edward Ray Gilley, Jr., 54, died on November 5, 2016 at the Trousdale Turner Correctional Center, a facility owned and operated by CoreCivic – previously known as Corrections Corporation of America.

In response to a public records request filed by Prison Legal News, on February 13, 2018 the TDOC's director of communication, Neysa Taylor, reported that Gilley's death was due to "natural causes."

Unless overdosing on meth is "natural," however, that cause of death was incorrect – though it evidently was not scrutinized or questioned by TDOC officials.

A previous news report by WSMV Channel 4 in Nashville indicated that Gilley had died of an overdose, though he wasn't mentioned by name in the report. PLN obtained a copy of the autopsy results from the medical examiner's office, which concluded that Gilley's death was caused by "toxic effects of methamphetamine complicating hypertensive cardiovascular disease." The report noted that a toxicology screen was "significant for methamphetamine" at almost four times the reporting threshold, and the cause of death was ruled accidental – as in an accidental overdose.

It was not listed as due to natural causes.

Yet "natural causes" was the entry made by CoreCivic employees Lt. Julie Englebrecht and Beverly Atwood, an administrative assistant to Trousdale's warden, according to records produced by the TDOC pursuant to another public records request filed by PLN.

Gilley's sister, Diana, said prison officials at Trousdale falsely informed her that her brother had died of a "massive heart attack."

"It was an overdose, an overdose of meth in this facility," his sister told WSMV. "Words cannot express the shock we have on so many levels that this could even possibl[y] be anything that would be considered in a state correctional center. Unbelievable. How he got it, where he got it. Was it manufactured in there? Who supplied him with this? It's beyond anybody's comprehension how this could happen."

CoreCivic's Trousdale prison has been plagued with problems since it opened in 2016, including understaffing, complaints about inadequate medical care, a suicide, and high levels of violence and gang activity. [See: PLN, Feb. 2018, p.46]. There have been at least nine prisoner deaths, including Gilley's, from 2016 through March 2018.

This was not the first time that CoreCivic incorrectly reported a prisoner's cause of death. When Estelle Richardson, a mother of two, died at the CCA-operated Metro-Davidson County Detention Facility in Nashville on July 5, 2004, the company recorded her death as being due to "natural causes" in an internally-compiled list of incidents provided to Florida officials as part of a contract bid.

In fact, the medical examiner had determined Estelle's death was a homicide.

On April 16, 2018, PLN managing editor Alex Friedmann provided public testimony before the state House Government Operations Committee. He raised the issue of Gilley's death being incorrectly reported by CoreCivic as due to "natural causes," noting that the company's employees had an incentive not to disclose adverse incidents such as overdoses – which would raise questions about how the drugs were obtained, how they were brought into the facility and whether the company had conducted an investigation.

"We have a problem with CoreCivic misrepresenting the cause of death of a prisoner, and we have a problem with the Tennessee Department of Correction accepting that information, apparently without question, and disseminating it to the public even though it conflicts with the medical examiner's report, which indicates a lack of oversight, a lack of monitoring," Friedmann told the legislative committee.

During the same hearing, TDOC Commissioner Tony Parker responded to that issue. With respect to a prisoner's overdose death, he stated, "it could appear to be a natural death depending on the circumstances ...," and noted it takes months to get autopsy results that list the official cause of death. "It is possible for a death to be assumed or listed as ... a natural cause [of] death, but after you get the reports back and other evidence comes forth, it can be changed," Parker said. He added that the TDOC had taken recent steps to improve oversight at Trousdale, including assigning additional contract monitors and imposing fines against CoreCivic.

However, in the case of Gilley, the autopsy report that determined his death was caused by a meth overdose was completed by the medical examiner in December 2016, yet the TDOC was still stating that he had died of "natural causes" in February 2018 – indicating the incorrect cause of death reported by CoreCivic had not been reviewed or changed by state prison officials in over 14 months.

Sources: www.wsmv.com, TDOC public records requests, www.legislature.state.tn.us

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LOCAL

Private prison company CoreCivic's history of issues in Tennessee

Staff reports

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CoreCivic is one of the nation's largest private prison firms. In Tennessee, it runs four state prisons and several county detention centers, housing about a third of the state's roughly 30,000 inmates.

But the company has faced scrutiny for a number of problems at its facilities, including criticism from state leaders, local politicians and the public. Here is an overview of some of the recent issues that put CoreCivic in the headlines.

Audits: Mishandled abuse claims, gang activity, staffing shortages

CoreCivic was named in an audit released earlier this month, which detailed the Tennessee Department of Correction's failure to properly classify inmate deaths and mishandling of sexual abuse claims.

Health staff at two CoreCivic facilities — Whiteville Correctional Facility and Trousdale Turner Correctional Center — did not record any serious accidents or injuries in a state database during the one-and-a-half-year audit period, an "unlikely" absence of such incidents, the audit said. Allegations of sexual abuse and harassment were also filed 10 days late at Whiteville and Trousdale Turner, according to the audit.

For subscribers: Nashville considers ending contracts with private prison companies. But can the city afford it?

It wasn't the first time the company had been the subject of a critical review. A 2017 state audit cited gang activity and staffing shortages at Trousdale Turner as evidence of CoreCivic's "continued noncompliance with contract requirements and department policies" while

managing the prison. CoreCivic later acknowledged it had been fined more than \$2 million by the state for issues related to the 2017 audit.

A spokesperson for CoreCivic said the company was "committed to providing a high standard of care for every person in our Tennessee facilities."

Problems at Trousdale Turner

The Trousdale Turner Correctional Center has been among CoreCivic's most troubled facilities in Tennessee. The company has a five-year, \$276-million deal to run the a 2,552-bed prison in Hartsville.

In 2016, Trousdale Turner abruptly stopped accepting new inmates amid concerns about "serious issues" at the prison, including inadequate staffing, solitary confinement problems and allegations of excessive force. The Tennessean reported that year that 306 jobs were unfilled at the state's four CoreCivic-operated prisons, representing an 18.6% vacancy rate.

In 2018, state lawmakers heard testimony from a former Trousdale Turner inmate who said he was raped twice while incarcerated there, and that nothing was done when he attempted to report it. Testimony from the parents of another former inmate blamed a lack of staffing and oversight for their son's suicide at the prison.

A spokesperson for CoreCivic later said the company has boosted pay and recruitment efforts to improve staffing at Trousdale Turner, and said CoreCivic makes extensive efforts to prevent and address sexual assault.

Sexual harassment, diabetes lawsuits

CoreCivic has also faced lawsuits in Tennessee from both inmates and former employees.

A female guard at a Chattanooga prison run by CoreCivic said she was repeatedly required to work alone with male inmates who sexually harassed, groped and attacked her, according to a federal lawsuit filed in 2019. Coworkers repeatedly ignored the guard's calls for help and shrugged off her reports of harassment, according to the suit, with a supervisor telling her to "grow a tougher skin."

Multiple lawsuits also claimed that diabetic inmates were denied timely access insulin or other necessary medical care. CoreCivic has denied wrongdoing in those suits and said it is committed to "high-quality health care" for inmates.

Scabies outbreak

In 2017, an outbreak of scabies at the CoreCivic-run Metro-Davidson County Detention Facility spread the infestation to hundreds of inmates and staffers. A lawsuit filed by employees at the jail alleged that they faced retaliation if they spoke out about the problem, which echoed a lawsuit on behalf of inmates that claimed they would be placed in solitary confinement if they discussed scabies.

Later that year, a CoreCivic guard was arrested and pleaded guilty to misdemeanor assault for pepper spraying an inmate without justification. The inmate, James Nelson, alleged that corrections officer Oluwatobi Ola attacked him because he was considering filing a lawsuit against CoreCivic over a scabies infection. CoreCivic fired Ola.

CoreCivic did not admit wrongdoing in the scabies outbreak, but did pay medical expenses for some Metro employees. CoreCivic CEO Damon Hininger said jail employees "have followed the standard of care and accepted protocols in correctional health care for managing these types of situations."



CoreCivic

PRISON
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State audit criticizes CoreCivic facilities

Private prisons had staffing, management problems

AUTHORS Stephen Elliott

Two state prisons run by Nashville-based CoreCivic were mismanaged and understaffed, according to a performance audit released Tuesday by the Tennessee Comptroller of the Treasury's office.

The two facilities — Trousdale Turner Correctional Center (pictured) and Hardeman County-based Whiteville Correctional Facility — did not follow state-approved staffing plans. Additionally, the **audit** found that Trousdale Turner's management was in "continued noncompliance with contract requirements and department policies."

The Trousdale prison, which opened in January 2016, has been plagued with problems from the start. It stopped taking new prisoners in May because of “growing pains,” the Associated Press reported, including trouble staffing the facility.

Other issues have been documented at the Trousdale facility. Inmates filed a federal lawsuit in February claiming that understaffing there had resulted in subpar care for diabetics, and families of inmates wrote in a letter that they were “deeply concerned” about the treatment of inmates there.

Facility management responded to the audit by citing pay increases and signing bonuses offered by CoreCivic, formerly known as Corrections Corporation of America, as a way to attract correctional staff.

“Trousdale Turner Correctional Center is a relatively new facility that has been operating for less than two years,” Tennessee Department of Corrections management wrote in response to the audit findings. “As such, considerable oversight has been required. ... Many noncompliance issues have been documented on the contract monitoring reports, annual audits, and quarterly medical and mental health audits.”

CoreCivic stock was trading nearly 5 percentage points down Tuesday afternoon.

CORECIVIC INC. TENNESSEE COMPTROLLER OF THE TREASURY TENNESSEE DEPARTMENT OF CORRECTIONS

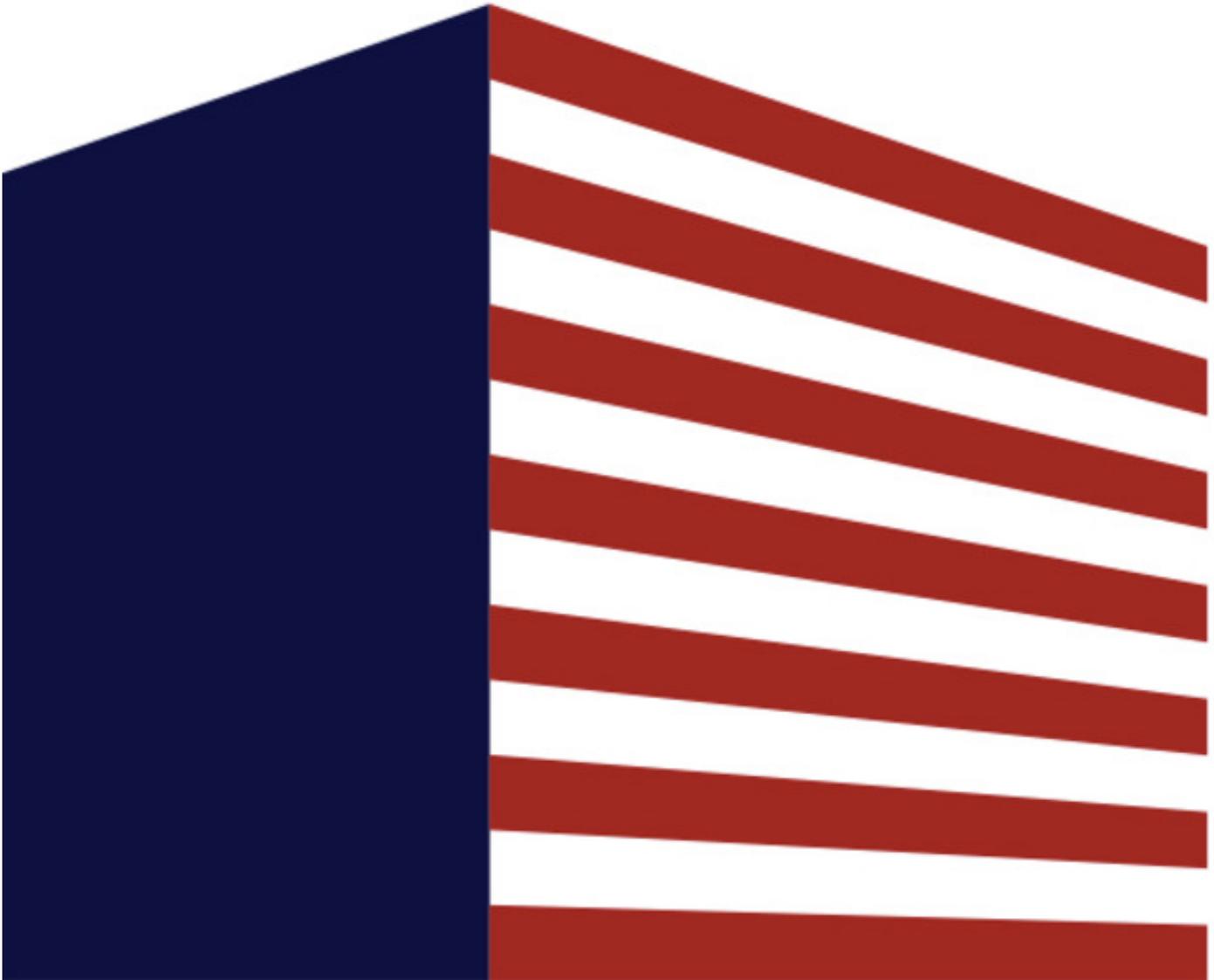
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CoreCivic reports \$25M in profits as COVID infects 2,500+ inmates

Facilities' population fell only 3% from March to April

AUTHORS [Matt Blois](#)



The coronavirus pandemic sent an intense wave of disruption through the prison system in the spring. Local jails emptied out and prison operators tried to implement social distancing rules to prevent the spread of the virus.

Despite those efforts, at least 75,000 inmates have been infected and more than 600 have died in the United States so far, according to reporting from The New York Times. Most of the country's biggest coronavirus clusters have occurred in jails and prisons.

With more than 70 correctional and residential re-entry facilities across the country, and an average inmate population of about 56,000 during the height of the pandemic, Brentwood-based private prison operator CoreCivic finds itself at the center of that problem. More 1,300 inmates at the company's Trousdale Turner Correctional Center

in Hartsville have tested positive for COVID-19 and three have died. Nearly 400 inmates tested positive for the disease at other CoreCivic locations in Tennessee.

U.S. Immigration and Customs Enforcement, CoreCivic's largest client, has reported nearly 700 cases of COVID-19 and two deaths in CoreCivic facilities. Colorado, Georgia and Ohio have reported a total of 124 COVID-19 cases and one death at CoreCivic prisons.

In total, more than 2,500 inmates have tested positive for the disease at CoreCivic facilities. Large outbreaks have occurred in many government operated prisons as well. So far, the vast majority of those cases have been asymptomatic.

CoreCivic has been screening inmates and staff for COVID-19 symptoms and encouraging hand washing, basic hygiene and social distancing. However, inmates and criminal justice advocates argue those basic measures won't keep people healthy in crowded prisons and that the best solution is to dramatically decrease inmate populations.

While the virus has infected thousands of people at CoreCivic facilities, the Brentwood company still reported \$25 million in profits during April and May. (The company in 2019 produced an average of \$15.7 million in net income per month.) Amid the uncertainty, the company isn't issuing financial predictions about the rest of the year, but executives are expressing confidence that the effects of the virus on the bottom line will be temporary.

In a statement, a representative from CoreCivic said the company is working hard to protect staff and inmates from the virus. That includes checking employees and inmates for symptoms, encouraging social distancing through "regular town hall meetings, posted flyers, information presented over the closed circuit television system, and the routine instruction of staff." The company says it's also cleaning frequently touched surfaces.

CoreCivic is limiting movement of inmates to reduce contact with other people. Inmates arriving at a new facility are quarantined for 14 days in a holding area, and people at high risk of becoming severely ill are separated from the general population.

In some places, the company is also conducting mass testing to identify sick inmates, but many inmates still haven't been tested. CoreCivic is following the direction of government clients when it comes to large testing campaigns.

Tennessee set a goal of testing all inmates. Other clients haven't asked for the same level of testing. ICE has tested about half of its detainee population. Colorado has tested about a quarter of its population and Arizona has only tested 8 percent of inmates. That means some infected prisoners may not have been tested yet.

On a conference call last month, CoreCivic executives argued that the company's facilities, which are often larger and more modern than state run prisons, make it easier to keep inmates healthy.

"When a facility is operating above its design capacity, there is less available square feet per resident, in some cases, making social distancing in accordance with the CDC guidance impossible," CEO Damon Hininger said. "Our facility designs are generally more modern and allow for easier separation and social distancing plans."

Some inmates and employees still say they don't feel safe from the new coronavirus inside CoreCivic facilities. Two workers at a CoreCivic facility in California claimed in a lawsuit that the company didn't provide staff with proper protective equipment and that their job duties made it difficult to avoid contact with other people.

Nearly 150 CoreCivic employees had been infected by early May, and several have died. In April, frontline employees received a bonus for working under high-risk conditions and additional sick leave to allow staff to stay home when feeling ill.

Also that month, a group of detainees at two ICE facilities in Arizona operated by CoreCivic asked a court to release them because they feared getting sick. They claimed it was difficult to maintain basic hygiene, impossible to practice social distancing and hard to find appropriate protective equipment. A judge concluded in May that ICE was not taking reasonable measures at the CoreCivic facilities to protect the detainees, ordering the agency to release one detainee and improve conditions for the others.

A spokesperson for CoreCivic said the company is providing masks to all staff and inmates and that disposable gloves are readily available to staff. To bolster supplies of protective equipment, "inmate-volunteers" have made tens of thousands of masks for use at CoreCivic facilities.

Jennifer Gaddy, a researcher at Vanderbilt University who studies bacterial infections and also advocates for prison reform, said that infectious diseases spread easily in jails and prisons even in the best of times, so it's not surprising that they are coronavirus hot spots as well. Gaddy argues that the spread of COVID-19 in jails and prisons is a threat to everyone and she's hoping that the pandemic will lead to lasting changes that reduce infectious disease transmission even after the coronavirus pandemic subsides.

"For years, we've seen that prisons have really high rates of transmission of hepatitis and HIV and tuberculosis. People have sort of shrugged their shoulders and said, 'These are disposable people to our community,'" she said. "Prison health is public health. These are members of our community. Staff come into these facilities and have to be exposed, and they turn around and go home to their families."

Gaddy said that releasing inmates is the only truly effective way to stop the spread of a disease like COVID-19 in jails and prisons. That has happened in many local jails — jail populations in Tennessee fell by about 31 percent in the spring — but CoreCivic's inmate population has declined only slightly.

The number of ICE detainees dropped sharply during the pandemic, mostly because migration at the Southern U.S. border slowed down. Populations at state prisons operated by CoreCivic declined modestly. In total, CoreCivic's inmate population declined by about 3 percent from March to April.

"This is due to disruptions in the criminal justice system as the number of courts in session and prosecutions have declined and with many state and local government agencies deciding to release certain offenders to reduce the risk of COVID-19 transmission," Hininger said on a conference call. "With some states already starting to reopen their economies and even more following similar plans over the next few months, we expect a coinciding gradual resumption of these government activities returning to pre-pandemic levels."

The reduction in the number of people incarcerated cut into CoreCivic's profits, but executives don't expect the pandemic to have long-term effects on its prison population. Alexandra Chambers, an advocate who has worked on prison reform in Tennessee for more than a decade, said she doesn't expect the pandemic itself to have any lasting impacts on the prison system or private operators like CoreCivic.

"Any long term sustained change would have to come from community demands and organizing for decarceration for the safety and wellbeing of those who are incarcerated and their loved ones," she said.

She said the pandemic showed it's possible to reduce inmate populations, and she's hoping the last several months will serve as an example for the public.

As a for-profit company, the pandemic doesn't change CoreCivic's ultimate goal. In the company's recent statement that it might drop its tax-advantaged real estate investment trust structure, CoreCivic reassured shareholders that it is still generating "strong cash flows" during the COVID-19 pandemic.

"While the unprecedented challenges posed by the COVID-19 pandemic continue to be a priority to ensure the safety of our staff and individuals in our care," Hiniger said "We are also focused on creating long-term shareholder value and delivering on our company's purpose."

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Problems Persist at Tennessee's Mismanaged Prisons

Former CoreCivic correctional officer alleges dehumanization and lack of accountability at Trousdale

BY STEVEN HALE — JAN 22, 2020 5 AM

One of the first things Ashley Dixon learned when she was training to be a correctional officer at CoreCivic's Trousdale Turner Correctional Center was that you never slam an inmate to the ground. At least not when you're writing up the incident report. She was told that, in writing, it's better to describe "using balance misplacement techniques to 'assist' an inmate to the ground." A captain would help new officers get the hang of it.

"You don't want to have to explain to the judge why you 'slammed' someone to the ground," Dixon recalls being told by an instructor.

Dixon lasted seven months working at the notoriously troubled prison, leaving after what she has called the hardest period of her life. That was in 2017, and she has been speaking out about what she experienced and witnessed there ever since. Dixon testified at a state legislative hearing months after resigning from the prison, describing, among other things, how she witnessed two inmates die due to medical neglect. Earlier this month, she testified again at the legislature in the wake of a highly critical state audit of Tennessee's state-run and CoreCivic-run prisons. The audit calls for increased oversight of the state's prison system and finds that the Tennessee Department of Correction and Nashville-based for-profit prison giant CoreCivic mishandled sexual abuse investigations as well as inmate deaths. Along with those were findings related to issues that have been constant at CoreCivic prisons, and Trousdale in particular: inadequate staffing and insufficient medical and mental health care.

Three years ago, when she was a new correctional officer at Trousdale, Dixon took detailed notes during her training. Those notes describe a culture in which prisoners are dehumanized and guards are rarely held accountable for their actions. The picture painted by Dixon's descriptions of training sessions and discussions with instructors makes the recent audit's findings seem inevitable.

The report concludes that prison leaders failed to "ensure that state and CoreCivic facilities staff collected and reported complete, accurate, and valid information" about inmate deaths and violent incidents. The findings make these practices look less like oversights than intentional results. Along with the advice about how to describe physical confrontations, Dixon notes how one instructor told her and her fellow officers-in-training: "We don't have riots, we have major disturbances. That's the term we use."

But beyond the education in Orwellian euphemisms, trainees were explicitly told, Dixon notes, that their well-being depended on viewing inmates not as humans but as dangerous animals.

"You have to be aggressive," one officer told her, as recorded in her notes. "That's why I have to separate my religion from my job. Because my behavior may not be the most godly. Once they get in here, they behave like animals. Like caged animals."

That attitude was combined with a notion that guards could act with relative impunity.

“I have never fired an officer over a grievance and I never will,” said one instructor, according to Dixon’s notes.

In an interview with the *Scene*, Dixon recalls the staffing issues that have been associated with Trousdale since it opened in early 2016. During her time at the prison, she was one of numerous employees commuting more than an hour to and from Nashville for long shifts and getting little sleep in between. Sometimes after working six days straight, she says, she would be called in to work on the seventh day because of staffing shortages.

In her fellow trainees, Dixon saw the effects of the prison’s culture.

“As the months went by, they either quit their jobs or they learned to accept it, and they were OK with it and they became part of it,” she says. “It was sort of like those were the only two options — to either walk away or to become part of this system that’s hurting people.”

CoreCivic spokesperson Amanda Gilchrist tells the *Scene* by email the company has taken steps to address the staffing issues plaguing Trousdale, and has recently “significantly increased pay to attract and retain employees.” The starting wage at Trousdale is now more than \$16.50 per hour, she says.

“As we’ve acknowledged previously, there were challenges with bringing the Trousdale Turner Correctional Center up to full speed after its opening,” Gilchrist says. “We’ve worked hard to address the challenges we’ve faced, and while we still have work to do, we are making progress.”

In response to the recently released audit, Gilchrist says CoreCivic “will continue to work closely with our partners at the Tennessee Department of Correction to ensure our administrative processes are fully compliant and provide total transparency into our operations.” In spite of the audit’s findings, Gilchrist says “all allegations of sexual misconduct are promptly, thoroughly and objectively investigated” and tracked.

As for Dixon’s allegations, Gilchrist says CoreCivic investigated her claims after she first made them in 2017. The company acknowledged staffing issues at Trousdale, but Gilchrist says an investigator “was generally unable to find sufficient evidence to validate Ms. Dixon’s other allegations.”

But troubling accounts continue to emerge from Trousdale. Earlier this month, a person with a loved one incarcerated there wrote to the *Scene* to relay the ongoing issues at the facility and the danger their loved one was facing. They described numerous assaults and gang violence, as well as “needed medical treatment and medication never received, rapes, stabbings, assaults, extortion, drugs by the pound, packages thrown over the fence, hundreds of cell phones, butcher knives, etc.”

Meanwhile, in Nashville earlier this week a bill was introduced at the Metro Council by Councilmember Emily Benedict that would end the city’s contract with CoreCivic to run a local prison.

What the state’s audit made clear, though, is that problems persist in prisons run by CoreCivic as well as those run by the Tennessee Department of Correction. And what legislators made clear — Republican legislators, anyway — is that they will mostly continue to trust the department to figure things out while providing limited oversight. After the damning testimony earlier this month, a committee of state lawmakers voted to approve the department’s continued operation, refusing even to delay the authorization so that the audit’s findings could be reviewed more closely.



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NEWS

CoreCivic investigating ex-officer's allegations of negligent deaths at private prison

Dave Boucher The Tennessean

Published 4:41 p.m. CT Dec. 12, 2017 | Updated 5:11 p.m. CT Dec. 12, 2017

Private prison operator CoreCivic will investigate serious allegations levied Tuesday by a former correctional officer about her time at the largest private prison in Tennessee.

Ashley Dixon fought back tears Tuesday as she told lawmakers about witnessing two inmates die due to medical neglect during her seven months as a correctional officer at Trousdale Turner Correctional Center, operated by the Nashville-based company previously known as Corrections Corporation of America.

"The first death, I missed work for days. I just couldn't go in. I actually attended the prisoner's funeral out of state," Dixon said after Tuesday's legislative hearing.

"I was just so wrecked because I don't think he needed to die, and I tried so hard to convince people of that for three days."

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Describing her time at the prison as the "hardest seven months of my life," Dixon said she was taught to downplay or soften language in reports describing physical encounters with inmates. After the hearing she said she was routinely sexually harassed by inmates and officers.

She told lawmakers she repeatedly reported problems to superiors, but nothing changed, prompting her resignation in September.

"We take these allegations seriously and are looking into the issues raised by Ms. Dixon. Until we've had an opportunity to investigate, it would be premature for us to comment," CoreCivic spokesman Jonathan Burns said after the hearing.

Several other people who spoke at the hearing alleged neglect and abuse at Trousdale. Burns said CoreCivic also is looking in to those allegations.

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Lawmakers called the hearing to follow up on a scathing state audit that listed issues with understaffing and gang violence at Trousdale, a facility about 60 miles northeast of Nashville.

The state used the hearing to blast CoreCivic, putting the Tennessee Department of Correction on notice to keep the company on a shorter lease to ensure it is fulfilling the terms of its contracts.

Dixon said it's a good sign CoreCivic is investigating now, but she remains skeptical anything will improve.

"My question would be why didn't they look into it already? I had been raising these issues for months," Dixon said.

"I question whether they would be taking it seriously now."

The warden of Trousdale said he has retrained some staff to address issues raised in the state audit. Department officials said they will do more to hold CoreCivic accountable in the future.

CoreCivic has a five-year, \$276 million contract to operate the Trousdale facility, which opened in 2016.

Reach Dave Boucher at dboucher@tennessean.com or 615-259-8892 and on Twitter @Dave_Boucher1.



[Elizabeth Weill-Greenberg](#)

Sep 06, 2018

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Illustration by Michelle Mildenberg

‘JUST LET HIM KICK’

Lawsuits allege that a private Tennessee prison neglected diabetic prisoners, contributing to at least one death.

Ashley Dixon first met Jonathan Salada when he was kicking his cell door.

It was spring of 2017 and Dixon had just started working as a correctional officer at CoreCivic’s Trousdale Turner Correctional Center in Tennessee. It was her first, and would be her last, job in corrections.

“What’s wrong with him?” Dixon asked the officer who was training her.

The officer told her “he wanted his insulin but they haven’t called for insulin yet,” Dixon recalled in a recent interview with *The Appeal*. The officer’s response? “*Just let him kick.*”

He continued kicking for two more hours. Dixon kept asking the officer what they could do. Finally, she told Dixon to call the infirmary if she wanted to. Dixon did and learned that people with insulin-dependent diabetes had already been called out of their cells to receive insulin injections hours earlier. They let Salada out to receive his shot.

when she was working.

About a month later, on May 24, 2017, she heard an emergency medical call for Salada over the prison radio.

According to an incident report Dixon later submitted to a captain at the prison, Salada “was in extreme pain and screaming for help.” The nurses initially refused to enter his cell; when they finally did, they checked his vitals and left. “I just can’t figure out what his game is,” one of the nurses said to a lieutenant, according to Dixon’s incident report.

Three days later, Salada would be pronounced dead.

The Appeal requested but has not yet received his autopsy report. His official cause of death, according to [a local media report](#), was an overdose of buprenorphine, a prescription opioid painkiller, with diabetes listed as a contributing factor.

Spotty, erratic, and dangerous

We all need insulin to survive, and most people produce it regularly on their own. But in [Type 1 diabetics](#) like Salada, the body doesn’t produce insulin. To stay healthy, Type 1 diabetics and some Type 2 diabetics must check their blood sugar with a finger prick and receive insulin via injection or an insulin pump multiple times a day, carefully timed with the consumption of carbohydrates.

Missing even a single dose of insulin can be harmful, explained Sarah Fech-Baughman, director of litigation for government affairs and advocacy at the American Diabetes Association (ADA). “If a patient goes without insulin for hours to days, he or she could develop a condition called diabetic ketoacidosis—which is life-threatening.” If a patient receives inadequate insulin and has chronically high blood glucose for a sustained period of time, she added, it can also cause serious complications like blindness and cardiovascular disease.

The legal advocacy program at the ADA receives roughly 200 requests per year from incarcerated people who are receiving inadequate medical care, according to Fech-Baughman. The care of people with diabetes held in Trousdale is the subject of a [class-action lawsuit](#) by the ADA against CoreCivic (formerly Corrections Corporation of America) and the Tennessee Department of Correction. There are [at least 60](#) Type 1 diabetics or Type 2 diabetics incarcerated at Trousdale who require insulin injections, according to the ADA’s complaint.

“

[T]hey did not bring me any insulin for two days and I got really sick. ... I could not stop throwing up.

Douglas Dodson, plaintiff in ADA suit

According to the [lawsuit](#), blood sugar checks and the delivery of insulin—both of which should be coordinated with meals—are sporadic, erratic, and at times nonexistent. Meals, blood sugar checks, and insulin injections are given at irregular times during the prison’s frequent lockdowns, the suit explains, forcing

unconscionable delay in receiving basic diabetes care is the functional equivalent of receiving no care at all,” the lawsuit alleges.

Firsthand accounts from prisoners with diabetes inside Trousdale detail their own metaphorical kicks at the door for insulin:

“[T]hey did not bring me any insulin for two days and I got really sick,” Douglas Dodson wrote in a handwritten note submitted as an exhibit in the ADA suit. “I could not stop throwing up.”

Another note from Dodson included with the ADA suit refers to a day he didn’t get any insulin until two hours after he had already eaten breakfast: “[M]y blood sugar was 476 at this time and we are still lock down.” (A normal blood sugar reading for an adult diabetic is between 80 and 130 before a meal, and less than 180 one to two hours after a meal begins.)

“I haven’t got any insulin at all today. It’s almost 1 pm,” Tazarius Leach writes in a grievance attached to his pro se complaint against the prison. “I’m not trying to cause a problem but its my health ... I’m getting force to miss shots I have no control over.”

Central to the ADA’s lawsuit is the claim that CoreCivic prioritizes profits over care. This, ACLU of Tennessee executive director Hedy Weinberg explains, is precisely why the ACLU opposes prison privatization.

“Handing control over to private prison companies is clearly a recipe for abuse and neglect,” said Weinberg. “A private prison is most concerned about their stockholders.”

Both CoreCivic and Correct Care Solutions, LLC, which handles all medical care at Trousdale, deny all wrongdoing. In response to a request for an interview, Steven Owen, managing director of communications for CoreCivic wrote in an email, “While we can’t speak to the specifics of pending litigation beyond our court filings, CoreCivic is committed to providing high-quality healthcare to those entrusted to our care.” The Tennessee Department of Correction did not respond to a request for comment.

Beyond Trousdale

Negligent medical care isn’t confined to for-profit prisons, notes Gabriel Eber, senior staff counsel with the ACLU National Prison Project. “I’ve seen bad care in state-run prisons,” he said. “I’ve seen bad care in private prisons.”

People with diabetes suffer in local jails and immigration detention facilities too—reflecting a broader inhumanity that snakes through the U.S. prison system.

In 2013, Carlos Mercado died of diabetic ketoacidosis about 15 hours after being taken to Rikers Island in New York. While at the jail, he carried around a bag of his own vomit and requested his insulin, which had been confiscated. Guards reportedly thought he was “dope sick.”

Also, in 2013, in Oklahoma’s McClain County jail, Kory Dane Wilson was not given insulin for three days—reportedly despite pleas from family, friends, and cellmates—and died of diabetic ketoacidosis.

Prison is punishment. But the punishment is the taking away of the liberty. It's nothing more. It shouldn't be a death sentence.

Gabriel Eber, ACLU National Prison Project

In 2014, William Joel Dixon died after going without insulin for a week while in jail in George County, Mississippi. The day of his death, Dixon passed out in the shower. When a jailer asked the nurse to help him, she reportedly said she didn't have time.

"Prison is punishment," said Eber. "But the punishment is the taking away of the liberty. It's nothing more. It shouldn't be a death sentence."

Maintaining a healthy blood sugar is a daily challenge for people with diabetes even on the outside. In a prison healthcare system that may oversee thousands of patients, diabetics far too often fall through the cracks, said Eber.

At Trousdale, for instance, the medical staff consists of just four nurses and two nurse practitioners, according to a March 2018 filing in the ADA's suit. As of July 5, 2017, 2,483 people were incarcerated at Trousdale.

"There is a sense of anger when I speak with insulin-dependent diabetics because they're being wronged in a way that they know is going to affect their health," Eber added. "And it's not if or maybe. It's certain."

Type 1 diabetics are often well-versed in their own care—their lives depend on it, Eber explained. But their expertise, he said, can clash with the views of prison medical staff.

Brenda Menjivar Guardado, a 22-year-old Type 1 diabetic who had fallen into a diabetic coma at 13, knew to bring her insulin with her when she came to the United States seeking asylum from El Salvador. But when she was placed in ICE custody, her insulin was confiscated.

While Guardado was detained at CoreCivic's T. Don Hutto Residential Center in Texas in 2017, she was provided with a different type of insulin than the one she had brought, causing her blood sugar to spike.

"They were giving Ms. Guardado what they were told was the best insulin treatment available, what most diabetic patients would want to receive," said Robert Painter, director of pro bono programs and communications at American Gateways, which represented Guardado. "They were not hearing her when she was saying this type of insulin would not be effective for her."

Eventually, Guardado was pushed into accepting the deportation, Painter told *The Appeal*. "Ultimately that was the only way she thought she could get the care she needed."

ICE declined to address Guardado's case specifically. In a statement to *The Appeal*, Nina Pruneda, a spokesperson for the agency said, "ICE is committed to ensuring the welfare of all those in the agency's custody, including providing access to necessary and appropriate medical care."

Salada's final days

unconscious in the cell. Dixon asked a nurse how Salada was doing, he had been admitted to the infirmary overnight. The nurse reported he was “sleeping like a baby” and that he was “likely doing this for attention,” Dixon wrote in her incident report. But a medical officer told Dixon that Salada had been “screaming in pain all night long.”

While it’s still unclear exactly what caused that pain, that morning a physician ordered Salada to be removed from the infirmary and returned to his cell, according to a lawsuit filed by Salada’s father. Salada’s father’s attorney stated via email that he prefers not to comment on active cases.

“[H]e continued to complain of pain and suffering and continued to request medical care but said requests were ignored and no further medical care or treatment was provided,” reads the complaint.

“

After his death, I was really haunted that my relationship had just been that of a guard and a prisoner, that I didn't get to know him.

Ashley Dixon, former correctional officer,
Trousdale Turner Correctional Center

On the night of May 26, Salada was “still in horrible pain,” Dixon wrote in her incident report. The following morning he was “shaking and moaning in pain.”

That morning, May 27, the nurse did not bring insulin for Salada, Dixon said, despite her pleas. At the end of her shift, at about 8 a.m., she went to the infirmary to report that Salada had still not received his insulin.

“Well, we will get to it when we get to it,” one of the nurses told her, according to Dixon’s incident report.

At about 8:40 a.m., Salada was found unconscious in his cell. His blood sugar was 587, more than three times what it should have been. He was pronounced dead at 9:34 a.m. at Trousdale County Medical Center. He was 25. He had been at Trousdale less than a year.

“After his death, I was really haunted that my relationship had just been that of a guard and a prisoner, that I didn’t get to know him,” said Dixon. “I went to his funeral and saw pictures of his childhood trips and saw him as a person, which is something we’re not able to do working in the prison.”

Dixon said regardless of what caused his death, his health was neglected. She wishes she could have done more for him. “I wish I could have held his hand or done something that was more comforting than being there,” she said, “being a witness to his suffering, not being able to do anything.”



If you or a loved one with Type 1 diabetes have experienced difficulties with care while incarcerated or if you have worked in a prison and witnessed such issues, please contact the author through Twitter at @elizabethweill. ■

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NEWS

Murfreesboro man charged in death of prison cellmate at Trousdale Turner Correctional Facility

Brinley Hineman Daily News Journal

Published 10:07 a.m. CT Feb. 20, 2020

A Rutherford County man has been charged in his cellmate's death at the Trousdale Turner Correctional Facility.

Jacob Kado, 40, was indicted by a Trousdale County Grand Jury on a second-degree murder charge after Tennessee Bureau of Investigation agents revealed Kado killed his former cellmate, Ernest Hill, in a fight.

In June, Hill, 42, was found unconscious by prison officials. Staff attempted to perform life-saving measures on Hill, and he was transported to an outside hospital where he was pronounced dead.

The TBI announced a fight between Kado and Hill ultimately led to Hill's death.

The prison, located in Hartsville, is a medium security facility.

Kado has faced murder charges before

This is the second time Kado has been charged with murder.

He was charged with second-degree murder in 2015 after his father was found dead at his home in downtown Murfreesboro. The elder Kado was found slumped over with a swollen forehead, police said at the time.

The father's autopsy showed he died of blunt force trauma, and not a heart attack or stroke like Kado originally claimed.

Kado eventually pleaded guilty to voluntary manslaughter and was sentenced to 12 years in prison, of which he was ordered to serve 45%, or nearly five and a half years, which is why he

was at Trousdale Turner at the time of Hill's death.

Public records list a slew of charges brought against Kado, who previously worked in building maintenance, over the years by various agencies including aggravated assault, multiple DUIs and aggravated burglary.

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Reach Brinley Hineman at bhineman@gannett.com, at 615-278-5164 and on Twitter @brinleyhineman.

Man killed during inmate-on-inmate altercation at Trousdale Turner prison

ETHAN ILLERS, DIGITAL CONTENT PRODUCER

POSTED JUN 16, 2019



AP Photo/David Goldman

HARTSVILLE, TN (WSMV) - The Tennessee Bureau of Investigation is investigating the death of an inmate at Trousdale Turner Correctional Facility in Hartsville.

TBI told News4 the incident happened inside a prison cell involving two inmates.

According to a spokesperson from CoreCivic, the owner and operator of the prison, a corrections officer found an inmate unconscious on the floor of his cell while conducting a formal count around 3 p.m. Saturday. Unit staff on scene initiated "life-saving measures until medical staff arrived."

EMS arrived and transported the inmate to a hospital outside the facility where he was pronounced dead at 4 p.m.

TBI identified the deceased inmate as 42-year-old Ernest Hill. The cause of death has not been released and no correctional officers were injured or involved.

CoreCivic spokesperson Brandon Bissell sent News4 this statement Sunday afternoon.

“ *"Trousdale Turner Correctional Center remains on partial lockdown status Sunday morning following an inmate-on-inmate altercation that resulted in one inmate losing his life.*

On Saturday, June 15 at approximately 3 pm CDT, while conducting formal count, an inmate was found unconscious on the floor of his cell. A medical emergency was called and unit staff initiated life-saving measures until medical staff arrived. EMS was called to the facility and the inmate was transported to an outside hospital where he was pronounced deceased at 4 pm CDT.

Our partners at the Tennessee Department of Correction were immediately notified and facility staff are cooperating fully with the investigation. The unit remains on lockdown status while the TDOC Office of Investigations and Compliance investigates the incident.

In deference to our government partner, other inquiries regarding the investigation should be directed to the TDOC Communications Division." **”**

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Ethan Illers

WSMV Digital Content Producer

A New York City native and a graduate of the Mizzou School of Journalism, Ethan joined the WSMV Digital Team in June 2019. Send him story ideas, food recommendations and sports topics to Ethan.Illers@wsmv.com and follow him on Twitter [@EthanIllers_TV](https://twitter.com/EthanIllers_TV)!

Recorded conversations reveal life inside prison ravaged by COVID-19

JEREMY FINLEY

POSTED MAY 6, 2020

HARTSVILLE, TN (WSMV) - In recorded conversations with family members, inmates at the Trousdale Turner Correctional Center describe a prison where correctional officers and case workers, not medical providers, treat COVID-19 patients, and the sick intermingle with healthy inmates.

Claims that Core Civic, the private company that runs the facility, repeatedly denied.

Because inmates are prohibited from doing interviews and staff are often hesitant to speak to reporters for fear of losing their jobs, family members of inmates in Trousdale recorded their conversations and provided them to News4 Investigates.

The family members asked that News4 Investigates not reveal they or their relatives' identities.

The state prison had its first death from COVID-19 this week, when convicted serial rapist Ronnie Johnson, 67, succumbed from the disease.

More than 1,200 other inmates have tested positive, and Core Civic said 50 employees are also sick.

"I'm really in fear for my life," said an inmate in conversation with his sister. "The CO's (correctional officers) keep on getting it. They're dropping like flies."

That same inmate said he's observing staff, not trained in medicine, are treating the sick.

"They got case managers, and correctional officers, treating the inmates. Ain't no doctors coming down here," the inmate said.

Amanda Gilchrist, director of public affairs for Core Civic, wrote in an email that the inmate's claim is false.

"Trousdale Turner's health services department has a full complement of medical providers to treat the individuals in our care including 3 physicians, 2 dentists, a Health Services Administrator, 2 clinical supervisors, dental assistants, 2 nurse practitioners, and several RN's and LPN's. The medical staff is conducting symptom and temperature checks on all positive inmates twice daily at the facility," Gilchrist wrote.

In a conversation with another inmate, a family member asked about if the inmate is being separated from the sick.

"Are they separating – like putting the positives in this pod and putting the negatives in this pod?" the family member asked.

"No, we're all together," the inmate said.

Sluss denied that claim as well.

"That is patently false. The cohort process was completed over the weekend. The positive inmates are housed with positive inmates and negative inmates with other negative inmates. None of the positive inmates are symptomatic at this time and the facility will continue to monitor," Gilchrist wrote.

Senator Brenda Gilmore, D-Nashville, said she's heard from several family members of inmates who echo the same concerns.

"A lot of time, people might not have sympathy for inmates. How do you convey to these people that this is something that they should be concerned about?" asked News4 Investigates.

"If (inmates) are infected, then they infect the staff. When a prison guard goes back onto the community, they take the virus to their families and out into that community," Gilmore said.

Below are the full responses from Core Civic about the inmates claims.

Inmate - "They got case managers, and correctional officers, treating the inmates. Ain't no doctors coming down here."

Response: This is false. Trousdale Turner's health services department has a full complement of medical providers to treat the individuals in our care including 3 physicians, 2 dentists, a Health Services Administrator, 2 clinical supervisors, dental assistants, 2 nurse practitioners, and several RN's and LPN's. The medical staff is conducting symptom and temperature checks on all positive inmates twice daily at the facility. In accordance with contract, non-medical staff such as unit managers and case managers are permitted to conduct temperature and symptom checks on negative inmates (twice weekly.)

Inmate: "That is not her ((talking about the case manager) job. She is not – she is not medical – she just don't have the experience in the medical field to even deal with a coronavirus patient."

Response: See above.

Inmate: "I'm really in fear for my life."

Response: Since even before any confirmed cases of COVID-19 in our facilities, we have rigorously followed the guidance of local, state and federal (CDC) health authorities, as well as our government partners. We have responded to this unprecedented situation appropriately, thoroughly and with care for the safety and well-being of those entrusted to us and our communities. Our practices have evolved and changed as the CDC guidance and recommendations have evolved over time and as we learn more about the novel coronavirus. We're also working closely with our partners at the Tennessee Department of Correction to ensure the health and safety of everyone at Trousdale Turner. (You have our full statement from the website, as well, that covers our COVID-19 plans and response on a global level)

Inmate: "The CO's keep on getting it. They're dropping like flies."

Response: CoreCivic conducted a facility-wide testing initiative with both inmates and staff at Trousdale Turner last week. We publicly disclosed the results of the COVID-19 tests and can confirm we have a total of 50 employees and contractors that have tested positive for the virus. These employees are isolated at home and in regular communication with their healthcare provider. In addition, there is a robust communication process in place at TTCC. Since the onset of the pandemic, those in our care have been notified whenever there was a positive case at the facility (staff or inmate) and we advised if they were affected or not (following contact tracing.) All inmates are notified of their test results (positive or negative.)

Inmate's relative: "Are they separating – like putting the positives in this pod and putting the negatives in this pod?"

Inmate: "No. We're all together."

Response: That is patently false. The cohort process was completed over the weekend. The positive inmates are housed with positive inmates and negative inmates with other negative inmates. None of the positive inmates are symptomatic at this time and the facility will continue to monitor.

Location	Number Tested	Number Positive	Number Negative	Pending
Bledsoe County Correctional Complex	2,319	586	1,730	3
Morgan County Correctional Complex	0	0	0	0
Northeast Correctional Complex	1	0	1	0
Lois M. DeBerry Special Needs Facility	5	0	5	0
Riverbend Maximum Security Institution	2	1	1	0
Tennessee Prison for Woman	5	0	4	1
Turney Center Industrial Complex	275	38	237	0
Turney Center Industrial Complex-Annex	38	2	36	0
Mart Luttrell Transition Center	3	1	1	1
Northwest Correctional Complex	898	45	848	5
West Tennessee State Penitentiary	1	0	1	0
Women's Therapeutic Residential Center	3	0	2	1
Contract & Private Managed prisons				
Hardeman County Correctional Facility	4	1	2	1
South Central Correctional Facility	2	0	2	0
Trousdale Turner Correctional Center	2,404	1,285	1,089	30
Whiteville Correctional Facility	2	0	2	0
Total	5,962	1,959	3,961	42

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Jeremy Finley

Chief Investigative Reporter

Jeremy Finley is the chief investigator for News4 Investigates. His reporting has resulted in criminal convictions, legislative hearings before the U.S. Congress, and the payout of more than a million dollars to scam victims.

Gang activity, security a concern at Trousdale Turner facility

REPORTED BY DEMETRIA KALODIMOS

POSTED JUN 21, 2017



Trousdale Turner Correctional Center in Hartsville, TN, is operated by CoreCivic. (WSMV)

The Trousdale Turner Correctional Center was supposed to provide quality jobs to residents of Trousdale County.

But according to the mayor and several other people the Channel 4 I-Team talked to, not many locals work there.

Until recently, before a contract expired, guards from another security company were recruited, put up at hotels and bused in to work. They told the I-Team they earned higher wages than those employed by CoreCivic.

But some say the people expected to keep the peace at Trowsdale Turner are known gang members chosen by administrators and transferred there.

“He called me and said, ‘I don’t know where I’m going. I’ll call you when I get there,’” said a woman who asked to be identified as Casey.

The I-Team first met Casey in December. She was panicked over her husband’s sudden transfer to Trowsdale Turner.

After 24 years in prison, the last five with a stellar record at Riverbend Maximum Security, he had a real shot at parole. But his wife said something he walked away from long ago was suddenly seen as a “valuable asset” to CoreCivic.

“Internal affairs told him he was transferred there because he’s considered an O.G. in the Crips,” Casey said. “An O.G. is shot for an original gangster. It means he’s been in a gang for a long time. He’s highly respected. He’s a leader.

“He has not been involved in any gang activity since he’s been at Riverbend, that was the purpose of him going there. And so they told him they were transferring him there so he could keep the peace and get them in line,” Casey added.

Keeping the peace has been a challenge at Trowsdale Turner. Families, inmates and even some of its former correctional officers told the I-Team it’s an institution on the brink.

“Trowsdale Turner is like no other facility I’ve ever experienced,” said Jacque Steubbel, a former chaplain. “The staff turnover there is tremendous. I’ve been told 245 percent in less than a year.”

CoreCivic will not say how many employees have quit or why.

“They put these huge facilities in the middle of nowhere you can’t staff. What are you going to do?” said Jeannie Alexander, an activist with No Exceptions.

The prison was built with the promise of 350 new jobs in a rural county where people need work. But they didn’t bite.

"If you asked 90 percent of the unemployed in the county, 90 percent would say, no, I don't want to work at the prison. Because law enforcement and corrections is not an easy thing," said Trowsdale County Mayor Carroll Carman.

Several former guards told the I-Team they were brought in from out of state, housed at a hotel, bused into work, paid a per diem, and made more money per hour than CoreCivic employees.

Records show some who were hired by G4s, a third party company, didn't stay because they couldn't pass the background check or walked off.

One female guard said she was left alone and in charge of 120 men without a radio or a weapon.

"We're getting reports of massive assaults and gang rapes in the middle of a pod, but with no intervention, because you simply cannot stop that sort of thing when you have one person," Alexander said.

And other guards seem to have also been at risk.

A recent emergency call described a female correction officer who "fell out." The caller was instructed to say she had a seizure, a description that seems to be used often when an ambulance is called.

There was no call placed at all for a county ambulance last month when inmate Dantwan Crump allegedly stabbed a lieutenant four times – in the arms, back, stomach and head – with a 7.5-inch sharpened, prison-made knife.

According to the official report, the correction officer had supposedly "sprayed his homie" and he had to jump in.

"They can't maintain that pod. They can't maintain security or control. So if something happens in the pod, if violence breaks out or if there's a medical emergency, there often isn't anyone in that pod, because if something happens, you don't stay in the middle of it," Alexander said.

That's where the imported gang members apparently fit in.

Casey, the inmate's wife, said she was told about the strategy personally by two prison administrators.

“He doesn’t want to participate in gang activity,” she said.

“It’s almost as if they are encouraging gangs to start up,” the I-Team said.

“Very much so,” Casey replied.

“They’re asking him to be a security threat, because once you’re involved in gang activity, you’re labeled a security threat,” she added.

“Over half the inmate population is gang affiliated, and the TDOC actually brought in a sort of team or special security op group to identify gang affiliations to every inmate at Trousdale,” Steubbel said. “I talked to one officer. I said, ‘How many gang affiliations did you find?’”

The officer told Steubbel they round 1,465 gang affiliations.

“The last month there have been three weeks where they were locked down four days out of the week without showers, without anything. They’re just in their cells,” Casey said.

“This is absolute chaos. It’s absolute chaos,” she added.

“Danger continues to brew in our correction systems across the state,” said Rep. John Ray Clemmons, D-Nashville.

Lawmakers say they’re convinced Tennessee is heading back toward the mess in the 1980s when the feds took over the entire prison system.

“We have long known of environments of harm not only in our state facilities, but also and especially those operated by private corporations, especially the Trousdale facility,” Clemmons said.

Clemmons had asked early in the fall to tour the new Trousdale facility. An invitation was granted, but when he asked to bring Channel 4’s Demetria Kalodimos along, it never happened.

“Prisons love to say they can’t allow people inside because of concerns for the security of the institution. What we’re really talking about here is security of their secrets. That’s why they don’t want people inside,” Alexander said.

Steubbel no longer works at Trousdale or for CoreCivic. The company said she was fired “for cause” after what they referred to as an investigation that “substantiated misconduct.”

The company claimed she was “providing misleading information to investigators” and now has a motive to “impugn our company.”

Prior to our interview, Steubbel told the I-Team she was terminated by CoreCivic based on what she claimed were false allegations from an incident at her previous post in Texas. She provided documentation of her claims.

She also shared an unemployment determination that awarded her compensation, charged to CoreCivic, with a finding that her employer fired her for a “reason that was not misconduct connected with the work.”

The I-Team has tried many times to get specific answers to questions and concerns we have heard about the prison.

Late last week, CoreCivic responded to some of our long-pending questions, saying in part, “Medical privacy considerations precluded them from providing details on deaths or injuries.” They also generically stated that their staff acted appropriately in all situations.

So far, no one from CoreCivic or the state will grant the I-Team an interview.

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NEWS

Gang activity, security a concern at Trousdale Turner facility

Posted Jun 21, 2017



Tennessee's Largest Prison Still Appears as Troubled as Ever

CoreCivic's Trousdale Turner Correctional Center continues to face claims of poor management

BY STEVEN HALE — FEB 13, 2019 8 AM

Since it opened in early 2016, Tennessee's largest prison — CoreCivic's Trousdale Turner Correctional Center — has also been one of its most deeply troubled.

A state audit in 2017 highlighted staffing shortages and mismanagement at the facility, and family members with loved ones on the inside have consistently raised concerns about the conditions there. Reports of rampant gang activity at the prison, which is located

about 50 miles northeast of Nashville, have been nearly constant. For years, CoreCivic, the Nashville-based private prison corporation that manages several Tennessee prisons, has faced similar claims of poor management at facilities around the country.

Now three years after it came online, and less than two months after state lawmakers heard testimony about violence at the facility, people close to the Trousdale prison tell the *Scene* that not much has changed. One lawyer who represents multiple Trousdale prisoners says inmates report that they face weeks-long lockdowns, which they see as largely driven by staffing issues.

“What the prisoners understand is basically that the place doesn’t operate without them,” the lawyer, who spoke under the condition of anonymity to protect the identity of prisoners, tells the *Scene*. “They’re the ones that are distributing meals three times a day. They’re the ones that are taking the trash out. They’re the ones that are keeping everything running. So there’s this very tricky relationship between the prisoners, who keep the wheels on the bus, and the guards, who have all of the theoretical power and control. I think there’s a lot of fear from the guard side that that power shift can go the wrong way basically at any time.”

As a result of that dynamic, the lawyer says, prison staff has been using what prisoners see as backdoor tactics, beyond official lockdowns, to keep the facility under control.

“They’ll do things like shut off the hot water for weeks at a time so that people just don’t go to the showers,” the lawyer says, adding that at a recent visit, a client hadn’t had a shower in more than a week.

Despite the conditions, the lawyer says, prisoners and families are often concerned about voicing complaints.

“There are an infinite number of ways that life can get worse,” she says.

One woman whose fiancé is a prisoner at Trousdale reports similar conditions. She also spoke on the condition of anonymity, fearing for the safety of her loved one on the inside.

“The [correctional officers] do not have control over that place,” she says.

She says her fiancé is essentially charged rent, under the threat of violence, by gang members who run his unit.

“He’s being extorted,” she says. “They’re making him pay to live there. The [nationwide street gang] Vice Lords, they run that unit.”

A group of men, she says, will come to her fiancé demanding money, or else they’ll be back at night.

“And they will,” she says. “He’s already gotten jumped before.”

Those sorts of stories and concerns are largely similar to ones that a group of family members expressed to Trousdale leadership in a 2017 letter, highlighting violence and a lack of medical care at the facility. The woman who spoke to the *Scene* recently says her fiancé has received needed mental health medication so inconsistently that he has stopped trusting what he is getting and often doesn’t take any medicine at all.

The *Scene* presented these claims to a CoreCivic spokesperson and received a statement from public affairs manager Rodney King. He did not respond to specific questions about how many days Trousdale has been on lockdown so far in 2019, or about the facility’s officer-to-inmate ratio.

King says CoreCivic has taken a number of steps to address the “challenges” at the facility. Among them: increasing wages and bonuses, which he says has “led to a 24 percent reduction in staff turnover from 2017” and improving the facility’s performance on audits by state and national oversight organizations.

King goes on:

“In addition to the improved scores on the TDOC audit referenced above, follow-up audits have continued to reflect the progress being made at TTCC. On the most recent audit, there were no findings related to any of the specific claims you referenced, many of which are outdated or inaccurate. Additionally, the facility currently has two full-time TDOC contract monitors onsite daily providing oversight, and CoreCivic has a full-time employee dedicated to reviewing and responding to concerns raised by inmate family members. Also, one technical point to note, the decision to place any part of a correctional facility on lockdown status is based on the need to address specific safety or security issues — it’s not related to staffing.”

The situation remains essentially unchanged. As prisoners and people close to them continue to report the same set of problems at Tennessee's largest prison — with a listed capacity of a little more than 2,500 prisoners — officials at the for-profit corporation that manages the facility continue to say the facility only gets better by the year.



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Posted by Concerned Parent

Jun 21 2019 12:47

I have been calling the facility since 11 Jun 2019, 3 to 4 times a day leaving messages each time about trying to set up special visitations. I called Family Advocacy, Visitations, Chaplains Office, and Wardens Assistant nobody has returned my call yet. It seems as that they don't care, how do they get away with not communicating with family members I live in Virginia and want to visit my son however I have to ask for special visitation and they do not help you set that up. I understand that they are a privately owned facility but they should have somebody they have to answer to if they are wrong. Who do I turn to for help can someone please tell me.



Posted by Ples lesley

Jun 03 2019 16:27

Trousdale denied my son medical help and when they did he had blood clots and stage 3 cancer there is much more to his story I need to find a lawyer to file a law suit he was granted a medical furlough 4-19-19 still incarcerated and needs immediate surgery to remove a tumor



Avatar

Posted by Dava Manning Silva

Mar 15 2019 00:13

Changing their name to CoreCivic is meaningless...they are still CCA. Still just as shady and sketchy as ever.



Avatar

Nothing but lies coming from their spokesperson. In the 6 weeks since the new year they've been locked down 4. They do essentially call for a "lockdown" if they are understaffed that day! They may not call it a lockdown but they do not allow these men to get out of their cells and stretch their legs or call their families. Meals are carted to the units at extremely sporadic times. One night they weren't given dinner at all with the promise of double portions in the morning. They went 24 hours without a meal. Vice Lord's absolutely RUN that place through extortion and violence. If you choose to stand up to them they will do everything in their power to shut you down. The "family advocate" position is a joke. They can't keep someone staffed in that position, I imagine because if someone goes in with the intentions of doing their job they are quickly overwhelmed by family members and complaints. The current "advocate" does not return calls or if he does he just simply states " that's not a part of my job description" he is rude and cold, what a perfect way to deter families from calling! For the love of all things holy TDOC take back control!!



Avatar

Posted by ladonnamayes

Feb 14 2019 11:58

I've written the news in 2017 my son James Hunt was in trousdale Facility stabbed twice was refused medical treatment when I called the Warden they act as if they didnt know what I was talking about but I hear my son telling them what happen to him while I was on the phone with him (James) my son so i filed a lawsuit against them for refusing medical treatment also the warden, Commander for refusing to let him press chargers against the individuals. This Facility should be shut down. Thank you LaDonna Dillard

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Trousdale Turner Corrections Officer Arrested

Written by Jessie Williams

Published: Tuesday, February 05, 2019



Brian Orrs

A Trousdale Turner Correctional Center corrections officers was arrested last week after allegedly being highly intoxicated and firing a handgun inside the home he shares with his son, his son's pregnant girlfriend and his grandchildren.

According to Macon County Sheriff Mark Gammons, he and other officers were dispatched to a residence on New Harmony Road around 7:30 p.m. on February 1, 2019, after reports of a shot fired inside of the home.

The caller stated that 43-year-old Brian Orrs had fired the shot in his bedroom with his family inside the home.

Orrs' son, his three grandchildren and his son's pregnant girlfriend - who was just days away from her due date - were located on the other side of the wall when Orrs was said to have fired the weapon.

Once officers arrived on the scene, they learned that Orrs' son was able to get his family out of the home and forced the two guns in Orrs' possession away from him. The family escaped to by car to another residence in Trousdale County.

Sheriff Gammons stated that Orrs would not come to the door after officers knocked and identified themselves.

When he did, he told authorities to leave and said he did nothing wrong.

While attempting to get Orrs to come out of the home, officers interviewed witnesses and learned he was highly intoxicated. One witness mentioned he had a white, powdery substance on his nose.

After nearly two hours, Orrs allegedly came outside in an aggressive manner with his pants down, shaking his private parts at officers.

Refusing to cooperate and resisting arrest, Mr. Orrs was tased by police to prevent him from doing further harm, and was then apprehended.

A search of the home and further investigation by deputies revealed that Orrs was in possession of a 12 gauge shotgun and a .40 caliber pistol. The pistol was the weapon used to shoot into the floor of Orrs' bedroom.

A razor blade with a small amount of white residue on it, marijuana paraphernalia, ammunition for the guns, two sets of scales and a container used to store marijuana were seized by authorities.

A the time of the incident, Orrs was a corrections officer employed by CoreCivic at Trousdale Turner Correctional Center.

Orrs was charged with six counts of aggravated assault, six counts of reckless endangerment, possession of a weapon while under the influence, indecent exposure, possession of drug paraphernalia, and resisting arrest.

His bond was set at \$73,000, and he is scheduled to appear in general sessions court on March 6, 2019.

NEWS

At Tennessee's largest prison, diabetic inmates say they are denied insulin to 'maximize profits'

CoreCivic, which runs Trousdale Turner prison, is facing three lawsuits over the care of inmates with diabetes

Brett Kelman Nashville Tennessean

Published 4:24 p.m. CT Aug. 7, 2018 | Updated 4:51 p.m. CT Aug. 7, 2018

Story Highlights

Class-action lawsuit says inmates wait for hours to get insulin during frequent lockdowns

Another suit says diabetic inmate Jonathan Salada died screaming in pain

For several nights in a row, Douglas Dodson says he did not receive the drug that keeps him alive.

Dodson, an inmate at Trousdale Turner Correctional Facility, had been stuck in his cell for weeks as a lockdown dragged on and on at Tennessee's largest and newest prison. The chow hall was off-limits, so food were served in his cell on cafeteria trays. Each meal was supposed to come with an insulin shot, which helps diabetics like Dodson control their delicate blood sugar, but sometimes the insulin wasn't provided until hours later.

Sometimes, Dodson alleges, it wasn't provided at all.

"For the past 2 1/2 weeks we have been on lock down, and it has been several evenings that we have not been called to the clinic to get our insulin," Dodson wrote on a prisoner complaint form, now filed as an exhibit in a lawsuit against the prison.

"I know my insulin is keeping me alive and I really need it everyday. This has went on long enough here at this facility!"

This complaint, which Dodson wrote during a three-week prison lockdown two years ago, is representative of what inmates describe as woefully inadequate diabetes care at Trousdale,

a for-profit prison run by CoreCivic. In a class-action lawsuit, Dodson and other former inmates allege that about 60 diabetic Trousdale prisoners face daily risk because of unhealthy food, unpredictable meal times and spotty access to insulin shots. Diabetics generally inject insulin when they eat, but inmates allege they often wait hours for the drug because of understaffing, which is designed to "maximize profits," and frequent prison lockdowns.

The class-action lawsuit is one of at least three ongoing suits that have accused CoreCivic of endangering diabetic inmates. Former Trousdale inmate Thomas Leach filed a separate suit levying similar allegations against the prison in 2016, and a third suit was filed this year after the death of inmate Jonathan Salada, who allegedly spent his final days in excruciating pain because of diabetes complications and negligent care.

CoreCivic has denied wrongdoing in all three suits and insisted that the plaintiffs in the class-action case are responsible for their own diabetes complications. In a court filing, the company has claimed that Dodson and the other inmates have a documented history of skipping meals, refusing insulin shots, using illegal drugs and buying sugary snacks at the prison store in "willful non-compliance" with a diabetic diet.

In a statement on Tuesday, CoreCivic declined to respond to discuss the specifics of the lawsuits but said it is committed to "high-quality healthcare" for inmates and "appropriate levels of staffing" in company facilities.

MORE: In ICE custody he lost his sight in one eye but gained a Tennessee town's support

Private prison protesters shut down CoreCivic

The three diabetes lawsuits against Trousdale, each filed over the past two years, have drawn little attention until this week, when mistreatment allegations were revived by a protest at the CoreCivic Nashville's headquarters.

A few dozen protesters on Monday blocked entry to the company parking garage by chaining themselves to cement-filled barrels and erecting a makeshift crow's nest on a 20-foot tripod. Police dispersed the protest after about nine hours and more than a dozen arrests.

During the protest, a former CoreCivic employee said she heard Salada shouting, desperately in need of help, in the days before his death.

"He screamed in pain for three days," said Ashely Dixon, who resigned from Trousdale about

told me he was faking it.”

Dixon's statements follow the lawsuit filed by Salada's family alleging the inmate was left screaming in pain in his cell in the days before he died. The lawsuit claims that Salada had three blood tests revealing his blood sugar was alarmingly high, and was taken to the prison infirmary twice, but still never received “appropriate or proper medical care.” Salada was returned to his cell still in pain, the lawsuit said, then later found unconscious. He died about an hour later.

But Salada's death appears more complicated than the lawsuit presents. According to Salada's autopsy, his blood sugar was dangerously high when he died, but his official cause of death was an overdose of buprenorphine, a prescription opioid painkiller. Diabetes was listed as a contributing factor.

OVERDOSES: These opioid addicts looked dead. Then Nashville police reached for their 'magic' drug.

Tennessee's biggest and newest prison

CoreCivic, previously known as Corrections Corporation of America, is one of the largest private prison companies in the U.S. with about 65 prisons and eight immigration detention facilities. The company has a five-year \$276-million deal to run Trousdale, a 2,552-bed minimum security prison in Hartsville, Tennessee.

The diabetes lawsuits follow other allegations raised against the prison since it opened in 2015, most of which stem from claims of understaffing. Last year, a scathing audit said the prison is plagued by gangs because of insufficient security and that staffing data provided by CoreCivic could not be trusted.

This understaffing claim also central to the class-action diabetes lawsuit, which alleges that Trousdale is run by a skeleton crew. The lawsuit says that that Trousdale goes into lockdown, sometimes for weeks at a time, purely for manpower reasons because CoreCivic does not hire enough staff to secure the entire facility. Inmates are confined to their cells and can't visit exercise yard or the chow hall.

It is during these lockdowns, the lawsuit says, when diabetic care is the worst.

"Meals are provided at irregular and often unpredictable times and are often not diabetic appropriate despite medical directions for a diabetic appropriate diet," the lawsuit states. "At

such times, inmates are frequently forced to eat their meals and only then, sometimes two to three hours after eating, allowed to go for blood sugar checks or insulin injections.”

This allegation appears to have specifically resonated with the American Diabetes Association, which has filed a court motion in March to join the class-action lawsuit against Trousdale. In a news release earlier this year, the association said it hopes the lawsuit will set a standard for all CoreCivic facilities, and by extension, all prisons.

“Just as children depend on adults to assist with their diabetes care, individuals who are incarcerated are at the mercy of prison staff to provide them with access to the health care tools, medications and reasonable accommodations necessary to manage their diabetes,” said Sarah Fech-Baughman, an attorney for the American Diabetes Association, in a news release.

“These individuals do not have access to appropriate medical care and have been subjected to discrimination on the basis of their diabetes. The ADA challenges both of these issues on behalf of this vulnerable population.”

PRISONS: Beatings, broken bones and the death of Inmate No. 81738

MORE: Tennessee prison chief vows review of 'shocking' inmate death

Tennessean reporter Natalie Allison contributed to this report.

Brett Kelman is the health care reporter for The Tennessean. He can be reached at 615-259-8287 or at brett.kelman@tennessean.com. Follow him on Twitter at @brettkelman.

POLITICS

Lawmakers hear from prison rape survivor, parents of man who hanged himself in CoreCivic facility

Natalie Allison The Tennessean

Published 12:23 p.m. CT Dec. 19, 2018 | Updated 5:04 p.m. CT Dec. 19, 2018

Edwin Steakley put on his coat and stepped out of the legislative hearing room, carrying with him a yellow envelope that contained his blood-stained boxers.

He sank to the hallway floor and wept with his head in his hands.

A former inmate at Trousdale Turner Correctional Center, 39-year-old Steakley had stood before a subcommittee of state senators and representatives Tuesday to tell them about his own traumatic experience of twice being raped at the facility operated by CoreCivic, a Nashville-based private, for-profit prison management company.

"Do you know what it feels like to have five grown men hold you down and rape you?" Steakley, who was released in April, said in public comments to the lawmakers at the hearing on the Tennessee Department of Correction.

"It is humiliating. It is disgusting."

Steakley became a target because he was Jewish, he told the lawmakers. He wrote to wardens, to lawmakers and others, but "nothing was done," he said.

"Where's the help we're supposed to get from the inside?" Steakley asked. "We look to y'all for our help, because y'all are our voice."

The USA TODAY NETWORK - Tennessee typically does not identify victims of sexual assault, but Steakley chose to tell his story publicly by speaking before the legislative committee.

In a statement, CoreCivic spokeswoman Amanda Gilchrist said the company was limited on what it could say about the rape allegations, but Trousdale Turner employees had complied

with Prison Rape Elimination Act requirements to report and investigate Steakley's claim and had notified the Department of Corrections.

Lawmakers hear testimony of inadequate staffing, lack of communication

The hearing, a follow-up on the department's progress following findings in a scathing 2017 performance audit, also drew family members of inmates who traveled from around the state to share their experiences with Tennessee's corrections system, which relies on CoreCivic to manage four of its 14 prisons.

The report released last fall noted that gangs and insufficient staffing plagued Trousdale Turner, the state's largest prison.

Bill and Teresa Anderson of Bradley County stood before the committee to talk about their 34-year-old son Ross, who was found hanging in his cell at Trousdale on Dec. 6. It was the third anniversary of his "psychotic breakdown," Bill Anderson said, when he fatally shot his girlfriend and her young daughter.

The prison chaplain called them 12 hours later to inform the couple of the death of their son, whom they say was suffering from severe mental illness and should have been in a psychiatric facility.

Ross Anderson had recently been threatened by a prison gang and had called his parents asking for \$200 to pay off someone for protection, his father said.

"All we know of his death after the chaplain's phone call is what we read in the newspaper," Anderson said, holding up an article clipping. "Calls to the warden, the family advocate and investigators have not been returned to any of us."

Sen. Mike Bell, R-Riceville, chairman of the Senate Committee on Government Operations, asked the couple — his constituents — what they believed led to their son's death.

"We believe a lack of oversight," Anderson said. "A lack of adequate staffing."

Ross Anderson had called the parents numerous times, he said, telling them his cell block was on lockdown because there weren't enough guards.

Following the 2017 audit, CoreCivic has increased starting salaries for officers. Staff turnover has been reduced by 24 percent since the audit, according to the private prison company.

TDOC commissioner Tony Parker said that while the starting salary for correctional officers at state-run prisons is \$27,000, CoreCivic's base salary at its facilities is now \$34,000.

On TDOC's follow-up audit this year, it scored Trousdale Turner at 95 percent

'When are we going to do something as a legislature and step up?'

A heated exchange erupted as Rep. Bo Mitchell, D-Nashville, reprimanded his colleagues for repeatedly failing to act after years of audits showing problems with CoreCivic-run facilities.

"When are we going to quit having citizens of the state come and tell stories like this and we aren't going to do anything?" Mitchell asked.

"When are we going to do something as a legislature and step up? We don't even make the people responsible come to the committee?"

Mitchell was referencing to CoreCivic's lack of representation at the meeting, despite hearing comments from Curt Campbell, program director of Christian reentry organization Men of Valor, that CoreCivic CEO Damon Hininger had attended a meeting with Campbell on Monday.

Hininger is on the board of Men of Valor, which has an agreement with CoreCivic to allow the nonprofit to work with inmates in its facilities. Gov.-elect Bill Lee is also a Men of Valor board member.

Mitchell also chastised Bell for cutting off Anderson's comments, which Bell had instructed the public to limit to three minutes.

"We tell them 'Your son's life is worth three minutes,'" Mitchell said. "I'm done, until somebody on this committee wants to step up. We're in a hurry here every time we come in here. This man has no answers whatsoever, ever."

Mitchell was pointing to TDOC commissioner Tony Parker, who had been speaking and answering questions about the department's progress.

"I felt bad, you were having to come in here and defend these people once again," Mitchell said to Parker, referring to his comments about CoreCivic.

"It's really hard to want to defend you when you come in here defending these people over and over and over again, knowing we have 20 years of findings in these audits that say the

exact same thing, but they have time to meet with Men of Valor yesterday. They have time to meet with the new governor. But they can't come in here and answer for their misdeeds of what all of these audits are full of."

'The punishment is going to prison'

Steakley, who was sentenced for theft, described how his life had "become a living hell" since he first went to Trousdale, where he was unsure if he would make it out alive.

"I had to pay for my crime," Steakley said. "I don't dispute that. Paying for my crime did not include sexual assault. It never included what I went through at Trousdale Turner. What happened to me should happen to no one else."

Rep. Mike Stewart, D-Nashville, pointed out that there was no record of a rape being reported at Trousdale Turner during the time period Steakley said the assault occurred, based on a summary document provided to him.

"This is something we would need to look into, obviously," Parker replied.

Rep. Jeremy Faison, R-Cosby, chairman of the House Committee on Government Operations, spoke out against the "cruel and unusual punishment" inmates like Steakley are subjected to inside prison walls.

"The punishment is going to prison," Faison said. "It is wrong and egregious for us as a body to allow a punishment to be inside of the punishment we've already given them."

As for the Andersons' testimony that they weren't informed about their son's death for 12 hours and have received no additional information since, Faison delivered a harsh rebuke to the department

"Shame on you, and shame on CoreCivic," Faison said, speaking to Parker. "Shame on everybody."

Gilchrist said the Trousdale Turner chaplain notified the Anderson family of Ross Anderson's death as soon as corrections representatives had completed their initial on-site investigation.

"I hope moving forward that we can get some type of dialogue between CoreCivic and y'all so that when something tragic like this takes place, that there's an immediate reach out to the family," Faison said. "It breaks my heart they find out more from the front page of the newspaper than they can from you or CoreCivic. That's egregious."

Reach Natalie Allison at nallison@tennessean.com. Follow her on Twitter at [@natalie_allison](https://twitter.com/natalie_allison).

NEWS

Private prison chief: 'We've got work to do' at Trousdale facility

Dave Boucher dboucher@tennessean.com

Published 1:49 p.m. CT Dec. 13, 2016

The rollout of Tennessee's newest private prison, the largest prison in the state, has not gone well, acknowledges CoreCivic CEO Damon Hininger.

"We've got work to do, clearly we've got work to do," said Hininger during a recent interview with The Tennessean, where Nashville-based company's recent rebranding from Corrections Corporation of America was also discussed.

"It's a very frequent occurrence when you're activating a facility, especially in a jurisdiction that maybe doesn't have a similar operation — public or private — and with that you've got workforce that is brand new to corrections, you're going to have some inconsistencies in the operations."

In the year since it has opened, the Trousdale Turner Correctional Center has been marred by safety and staffing concerns. Family of inmates and officers frequently say the facility has not done enough to ensure security. Officers say they're not getting paid enough to work in such conditions, leading to a consistent churn in the workforce.

All of those issues boiled over in May, when the Tennessee Department of Correction advised the facility stop accepting new inmates. A memo from state Correctional Administrator Tony Howerton outlined a litany of "serious issues" with facility leadership, along with concerns about the haphazard use of solitary confinement, inadequate staffing and allegations of excessive force. The facility also installed a new warden in March, swapping leaders with the CoreCivic-operated jail in Nashville.

DOJ to end CCA contracts, shares tumble

Hininger characterized the problems as "choppiness in the operations." Steve Owen, a spokesman for the company, said it's common for there to be "growing pains" and "hiccups" when opening a new private prison.

In letters, emails and conversations, families of inmates and officers have characterized the problems at the remote facility in Hartsville very differently.

James Kelley worked as a teacher at the facility from late November to early April. The 45-year-old has a master's degree and is licensed to teach in the state. He came to the facility after retiring from the military in 2011, having served for more than 21 years, including service in Desert Storm.

"I felt like I was in more danger when I was in the prison. And I didn't even have to think about that," Kelley told The Tennessean earlier this year.

"In a military environment, where I go out there and we're professionals, I have control over the battlefield aspects, I have control over the command aspects ... in the prison, it's completely opposite. There's no control and there's no identifying any immediate threats."

More than 800 staff vacancies in Tennessee prisons

This week, Kelley said there's a clear disconnect between company executives in their "ivory tower" in Nashville and the officers working the site every day.

Hininger and other CoreCivic executives admitted they need to work with the Department of Correction to review what went well with the rollout and what they need to improve.

"We both need to go back and do a post-mortem on it. We need to assess where we could have improved the process. We think that's a smart thing to do," said Tony Grande, chief development officer for CoreCivic and former Tennessee Department of Economic and Community Development commissioner.

CCA announces ICE contract extension

The company underestimated the revolving door of employees, Hininger said. To help attract and keep officers, the company recently announced it would increase the starting officer pay to \$15.75 an hour. They plan to give raises to all employees hired in recently at lower rates.

But problems persist: the facility remained on lockdown from Nov. 24 through at least Friday, and was on lockdown during the Tennessean interview with CoreCivic executives. Lockdown means offenders remain in their cells unless going to work, attending programming like school or rehabilitation or going to visitation. However, family members consistently tell The Tennessean they have issues contacting their loved ones during lockdowns.

CoreCivic spokesman Jonathan Burns said the lockdown was part of a standard "security sweep."

The prison housed 2,434 inmates as of Nov. 30. The county has a five year, \$276 million contract to operate the facility, paid for by the state in a system in a pass through that skirts a Tennessee law which essentially mandates the state have only one private prison.

Reach Dave Boucher at 615-259-8892 and on Twitter @Dave_Boucher1.

Former chaplain describes conditions inside TN prison

REPORTED BY DEMETRIA KALODIMOS

POSTED JUN 19, 2017



Trosdale Turner Correctional Center (WSMV file photo)

By design, prisons are places shut off from the rest of society.

But the state's newest and largest prison is unlike any other. It's run by a private company with public money.

Lawmakers say they've been kept out. Volunteers say they've been turned away.

The Channel 4 I-Team was told months ago we would not be visiting the facility or interviewing anyone connected to the company, CoreCivic.

But some former employees and inmates' families are calling the new Trousdale Turner Correctional Facility the worst prison they have ever seen.

It's a challenge to tell the story of the Trousdale Turner Correctional Facility, when no one from the state or the prison will grant an interview or a tour of the facility.

The I-Team has relied on interviews with several current and former employees, lawmakers, advocates, and families members of those housed at the facility.

We have obtained internal documents and some public records we requested and were initially billed hundreds of dollars for, but only after many months of stonewalling by CoreCivic.

The stories the I-Team has heard consistently describe a prison severely understaffed and overrun with gangs, violence, drugs and inefficiency.

Families say medium security inmates, men who theoretically pose a moderate risk, have been locked down in cells for weeks without showers and sometimes food.

"These lockdowns didn't last for one or two days, they'd last for weeks and weeks and weeks," said Jacque Steubbel, a former chaplain at Trousdale. "And if you take that many men and put them in a pressure tank, you're going to have problems."

As a chaplain, Steubbel said she saw plenty of problems, and meticulously documented them.

A month into the job, Steubbel was told by an inmate that a half dozen sharp daggers were hidden in a ceiling.

"They would go up through an AC vent and unscrew part of the roof," she said. "And some of those shanks were this long, and they were selling them.

But the door was open for the same thing to happen again.

"When we left, they didn't lock the utility door back and the opening was still there," Steubbel said. "And I told the correctional officer this really needs to be secure, this area. They'll just go up into the ceiling."

That's just one example of what the former chaplain called lax security.

An incident report tells the story of an inmate who controlled all the keys to the educational offices and more, with the administrator's blessing.

"They found keys, TOMIS codes, other entry passwords and so forth in this inmate Joseph Brennan's cell," Steubbel said. "You could access the entire TDOC computer system. The teachers had to go to the inmate to get keys in education."

Steubbel didn't go to Trousdale with unrealistic expectations. She had been a prison chaplain at three other correctional facilities also run by CoreCivic.

Steubbel said she didn't intend to become a whistleblower. She said it became her duty, ethically and morally as a minister, to speak out.

"I had an inmate come to me and he had lost his tooth. He was in a lot of pain and was holding his tooth. He said, 'I can't get seen by a dentist,'" Steubbel said.

"He had tried for three days carrying his tooth around, and he was going to try to glue it back in with Super Glue. There for the grace of God could be one of us," she added.

A suicidal inmate was also discovered hanging in a cell.

"I heard on the radio, cut down tool immediately. And so I went to the cellblock myself, because cut down tool means there's a suicide," Steubbel said.

"They told me, 'You can't go in there, chaplain.' And I said, 'Yes I can.' And I went in there and here's a man hanging and they're spraying him with pepper spray," she added.

"I'm holding his hand and it's covered in pepper spray. And he happened to be Muslim. I said, 'Brother, I'm with you. You're not alone.' And he was covered with pepper spray and he was not a threat. I mean, when you're dangling like this, that's the response. Spray them," Steubbel said.

Excessive use of pepper spray at Trousdale was criticized by Tennessee Department of Correction officials shortly after the prison opened.

After seeing video of a disciplinary takedown, correctional administrator Tony Howerton wrote, "The inmate in my opinion was already compliant ... but he was sprayed."

Howerton called the action, “at minimum, unnecessary force ... but could be classified as excessive force.”

The I-Team asked to see that video, but CoreCivic refused, saying it would reveal too much about security.

But an internal memo obtained by the I-Team reveals some telling numbers. It shows Trousdale Turner Correctional Facility at the top of the list of Tennessee prisons when it comes to using chemical agents, with 102 incidents in a 10-month span. That is compared to seven at Riverbend Maximum Security Institution.

Riverbend holds just over 800 prisoners. Trousdale holds over 2,600.

The five highest numbers on the list where pepper spray was used the most are all places the state has entrusted to CoreCivic.

Apart from pepper spray, Steubbel said force was many times excessive and unforgettable.

“I heard there was a disturbance in one of the pods, and I looked through the entrance door and in the hallway, and this image will never leave my mind,” Steubbel said.

Steubbel said she saw two guards beating a prisoner who was on the floor.

“His hands were shackled behind his back, young African American man, hitting him and hitting him and hitting him over and over. And he was screaming, ‘Stop,’” Steubbel said.

“That’s not right, it’s not necessary. And I will never get that image out of my mind,” she said.

In the small town of Hartsville, where the prison pays the biggest tax bill, Trousdale County Mayor Carroll Carman said the problems are news to him.

“You can count the number of calls my office has received in these fingers right here. It’s hidden primarily in our county and no one thinks about it,” Carman said.

Steubbel no longer works at Trousdale or for CoreCivic. The company said she was fired “for cause” after what they referred to as an investigation that “substantiated misconduct.”

The company claimed she was “providing misleading information to investigators” and now has a motive to “impugn our company.”

Prior to our interview, Steubbel told the I-Team she was terminated by CoreCivic based on what she claimed were false allegations from an incident at her previous post in Texas. She provided documentation of her claims.

She also shared an unemployment determination that awarded her compensation, charged to CoreCivic, with a finding that her employer fired her for a “reason that was not misconduct connected with the work.”

After charging the I-Team more than \$200 for copying those public records, CoreCivic returned that check, but not others, saying our request didn’t take as many man hours as anticipated.

The I-Team has been investigating claims at Troupdale Turner Correctional Facility since early last summer. Whenever new reports of assault, deaths and other disturbances surfaced, we have asked for incident reports, photos, videos and answers to questions.

Our most recent request was on June 1. No photos or videos have ever been shared.

The I-Team has not yet received the batch of records we requested in late March.

A state representative and the I-Team repeatedly asked for access to the facility or in-person interviews, and those requests were denied.

While the company offered a media tour on a short notice in April, it was at a time when Demetria Kalodimos was on assignment out of state. We asked to reschedule, and CoreCivic has yet to do that.

Late last week, CoreCivic responded to some of our long-pending questions, saying in part medical privacy considerations precluded them from providing details on deaths or injuries. They also generically stated that their staff acted appropriately in all situations.

Watch Channel 4 News at 6:00 on Tuesday for more on the many calls to 911 and why several employees said “no one is allowed to die at a CoreCivic prison.”

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NEWS

Former chaplain describes conditions inside TN prison

Posted Jun 19, 2017

https://www.lebanondemocrat.com/hartsville/trousdale-turner-employee-charged-with-smuggling-contraband/article_6b865daf-fbc8-5a59-9a35-e84b61ace2e4.html

Trousdale Turner employee charged with smuggling contraband

By Chris Gregory Managing Editor
Apr 23, 2020



Shinitara Kemp

An employee at the Trousdale Turner Correctional Center was arrested Friday and charged with attempting to introduce contraband to the CoreCivic-owned prison.

Shinitara Neikia Kemp, 34, of Clarksdale, Miss., was arrested after arriving for work at the prison early on the morning of April 17. She was reportedly a correctional officer brought in for temporary duty from another CoreCivic facility.

Arrest affidavits obtained by The Vidette stated that during a patdown of Kemp, security personnel found a package in her pants pocket. Three similar packages were reportedly found in a restroom that Kemp had exited as well.

The Trousdale County Sheriff's Department was called and opened the packages, which allegedly contained 14.75 ounces of marijuana. Kemp reportedly told investigators she was being paid \$2,000 by an inmate, identified as David Von Brown, to bring the contraband into the prison.

Kemp's vehicle was searched and a loaded 9mm pistol was reportedly discovered.

CoreCivic spokesman Ryan Gustin issued the following statement: "On Friday, April 17, Correctional Officer Shinitara Kemp was caught at checkpoint attempting to introduce drugs into the Trousdale Turner Correctional Center. This incident was immediately reported to the Trousdale County Sheriff's Department (TCSD) and our government partner, Tennessee Department of Correction. TCSD responded to the facility and arrested this individual for attempted introduction of contraband into a correctional facility. A search of the individual's vehicle, incident to arrest, resulted in the discovery of a weapon.

"We are cooperating fully with the investigation and the arrested individual's employment has been terminated.

"CoreCivic has a zero-tolerance policy for the introduction of contraband into our facilities and our actions in this matter reflect that."

Kemp was charged with attempting to introduce contraband to a penal facility, possession of Schedule VI for resale, unlawful drug paraphernalia and possession of a weapon during a felony.

Kemp was booked into the Trousdale County Jail and released on \$41,500 bond. She is scheduled to appear in general sessions court on June 12.

Reach Chris Gregory at 615-374-3556 or cgregory@hartsvillevidette.com.

34°

NEWS

Prison corrections officer in Trousdale County arrested carrying drugs

by: [Andy Cordan](#)

Posted: Jan 20, 2021 / 04:15 PM CST / Updated: Jan 20, 2021 / 05:02 PM CST

TROUSDALE COUNTY, Tenn. (WKRN) – A CoreCivic corrections officer is under investigation after he was on his way to the prison in Trousdale County with drugs on his person

Officer: Do me a favor. Step out of the car for a minute, I need to take a look at your eyeballs.

When the 32-year-old corrections officer protested, the officer made the following statement.

Officer: Listen, if I am going to let you get back on the road and drive, I have to make sure you are sober.

The officer examined the driver's eyes and then made another statement.

Officer: You might not be drunk, but you are intoxicated. What did you take?

Blayde: Nothing.

Officer: Nothing?

Blayde was wearing his corrections uniform as he told police he doesn't doesn't drink or smoke.

Blayde: I swear on my granddaddy, I don't drink or smoke. I don't do none of that.

Officer: Did you take any prescription medication?

Blayde: No, all I maybe took was an Advil. I don't do no drugs sir.

Body cam then shows Blayde performing poorly on his field sobriety tests and police arrest him for DUI.

Blayde: But I'm not drunk though, bro!

Captain Ray Amalfitano says, "He failed miserably."

According to CoreCivic, Blayde started his job on November 16, 2020.

Capt. Ray Amalfitano said, “What comes to mind is, you are in that profession, and held to a higher standard, and what do you even have that on you for? Are you trying to get that smuggled in, to get it to people locked up on the inside?”

CoreCivic issued the following statement:

CoreCivic has a zero tolerance policy for the introduction of contraband into our facilities.

The incident was immediately reported to our partners at the Tennessee Department of Corrections and the Office of Investigation and Compliance (OIC) is investigating the circumstance of his arrest.

- CORECIVIC

Officials with CoreCivic confirmed that Joseph Blayde Jr. is on administrative leave pending the outcome of the investigation.

Jail officials confirm Blayde Jr. is out of jail on a \$20,000 bond.

He is due in court on April 20th.

is tracking crime where you live. [CLICK HERE](#) for more coverage.



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POLITICS

Gangs, insufficient staffing plague troubled Tennessee private prison, state audit finds

Dave Boucher The Tennessean

Published 9:10 a.m. CT Nov. 14, 2017 | Updated 4:40 p.m. CT Nov. 14, 2017

Staffing and vacancy data at the largest private prison in Tennessee cannot be trusted, according to a scathing state audit that raises new questions about oversight of a quarter-billion dollar contract.

The audit, released Tuesday, blasted prison operator CoreCivic, previously known as Corrections Corporation of America, for ongoing problems at the Trousdale Turner Correctional Center, the newest and largest prison in the state.

"Trousdale Turner Correctional Center management's continued noncompliance with contract requirements and department policies challenges the department's ability to effectively monitor the private prison," the audit states.

Related:

▶ **New Tennessee CCA prison stops taking inmates amid 'serious issues'**

▶ **Private prison chief: 'We've got work to do' at Trousdale facility**

Tennessee House Democratic leaders, frequent critics of private prisons and advocates for additional prison oversight, pounced on the audit findings. House Minority leader Mike Stewart, D-Nashville, said he would support a legislative procedural move to delay department operations until the audit findings are addressed.

"Today we have explosive findings. Clearly we have CoreCivic facilities that are a powder keg waiting to explode, potentially endangering the public," Stewart said.

"Clearly, the Department of Correction has not been doing its job supervising this contractor, and we have to have a separate, independent agency come in and find these problems."

The Tennessee State Employee Association, an organization that represents prison officers and other state workers, pointed to the audit findings to renew its call for Tennessee to end using private prisons.

"In light of these findings, we believe it is time to move on from this and all private prison contracts and operate all Tennessee state prison facilities with state employees who have proven their ability to effectively maintain and operate safe and secure prisons," said TSEA Executive Director Randy Stamps in a statement Tuesday afternoon.

While the audit did find some issues within state-run probation and parole operations — and auditors have previously blasted state-run facilities for many different problems — this audit focused almost exclusively on private prison issues.

The stock market reacted to the news as well. CoreCivic share prices dropped almost 6 percent, closing the day down \$1.45 to \$22.92, the lowest price all year.

A CoreCivic spokeswoman acknowledged previous challenges at the facility and said "we still have work to do" but said the company has made progress since the prison opened.

"For example, we've significantly increased pay to attract and retain employees, with the starting salary at Trousdale now more than \$16 per hour," spokeswoman Amanda Gilchrist said in an email Tuesday afternoon. She said the firm is awaiting the results of a follow-up audit.

Department spokeswoman Neysa Taylor issued a similar statement Tuesday afternoon.

"We continue to work closely with our government and other partners, and are confident in the progress we have made and the services which are provided," Taylor said.

Gang activity cited as problem

Advocates, inmates, officers and their families have long said the facility is overly dangerous. A former employee previously told USA TODAY NETWORK-Tennessee he felt less safe in Trousdale than he did during his two decades in the Army, which included a deployment during Desert Storm.

Part of that problem is a large number of gang-affiliated inmates, advocates and families have said.

"Wardens at other facilities asked to transfer inmates to Trousdale Turner might move those with disciplinary issues, inmate compatibility issues, or security threat group (gang) affiliation," the audit states.

"When we visited Trousdale Turner, the department was in the process of transferring approximately 40 inmates per day in and out of the facility to reduce the percentage of confirmed gang-affiliated inmates at the facility."

Although many of these potentially problematic inmates may have higher security restrictions, Trousdale is classified as a medium-security prison.

At the time Trousdale opened, West Tennessee State Penitentiary was in the midst of ongoing violent episodes. Advocates, inmates and other sources say potentially dangerous inmates from that prison and other large prisons were transferred to Trousdale.

'Instability in leadership' and staffing questions concern auditors

The audit reviewed staffing and additional documentation for Trousdale, Whiteville Correctional Center and Hardeman County Correctional Center. All of the three CoreCivic-run facilities had issues, but Trousdale's were consistently the most egregious.

"A sample of 3 different days in 3 months revealed 44 critical posts unstaffed. We might have identified more unstaffed posts, but our review was limited by the blank staffing rosters," the audit states, referencing Trousdale staffing reports.

CoreCivic has a five-year, \$276 million contract to operate the facility. Although state law essentially allows for only one private prison, the department is using Trousdale County as something of a pass-through: Trousdale pays the money to CoreCivic after receiving the money from the state.

The roughly two-year-old facility has been plagued by problems since it opened. In the first months of operation, Trousdale was forced to stop accepting new inmates by the Tennessee Department of Correction due to a litany of issues.

The audit notes some issues may be due to "instability in leadership," observing Trousdale is on its third warden since opening.

Every private prison in Tennessee operates with a state employee called a contract monitor. The contract monitor is in place to watch daily operations to ensure CoreCivic is living up to

contract obligations.

During a recent media tour of CoreCivic, the warden noted that the facility has a contract monitor as evidence there is constant oversight at the facility.

But the audit found errors by contract monitors at several facilities, and said department cuts have forced those monitors to have too many job responsibilities.

Although CoreCivic officials say they have made improvements, auditors said inmates could be in danger.

"While the department's contract monitoring efforts regularly report the facility's shortcomings, cuts in monitoring staff may have reduced the department's ability to effectively monitor key contract requirements," the audit states.

"This lack of effective monitoring has resulted in situations that may undermine the department's ability to achieve its stated mission and could result in harm to inmates."

This points to willful negligence or sloppy operations by the department, Stewart said.

"If they're not able to do what they're asked to do then we have a systemic problem. I don't know what the motivation is. What I know is we have a department that has either been incapable of doing its job properly or has elected not to do its job properly," Stewart said.

What happens next?

The department agreed with most of the audit findings, but objected to accusations staffing data is inconsistent or potentially inaccurate.

"The Department of Correction works daily with CoreCivic to support consistent staffing patterns and gives thoughtful consideration to any proposed staffing changes," the management response states.

The audit will be addressed Wednesday morning during a meeting known as a "sunset hearing." Every year, the state legislature reauthorizes every state department, a process that in theory allows for oversight of operations.

While Stewart and Nashville Democrat Bo Mitchell say they will oppose recertification, the effort is almost assured to fail. Moreover, even if the department were not recertified, that would open the door to privatizing the entire system, a move Democrats oppose.

Reach Dave Boucher at 615-259-8892, dboucher@tennessean.com and on Twitter @Dave_Boucher1.

Tennessean.

NEWS

'This is unreal': Family seeks answers in death of Trousdale Turner prison inmate

Keith Sharon and Adam Tamburin Nashville Tennessean

Published 9:30 p.m. CT Feb. 2, 2021

The mortician had to reconstruct the victim's face so his family could mourn him with an open casket at his funeral.

Six weeks after Aaron Blayke Adams was found dead at Trousdale Turner Correctional Center, his family still doesn't know who is responsible, even though they say the 29-year-old inmate was in protective custody while being held on a probation violation at the time he died.

"They had to rebuild his jaw and his face and put a wig on him," said a distraught Deborah Henson, of Pine Bluff, Ark., the grandmother who raised Adams, who went by Blayke.

Despite sometimes daily phone calls to authorities, Henson said the family has no idea how Adams could have died or who may have killed him.

The family has attempted to get details from the Tennessee Bureau of Investigation, the Hartsville District Attorney's Office, the medical examiner and prison officials, but so far they have been denied.

The Tennessee Department of Correction told The Tennessean his death is being investigated as a homicide. The investigation is ongoing; Carter said the case could result in charges against an inmate.

'I'm so scared in here'

Adams, who was taken to Trousdale in May 2018, was scheduled to be released the day after Christmas, she said. Department of Correction spokesperson Dorinda Carter said state records show Adams' sentence would have expired October 2022.

Henson said Adams told her in a November phone call his life was in danger and that other inmates had "jumped" him and broken his ribs.

"He told me, 'You've got to get me out of here,'" said Henson, whose grandson called her Gaga. "Every time he called me, he would say, 'Gaga, I'm so scared in here.'"

Henson has focused her anger on the prison.

"This is unreal," she said. "That place needs to be shut down."

Prison officials declined to answer questions about Adams' death, saying only that staff "discovered" him unresponsive at 2:07 a.m. on Dec. 17. First responders tried to render life-saving aid, but Adams was declared dead at the prison, according to Ryan Gustin, a spokesperson for CoreCivic, the company that runs Trousdale Turner.

Officials would not say if any action had been taken against other inmates or prison officers. Gustin said "Trousdale Turner staff are cooperating fully" with a state investigation. He referred questions to the state.

The Tennessee Department of Correction Office of Investigations and Conduct is investigating Adams' death as a homicide, Carter said. Investigators will share their findings with the local district attorney's office.

Adams was not a violent offender.

Adams' criminal history in Tennessee dates to 2009, when he was arrested two days after his 18th birthday on a charge of criminal impersonation, according to state records.

A series of arrests followed for theft, drug possession, simple assault and probation violation, among other charges. His last arrests, in 2017, were on charges of probation violation and theft, according to state records.

His grandmother said his last arrest was for leaving the jurisdiction of his probation.

Problems at Trousdale Turner

Adams' death raises new questions about conditions at Trousdale Turner, a state prison managed by the private contractor CoreCivic. The facility has been roiled by safety and staffing concerns since it opened in 2016.

"The latest homicide fits a long and consistent pattern, as does the lack of response and accountability," said Jeannie Alexander, director of the Nashville-based No Exceptions Prison Collective and a long-time critic of conditions at Trousdale Turner.

"Trousdale Turner is hell for the people forced to live behind its walls, and hell for the people who work there," Alexander said. "And yet our state government chooses to ignore that people's children, loved ones, and family members are traumatized and subjected to violence on a daily basis."

Families complained for years of shoddy security at the facility. Those concerns mirror widespread problems reported throughout the state prison system.

A December 2019 audit found prisons across the state were mismanaged. The audit singled Trousdale Turner out for its poor record keeping related to inmate and employee safety.

For instance, health staff at Trousdale Turner failed to record any serious accidents or injuries during the 1½-year audit period. State auditors deemed the dearth of records suspicious.

"Given the nature of the correctional environment and when compared to other correctional facilities, it is unlikely that a facility would have no serious incidents to report," the auditors wrote.

Auditors also found staff at Trousdale Turner failed to file timely reports about sexual abuse and harassment allegations.

Then, last May, Trousdale Turner was the site of one of the biggest COVID-19 prison outbreaks in the country. The state said more than half of the inmates and staff tested at Trousdale Turner tested positive for the virus.

Adams is one of 25 inmates who died at Trousdale Turner in 2020. His is one of two deaths classified as a homicide in that timeframe, according to state records.

The other Trousdale Turner inmate to die in a homicide, Frank Lundy, was killed in January 2020 during a fight between inmates, officials said. Prison staff found Lundy injured "at the entrance to the housing unit." He was rushed to a local hospital, where he was declared dead.

Henson said she was very close with grandson. She said Adams told her he worked in the kitchen and he cut weeds at the prison for 15 cents per day.

She said he was in "medium security."

In 2020, Henson said she bought Adams a television to watch in his cell. Shortly after, she said he called her to say that the television had been stolen and that he and his cell mate had been beaten by other inmates.

She said she wants to know name of the person who killed Adams.

"I want to make sure this guy doesn't get out and come after us," Henson said.

Reach Keith Sharon at 615-406-1594 or ksharon@tennessean.com and on Twitter @KeithSharonTN.

Reach Adam Tamburin at 615-726-5986 and atamburin@tennessean.com. Follow him on Twitter @tamburintweets.

49°

NEWS

Investigation underway following death of inmate at Trousdale Turner Correctional Center

by: [Alex Corradetti](#)

Posted: Sep 8, 2021 / 10:45 AM CDT

Updated: Sep 8, 2021 / 12:19 PM CDT

SHARE



TROUSDALE COUNTY, Tenn. (WKRN) – The Tennessee Department of Correction’s Office of Investigations is looking into the death of an inmate at the Trousdale Turner Correctional Center.

According to the Director of Public Affairs for CoreCivic, an inmate was found unresponsive around 6:12 p.m. Tuesday at the facility.

[Case 3:22-cv-00093](#) [Document 1-6](#) [Filed 02/11/22](#) [Page 133 of 141](#) [PageID #: 533](#)

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Staff called a medical emergency and responded immediately. They began performing emergency life-saving measures. EMS were requested but the inmate was pronounced deceased before EMS arrived.

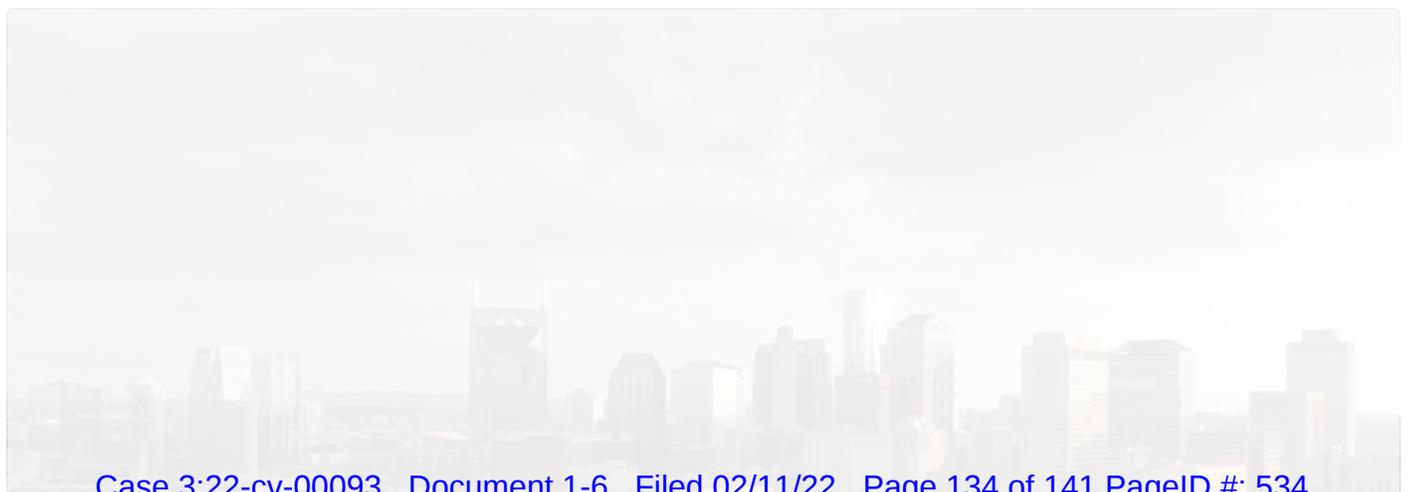
Facility administrators informed TDOC's Office of Investigations and Conduct and are looking into the incident. The inmate has yet to be identified and no other information was immediately released.

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Case 3:22-cv-00093 Document 1-6 Filed 02/11/22 Page 134 of 141 PageID #: 534

https://www.lebanondemocrat.com/hartsville/former-trousdale-turner-corrections-officer-indicted/article_aac20d8d-16e5-5edc-9e7e-d5fd9f8bfd0e.html

Former Trousdale Turner corrections officer indicted

By Chris Gregory Managing Editor
Oct 7, 2021

A former corrections officer at the Trousdale Turner Correctional Center has been indicted by a federal grand jury on various charges.

A press release from the Department of Justice stated that Kenan Lister, 42, was indicted after allegedly assaulting an inmate at the Hartsville prison on Aug. 30, 2019. He was arrested by FBI agents at his Clarksville home on Tuesday morning and was scheduled to appear before a U.S. magistrate later Tuesday.

The victim was not identified but sources told *The Vidette* it is Robert King Vaughn Jr., who allegedly assaulted a TTCC staff member earlier that same day. Vaughn was indicted by the Trousdale County Grand Jury in December 2020 on charges of attempted first-degree murder and aggravated rape, and those charges are still pending.

Loki's time has come

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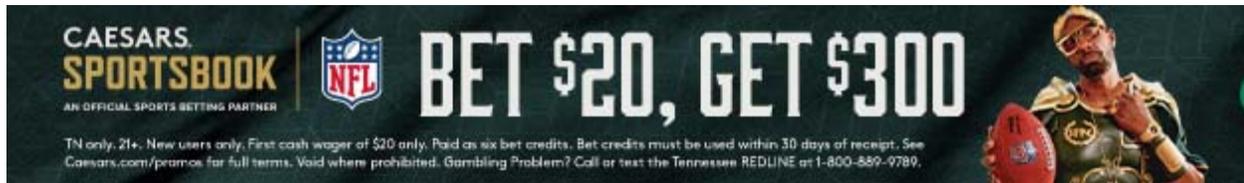
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According to the DOJ, Lister allegedly "punched the inmate in the head, knocking him to the ground, and then kicked, punched and struck the inmate multiple times in his head, chest and torso after he was on the ground." The DOJ release also claims that Lister failed to make notifications to get the inmate medical care and submitted a false report that omitted his use of force on the victim.

The case was investigated by the FBI and is being prosecuted by Assistant U.S. Attorney Sara

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"The safety of our staff and the inmates entrusted to our care is our top priority, and we have a zero-tolerance policy for any form of violence against inmates," stated Ryan Gustin, Public Affairs Director for CoreCivic. "The employee in question was terminated immediately following the incident, and we cooperated fully with the investigation."



⚠ Lister is charged with one count of deprivation of right under color of law, one count of being deliberately indifferent to the inmate's medical needs and one count of obstructing justice.

If convicted, Lister could face up to 20 years in prison, as well as a maximum of three years of supervised release and a fine of up to \$250,000.

Reach Chris Gregory at 615-450-5756 or cgregory@hartsvillevidette.com.

cgregory@hartsvillevidette.com



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NEWS



NAACP calls for closure of Trousdale Turner Correctional Center, cites 'barbaric treatment' of Black men

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The Nashville branch of the NAACP is calling for the closure of the Trousdale Turner Correctional Center citing its “barbaric treatment” of African American men.



By: [Levi Ismail](#)

Posted at 1:45 PM, Nov 11, 2021 and last updated 7:10 PM, Nov 11, 2021

NASHVILLE, Tenn. (WTVF) — The Nashville branch of the NAACP is calling for the closure of the Trousdale Turner Correctional Center citing its "barbaric treatment" of African American men.

The NAACP called for the private prison's closure during a news briefing, Thursday. The organization also called for the state and U.S. Department of Justice to investigate Trousdale Turner's treatment of Black men.

| *Watch the full press conference below:*

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NAACP Nashville President Sheryl Guinn said they have received an "inordinate" amount of complaints about Trousdale Turner, which has alarmed them.

Guinn said they have gotten reports detailing the "brutal" treatment of inmates, the majority of whom are Black men. She said they have also heard disturbing reports of guards beating inmates until they are "bloody" and inmates not receiving adequate medical care — and in some cases being denied medical care.

The same guards allegedly used racist remarks while beating inmates. Once an inmate spoke out to prison staff, guards are reprimanded. Guards are then suspected of paying gang members to finish the beatings as a form of

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correctional facility.

Gilmore said she's not opposed to introducing legislation to cut ties with for-profit prison companies. That begins with an investigation on both the state and federal level.

"The bottom line with CoreCivic is money. So I think that they're taking shortcuts and as a result of them taking shortcuts and being understaffed, these prisoners are being treated less than human," Gilmore said.

We also heard from Martha Carter who spoke about her still incarcerated son. She says he was diagnosed with blood cancer after complaining about his injuries that were never properly treated.

A tearful Carter said she thinks about her son every day and says it's time an investigation brought an end to the facility.

"We think about him all the time. That he's alone and sick. They won't give him special care or help," Carter said.

Members of the NAACP said they have not heard back from CoreCivic. We contacted the company and they offered the following statement:

"These unsubstantiated claims are inaccurate and misinformed. In both policy and practice, CoreCivic respects the dignity of every individual entrusted to our care, and we take any claims to the contrary seriously. We have clear lines of communication for those in our care to make concerns known. These concerns can be shared without fear of repercussion. Channels include in-facility

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inmate rights and treatment including legal rights, safety and security, healthcare, reentry programming, visitation and standards of living. We train 100% of our professionals on this policy before their first day of work.

Trousdale Turner Correctional Center (TTCC) provides those in our care comprehensive medical and mental health care. TTCC is monitored very closely by our government partners at the Tennessee Department of Correction (TDOC) who employ two, full-time on-site contract monitors at TTCC that work to ensure our full compliance with prescribed policies and procedures. TDOC also conducts regular reviews and audits of the entire facility to ensure appropriate standard of living for all inmates."

Members of the NAACP says they've heard back from the Department of Justice who have heard a number of these complaints against the facility. They say there have been several calls from inmates over the past year, but the DOJ has not confirmed an investigation.

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CURATION BY

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**OFFICE OF THE MEDICAL EXAMINER
Center for Forensic Medicine
Nashville, Tennessee**



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by Emma
Hampton
Reason:
Certified Copy
Date:
2021.05.30
17:35:18 -05'00'

REPORT OF INVESTIGATION BY COUNTY MEDICAL EXAMINER

Trousdale County Medical Examiner: Alexander Badru M.D.

State Number: 21-85-0001

Judicial District Number: 15

District Attorney: Honorable Jason L. Lawson

Case Number: MEC21-0816

Name of Decedent Terry Deshawn Childress		Age 37 Years	Race Black	Date of Birth 01/30/1984	Sex Male
Address Trousdale Turner Correctional Facility - TDOC, 140 Macon Way, Hartsville, TN 37074					
Date of Death 02/24/2021 7:38 PM	Type of Death In Jail/Prison/In Police Custody		Investigating Agency/Complaint #: TN Department of Corrections		
Place of Death 140 Macon Way, Hartsville, TN					
Narrative Summary decendent and his cellmate have been having escalating arguments. per report from the facility cellmate stated he was afraid for his life and took decendent life. decendent found on metal bedframe supine. has 2 parallel deep lacerations to RT occipital head approx 3cm and 4 cm. upon arrival, assessed by ambulance crew and found to be asystole all leads. i arrived as first responder with the ambulance to assist due to nature of call being unresponsive no pulse. blood splatter to back wall of cell near inmate head.					
Jurisdiction Accepted Yes		Autopsy Ordered Yes		Toxicology Ordered Yes	
Physician Responsible for Death Certificate Erin M Carney, M.D.					
Cremation Approved No		Funeral Home Nelms Funeral Home			
Cause of Death Blunt force injuries of the head					
Contributory Cause of Death					
Manner of Death Homicide					

OFFICE OF THE MEDICAL EXAMINER
Center for Forensic Medicine
850 R.S. Gass Blvd.
Nashville, Tennessee 37216-2640

CASE: MEC21-0816
County: TROUSDALE

AUTOPSY REPORT

NAME OF DECEDENT: CHILDRESS, TERRY RACE: Black SEX: Male AGE: 37
DATE AND TIME OF DEATH: February 24, 2021 at 7:38 p.m.
DATE AND TIME OF AUTOPSY: February 26, 2021 at 10:30 a.m.
FORENSIC PATHOLOGIST: Erin M. Carney, M.D.
COUNTY MEDICAL EXAMINER: Alexander Badru, M.D.
DISTRICT ATTORNEY GENERAL: Honorable Jason Lawson

PATHOLOGIC DIAGNOSES

1. Blunt force injuries of the head:
 - A. Abrasions, lacerations, and ecchymoses.
 - B. Petechial and confluent hemorrhages of the eyes and lip mucosa.
 - C. Scalp, temporalis muscle, subdural, and subarachnoid hemorrhage.
 - D. Contusions of the brain.
 - E. Tongue hemorrhage.

 2. Other injuries:
 - A. Abrasions and ecchymoses.
 - B. Fractures of two left ribs.
-

CAUSE OF DEATH: Blunt force injuries of the head
MANNER OF DEATH: Homicide
CIRCUMSTANCES OF DEATH: Beaten by assailant

I hereby certify that I, Erin M. Carney, M.D. have performed an autopsy on the body of Terry Childress on the 26th day of February, 2021 at 10:30 a.m. in the State of Tennessee Center for Forensic Medicine. The purpose of this report is to provide a certified opinion to the County Medical Examiner and District Attorney General. The facts and findings to support these conclusions are filed with the Tennessee Department of Health. The autopsy was performed in the presence of William McClain, M.D.

EXTERNAL EXAMINATION

The body is that of a well-developed, well-nourished (body mass index of 20.9 kilograms per meter squared), black male clad in a gray shirt, white shirt, white undershorts, and white socks. The body weighs 150 pounds, is 5 feet 11 inches in length, and appears consistent with the reported age of 37 years. Rigor is present to an equal degree in all extremities. Fixed lividity is on the posterior surface of the body, except in areas exposed to pressure. The scalp hair is brown and short. Facial hair consists of a mustache and hair on the lower lip and chin. The irides are brown. The corneas are hazy. The right sclera is unremarkable. The external auditory canals and oral cavity are free of foreign material and abnormal secretions. The teeth are natural and in fair condition. Skin slippage is on the left ear. The neck is without deformity or palpable masses. The abdomen is flat. The extremities are symmetric and without deformity. The fingernails are trimmed, lightly soiled, and intact, except for the right index fingernail and right middle fingernail which are broken. Tattoos are on the chest, right arm, and forearms. Needle tracks are not observed. Scars are on the right side of the chest, arms, left forearm, hands, left thigh, knees, legs, and left foot. Crusted abrasions are on the right side of the neck, right hand, and right leg. Brown patches are on the left side of the chest and right arm. The external genitalia are those of an adult male. The penis is circumcised and both testes are descended within the scrotum. The posterior torso exhibits a normal contour, and the anus is unremarkable.

EVIDENCE OF THERAPY: Defibrillator pads are on the body.

EVIDENCE OF INJURY:

- 1. Blunt force injuries of the head:** A 2 x 1 inch area of abrasion is on the right frontotemporal scalp with red ecchymoses. Additional abrasions (1/2 x 1/4 inch and 3/4 x 3/8 inch) are on the right cheek. Abraded lacerations (3/4 inch and 1/2 inch) are on the right parietal scalp. Abrasions and superficial lacerations are on the left side of the lips. A 2-1/2 x 2 inch area of abrasions and edema is on the lateral left eyelids, left cheek, and left temple. A 1/2 inch superficial laceration is on the lateral left supraorbital ridge. Petechial hemorrhages are in the upper and lower palpebral and bulbar conjunctivae of the right eye and in the upper and lower lip mucosa. Diffuse hemorrhage is in the left sclera and conjunctivae of the left eye. Lacerations are in the left side of the lip mucosa and buccal mucosa. Blood is in the nares. Internal examination reveals diffuse hemorrhage in the temporalis muscles and lateral frontal, lateral parietal, and temporal scalp; subdural hemorrhage (more on the right cerebral hemisphere than the left), and subarachnoid hemorrhage of the inferior and lateral frontal lobes and inferior temporal lobes above the cerebellum. Cortical contusions are on the inferior and lateral frontal lobes, temporal lobes, and left parietal lobe. White matter contusions are in the left frontal lobe. Hemorrhage is in the tip of the tongue.
- 2. Other injuries:** Red ecchymoses are on the right arm, and an orange abrasion is on the right wrist. Abrasions are on the left middle finger and right leg. Internal examination reveals a fracture of the anterior aspect of left rib 4 with hemorrhage and of left rib 5 with minimal associated hemorrhage.

INTERNAL EXAMINATION

BODY CAVITIES: The body is opened by the usual thoraco-abdominal incision and the chest plate is removed. No adhesions or abnormal collections of fluid are in the pleural, pericardial, or abdominal cavities. All body organs are in the normal anatomic position.

HEAD: The scalp is reflected. The calvarium of the skull is removed. The dura mater and falx cerebri are intact. There is no epidural. The leptomeninges are thin and delicate. The cerebral hemispheres are symmetrical. The structures at the base of the brain, including cranial nerves and blood vessels, are intact. There is no evidence of herniation. Coronal sections through the cerebral hemispheres reveal injuries as previously described. Transverse sections through the brain stem and cerebellum are unremarkable. The brain weighs 1470 grams.

NECK: Examination of the soft tissues of the neck by a layered anterior neck dissection, including strap muscles and large vessels, reveal no abnormalities. The larynx and trachea are normally formed and patent with unremarkable mucosa and scant bloody fluid. The hyoid bone and thyroid cartilage are intact. The cervical spine is unremarkable.

CARDIOVASCULAR SYSTEM: The pericardial surfaces are smooth, glistening, and unremarkable. The coronary arteries arise normally, follow the usual distribution with right dominant circulation, and are widely patent, without evidence of significant atherosclerosis or thrombosis. The chambers and valves exhibit the usual size-position relationship and are unremarkable. The myocardium is pink-brown, firm, and unremarkable; the atrial and ventricular septa are intact. The thickness of the heart walls as measured 1 cm below the atrioventricular valve annuli are as follows: right ventricle, 0.3 cm; left ventricle, 1.0 cm; and interventricular septum, 1.1 cm. The aorta and its major branches arise normally, follow the usual course and are widely patent, free of significant atherosclerosis and other abnormality. The vena cava and its major tributaries return to the heart in the usual distribution and are free of thrombi. The heart weighs 330 grams.

RESPIRATORY SYSTEM: The bronchi and bronchioles are free of foreign material; the mucosal surfaces are smooth, yellow-tan, and unremarkable. The pleural surfaces are smooth, glistening, and intact. The lungs exhibit normal lobar configurations. The pulmonary parenchyma is pink to red-purple, exuding slight to moderate amounts of bloody fluid; no focal lesions are noted. The pulmonary arteries are normally developed and patent, without thrombus or embolus. The right lung weighs 650 grams, and the left lung weighs 610 grams.

HEPATOBIILIARY SYSTEM: The hepatic capsule is smooth, glistening, and intact, covering dark red-brown parenchyma with no focal lesions. The gallbladder contains brown, mucoid bile; the mucosa is velvety and unremarkable. The extrahepatic biliary tree is patent, without evidence of calculi. The liver weighs 1540 grams.

ALIMENTARY TRACT: The tongue exhibits no evidence of recent injury. The esophagus is lined by a gray-white, smooth mucosa. The gastric mucosa is arranged in the usual rugal folds and the lumen contains 340 mL of tan fluid with white and orange food particles. The small and large intestines are unremarkable. The pancreas has a normal pink-tan lobulated appearance. The appendix is unremarkable.

GENITOURINARY SYSTEM: The renal capsules are smooth and thin, semi-transparent, and stripped with ease from the underlying smooth, red-brown cortical surfaces. The cortices are

sharply delineated from the medullary pyramids, which are red-purple to tan and unremarkable. The calyces, pelves, and ureters are unremarkable. The right kidney weighs 120 grams; the left kidney 140 grams. The urinary bladder contains 200 mL of urine; the mucosa is gray-tan and smooth. The prostate gland shows no focal lesions. The seminal vesicles and testes are unremarkable.

RETICULOENDOTHELIAL SYSTEM: The spleen has a smooth capsule covering a pink-purple, soft parenchyma; the lymphoid follicles are unremarkable. The regional lymph nodes appear normal. The spleen weighs 130 grams.

ENDOCRINE SYSTEM: The thyroid gland is symmetric without focal lesions. The parathyroid glands are inconspicuous. The adrenal glands and pituitary gland are unremarkable.

MUSCULOSKELETAL SYSTEM: Muscle development is normal. No bone or joint abnormalities are noted.

TOXICOLOGY: Blood and vitreous fluid are submitted for toxicologic analysis (see separate report).

HISTOLOGY: No tissue cassettes are submitted.

ADDITIONAL STUDIES: A full body postmortem radiograph is performed and reviewed.

SUMMARY OF CASE & OPINION

This 37-year-old black male, Terry Childress, was in jail when reportedly he and his cellmate were engaged in escalating arguments. Mr. Childress was found unresponsive in his cell with blood on the wall near his head.

Autopsy reveals blunt force injuries of the head including lacerations and abrasions, bleeding on the brain and in the scalp and tongue, and bruising of the brain. Mild organ pallor is noted. Two left ribs are fractured, possibly due to the assault and/or due to cardiopulmonary resuscitation (CPR). Postmortem toxicology testing of the blood is negative for drugs and alcohol.

The cause of death is blunt force injuries of the head, and the manner of death is homicide.

*****Electronically signed by Erin M. Carney, M.D. on Wednesday, May 19, 2021*****

Erin M. Carney, M.D.
Assistant Medical Examiner



NMS Labs

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200 Welsh Road, Horsham, PA 19044-2208
Phone: (215) 657-4900 Fax: (215) 657-2972
e-mail: nms@nmslabs.com

Robert A. Middleberg, PhD, F-ABFT, DABCC-TC, Laboratory Director

Toxicology Report

Report Issued 03/09/2021 12:36

Patient Name CHILDRESS, TERRY
Patient ID 21-0816
Chain NMSCP100621
Age 37 Y **DOB** 01/30/1984
Gender Male
Workorder 21070520

To: 10341
Forensic Medical Management Services - Nashville
850 R.S. Gass Blvd.

Nashville, TN 37216

Page 1 of 2

Positive Findings:

None Detected

See Detailed Findings section for additional information

Testing Requested:

Analysis Code	Description
8041B	Postmortem, Basic w/Vitreous Alcohol Confirmation, Blood (Forensic)

Specimens Received:

ID	Tube/Container	Volume/ Mass	Collection Date/Time	Matrix Source	Labeled As
001	Gray Top Tube	11 mL	02/26/2021 11:23	Femoral Blood	21-0816
002	Red Top Tube	5 mL	02/26/2021 11:23	Vitreous Fluid	21-0816
003	White Plastic Container	58 mL	02/26/2021 11:23	Urine	21-0816

All sample volumes/weights are approximations.

Specimens received on 03/03/2021.



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Workorder 21070520
Chain NMSCP100621
Patient ID 21-0816

Page 2 of 2

Detailed Findings:

Examination of the specimen(s) submitted did not reveal any positive findings of toxicological significance by procedures outlined in the accompanying Analysis Summary.

Sample Comments:

- 001 Physician/Pathologist Name: CARNEY
- 001 County: TROUSDALE COUNTY

Unless alternate arrangements are made by you, the remainder of the submitted specimens will be discarded one (1) year from the date of this report; and generated data will be discarded five (5) years from the date the analyses were performed.

Workorder 21070520 was electronically signed on 03/09/2021 11:13 by:

Erik Flail, B.A.
Certifying Scientist

Analysis Summary and Reporting Limits:

All of the following tests were performed for this case. For each test, the compounds listed were included in the scope. The Reporting Limit listed for each compound represents the lowest concentration of the compound that will be reported as being positive. If the compound is listed as None Detected, it is not present above the Reporting Limit. Please refer to the Positive Findings section of the report for those compounds that were identified as being present.

Acode 8041B - Postmortem, Basic w/Vitreous Alcohol Confirmation, Blood (Forensic) - Femoral Blood

-Analysis by Enzyme-Linked Immunosorbent Assay (ELISA) for:

<u>Compound</u>	<u>Rpt. Limit</u>	<u>Compound</u>	<u>Rpt. Limit</u>
Amphetamines	20 ng/mL	Fentanyl / Acetyl Fentanyl	0.50 ng/mL
Barbiturates	0.040 mcg/mL	Methadone / Metabolite	25 ng/mL
Benzodiazepines	100 ng/mL	Methamphetamine / MDMA	20 ng/mL
Buprenorphine / Metabolite	0.50 ng/mL	Opiates	20 ng/mL
Cannabinoids	10 ng/mL	Oxycodone / Oxymorphone	10 ng/mL
Cocaine / Metabolites	20 ng/mL	Phencyclidine	10 ng/mL

-Analysis by Headspace Gas Chromatography (GC) for:

<u>Compound</u>	<u>Rpt. Limit</u>	<u>Compound</u>	<u>Rpt. Limit</u>
Acetone	5.0 mg/dL	Isopropanol	5.0 mg/dL
Ethanol	10 mg/dL	Methanol	5.0 mg/dL

DECLARATION OF ROY T. GRAVETTE

Comes Now Roy T. Gravette and pursuant to 28 U.S.C. § 1748, declares under penalty of perjury that the foregoing is true and correct:

1. My name is Roy T. Gravette. I am over the age of 18 years old and have personal knowledge of the facts stated in this declaration.
2. I make this declaration after review of over three-hundred pages of public records related to both Terry Childress and his assailant Timothy Willis.
3. I am a twenty-year corrections veteran. Nine of my twenty years was as Associate Warden with the Federal Bureau of Prisons.
4. My career assignments included work as a Correctional Officer at the Federal Correctional Institution in Talladega, Alabama from June 1990 until October 1993. Lieutenant at the Federal Detention Center and the Metropolitan Correctional Center in Miami, Florida and Lieutenant at the Federal Correctional Institution in Estill, South Carolina. I was a Lieutenant from October 1993 until December 1997. I was a Captain at the Federal Detention Center in Oakdale, Louisiana and at the Federal Correctional Institution in Edgefield, South Carolina. My tenure as a Captain was from December 1997 until November of 2001. My assignments as Associate Warden were from November of 2001 until my retirement in June 2010.
5. My assignments were at the Federal Correctional Institution Talladega, Alabama, the Federal Correctional Complex in Beaumont, Texas and at the Federal Correctional Institution in Three Rivers, Texas. During my assignment at the Federal Correctional Complex in Beaumont I was assigned to the medium security facility for two years, as the Associate Warden at the Central Administration Building for a period of five months and to the United States Penitentiary for my final seven months.
6. When my career began as a Correctional Officer, I was assigned in the inmate housing units, as a compound patrol officer, and to various other duties assigned where I had direct supervision of the inmate population. As a Lieutenant, I would make rounds throughout the facility as part of my daily duties and interact with the inmate population in their assigned units, work assignments and leisure time activities. As my career progressed, I was promoted to Captain. During my time as a Captain, I was responsible for the Correctional Officers daily duties and all other aspects of the safety, security, and orderly running of the facility.
7. As an Associate Warden, I had the responsibility to oversee and direct staff in the performance of their daily duties. I wrote and critiqued local policy and made

decisions which affected the safety, security, and orderly running of the facility to which I was assigned. The policies were written using the principles of sound and proven correctional management, Federal law and standards provided by the American Correctional Association (ACA). I wrote lesson plans, taught classes, and wrote performance appraisals for our staff. I have commanded and been involved in incidents of emergency response for medical emergencies, inmate disturbances, hostage situations, assaults, suicides, homicides, and attempted escapes.

8. Attached as **Exhibit A** is a true and accurate copy of my curriculum vitae.
9. After a careful evaluation of the facts and circumstances that are known to me as a result of the review of the materials available, and taking into account my experience, training and knowledge of the practices that should be standard in all correctional facilities, I have formed several opinions, to a reasonable degree of certainty that are applicable to the correctional profession and the treatment and care of Terry Childress during his period of incarceration at the Trousdale Turner Correctional Center (TTCC).
10. Based on my review of the available incarceration records for Tymothy Willis I am of the opinion Willis was Medium Security inmate. Willis should not have been housed in the same cell Childress on 02/24/2021. In the description of the incident Willis is identified as a Medium Security inmate. Additionally on Willis's Offender Attributes print-out dated 07/31/2018 Willis had a custody level of Maximum with a high risk for violent behavior. Based on my experience an inmate with such a high custody classification as Maximum with a propensity for violent behavior it is unlikely their custody level would drop dramatically enough in two and a half years that he would be housed with a Minimum security inmate in a segregated housing unit with the inmates both locked in a small cell with no means of escape if one of the inmates attacks the other. *See* CCI314, eTomis Offender Attributes RNA Level; CCI001, Incident Report. (Collectively **Exhibit B**)
11. TTCC was at all times aware that Childress was classified minimum. *See* Exhibit B.
12. On December 8, 2020, TTCC Counselor Shawna Curtis misclassified Willis as Minimum custody inmate when she failed to account for the severity of Willis's Current Offense (Reckless Endangerment with a deadly weapon) and two or more of Willis's prior felony convictions. Counselor Curtis also failed to account for Willis's in custody disciplinary record with included an incident report in the past six months and Willis's history of incident report severity. Counselor Curtis classified Willis as a Minimum custody inmate with 2 points. I have gone over the classification information and based on my review and experience Willis should have been a Medium custody with a minimum of 13 points. *Compare* CCI 261-62, Willis's 2020 classification (**Exhibit C**), *with* CCI 269, Willis's 2019 classification (**Exhibit D**).

13. Placing minimum classified inmates with medium or higher classified inmates is a violation of known correctional customs and practices. TTCC staff failed to follow this sound correctional technique which is accepted throughout the corrections industry and Childress was placed in harms way in a locked segregation cell with Willis an inmate who had a documented propensity for violent behavior.
14. Upon information and belief, TTCC was aware that Willis was a “snitch” and that informing on other inmates was the reason Willis was placed into Segregation. Based on my experience and training it is reasonable TTCC staff should have been aware of inmate culture where inmates prey on weaker inmates in an attempt to get a transfer to another facility. This information about Willis has been corroborated by a former TTCC staff member.
15. Correctional officers should routinely conduct rounds every 30 minutes. The 30-minute checks are routinely used as safety and security checks of the inmate population who are housed in segregated housing units. This practice is utilized to ensure the safety and wellbeing of each and every inmate housed in the area.
16. Upon information and belief, TTCC was and still is severely understaffed leading to correctional officers not conducting proper and completing safety and security checks in a timely manner. During those critical 30-minute checks the staff members are required to observe each inmate assigned to the unit. Staff are to observe a living breathing inmate and ensure each inmate is not in any type of distress. When staffing is not adequate staff will take short cuts and the overall security and proper observation of the inmates falls below national standards of care.
17. Upon information and belief, TTCC’s understaffing issue is a deliberate choice.
18. It is my expert opinion that TTCC’s understaffing and disregard for known correctional standards is more likely than not a direct cause of the harm suffered by Terry Childress.

I swear under penalty of perjury under the laws of the United States that the foregoing is true and correct to the best of my knowledge.

Dated this 8th day of February 2022.



ROY T. GRAVETTE

Curriculum Vitae

Tim Gravette

ROY T. GRAVETTE (TIM)

126 Playfair Drive, Lafayette, Louisiana 70503 | 361-742-2500 | tim@gravetteconsulting.com

EDUCATION

Federal Law Enforcement Training Center

Glynco, Georgia

- Introduction to Correctional Techniques (112 hours) 1990
- Firearms/Self Defense (32 hours) 1990
- Spanish Immersion for Law Enforcement Officers (141 hours) 1992
- Training for Trainers for Side Handle Baton Instructors (26 hours) 1994

Federal Law Enforcement Training Center

Artesia, New Mexico

Prisoner Transportation and Bus Transportation Training (80 hours) 1993

Federal Bureau of Prisons Management Training Center

Aurora, Colorado

- New Lieutenant Training (76 hours) 1995
- Advanced Lieutenant Training (72 hours) 1995
- Special Investigative Supervisor Training (64 hours) 1997
- New Captain Training (40 hours) 1998
- CORE Skills Training (40 hours) 1998
- Discipline Hearing Officer Training (52 hours) 1998

ROY T. GRAVETTE (TIM)

- New Associate Warden Training (36 hours) 2001
- Public Speaking and Media Relations (36 hours) 2002
- National Incident Management Training (36 hours) 2007

Miami-Dade Community College

Miami, Florida

Arson and Crime Scene Photography/Documenting Domestic Violence 1995

National Crisis Prevention Institute

Milwaukee, Wisconsin

Instructor Certification 1996

Federal Bureau of Prisons Employee Development Center

Washington, D.C.

Leadership Forum (40 hours) 1997

National Institute of Corrections

Longmont, Colorado

Correctional Leadership Development 2003

Management Development Center

Denver, Colorado

Strategic Leadership: Leading Culture Change and Building Performance Based Organizations
2005

Offices of the United States Attorneys

The National Advocacy Center

Columbia, South Carolina

Prison Rape Elimination Act Certification Training 2013

ROY T. GRAVETTE (TIM)

De-Escalation – What Does This Mean?

Use of Force Policy Development and Training Standards

Webinar Daigle Law Group Eric P. Daigle 2018

OTHER TRAINING

- Safety Cross Development Course 1991
- Annual Correctional Refresher Training 1991-2010
- Correctional Services Cross Development Course 1992
- Computer Security 1992
- Hostage Survival Skills 1993
- Stun Munitions 1993
- Case Management 1998
- Financial Management 1999
- Religious Services Cross Development 2000
- Suicide Assessment and Management 2001
- Employee Services Cross Development Course 2002
- Psychology Services Cross Development Course 2002
- Human Resource Cross Development Course 2002
- Labor Management 2002
- FEMA Emergency Management Training 2007
- Prison Rape Elimination Act Auditor Training 2014

AWARDS

Norman A. Carlson Award 2000

Supervisor of the Year 2000

Excellence in Operational and Program Review 2000

ROY T. GRAVETTE (TIM)

Specialized Experience

Disturbance Control Squad Member

Disturbance Control Squad Leader

Special Operations Response Team Member

Special Operations Response Team Leader

Special Operations Response Team Commander

TEACHING EXPERIENCE

Federal Bureau of Prisons

Instructor for General Classes 1993-2009

Instructor for the following classes during annual training sessions: Terrorism both Domestic and Foreign, First Responder, Key Control, Security Procedures and Report Writing.

Instructor PR-24 Side Handle Baton 1994-1995

Conducted training classes and certified correctional staff in the proper use of a side handle baton and use of force techniques.

Instructor Nonviolent Crisis Intervention 1995-1996

Conducted training for staff in the standards for crisis prevention and intervention training. This training provided staff with the skills to safely and effectively respond to anxious, hostile, or violent behavior while balancing the responsibilities of care.

Instructor Use of Deadly Force 1998-2001

Conducted training for all institution staff in the use of deadly force.

Instructor Ethics 2002-2009

Conducted training for all staff during annual training sessions in policies related to ethical behavior both in the workplace and outside activities.

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RELATED EXPERIENCE

Litigation Consultant

Gravette Consulting LLC

2010 - Present

As a Litigation Consultant, I provide litigation support and expert witness testimony. I have the responsibility to review and analyze case materials to include written reports, video footage and if available recorded phone conversations. I assist the attorney client with deposition and trial preparation focusing on discovery and evidence. I prepare a written report of opinions I have formulated from research and materials provided for each case. Inmate standards of care and conditions of confinement are a central focus point of my work and preparation.

I have been involved in cases on the Federal, State, Parish, and County levels. My years of experience as a correctional professional has led to cases ranging from homicides, suicides, assault, and death in custody. I have prepared Federal Rule 26 reports and provided deposition testimony. I have provided expert testimony in Federal Court and have been qualified in the following areas: prison culture, Bureau of Prisons policy, prison homicide and investigations, prison staffing and policy, inmate behavior and comparative disciplinary records. Attention to the details of each case and interpretation of policy is utilized as the basis for my opinions.

Subject Matter Expert

Creative Corrections

2012 - 2014

I was employed as a Subject Matter Expert in the field of corrections for Creative Corrections in Beaumont, Texas. I conducted Office of Detention and Oversight (ODO) audits for the United States Immigration and Customs Enforcement Office of Professional Responsibility. I was involved in four to five audits per year during my tenure with Creative Corrections. I would go with a team of other subject matter experts and review a facility's overall operation and physical plant layout. The audits were completed utilizing Performance Based National Detention Standards. Of the areas I have been assigned during the audits, I have reviewed and documented facilities' compliance in Use of Force and Restraints, Special Management Units, Food Service Operations, Classification System, Staff-Detainee Communication, and Sexual Abuse and Assault Prevention and Intervention.

Contract Special Investigator

KeyPoint Government Solutions

2011 – 2014

As a contract special investigator, I conducted background investigations in support of national security, focusing on casework for the Office of Personnel Management (OPM). My primary duties included conducting background investigations for determining employment suitability of

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persons who require access to sensitive or classified U.S. Government information. I conducted face-to-face interviews with the subjects and his/her neighbors, employers, friends, and family. I also performed records searches at law enforcement agencies, courthouses, educational institutions, financial institutions, and medical/mental health facilities. Following the interviews and records searches, I provided written reports to the Office of Personnel Management which were used for official purposes.

Prison Rape Elimination Act Auditor

2015-2018

I am a certified Prison Rape Elimination Act (PREA) Auditor for Adult Facilities by the United States Department of Justice. I completed a one-week intensive certification class at the National Advocacy Center in Columbia, South Carolina. I am available to assist with the certification process and complete the required audit process for Adult Facilities as directed by the PREA Resource Center utilizing the standards and guidelines required to meet the standards and laws of the Department of Justice.

Motion Picture Industry Consultant

2015

I consulted on production of the motion picture Trumbo, filmed in New Orleans, Louisiana. The film was directed by Jay Roach and starred Brian Cranston, John Goodman, Helen Mirren, and Diane Lane. The film was nominated for an Oscar and other prestigious awards. I assisted the production personnel with costumes and prison dialog. I also wrote the scene in the movie of the searching of Trumbo when he was processed into the prison. I was on location during the filming to assist with prison related scenes and to help with the actions of the extras involved in the prison scenes.

Federal Bureau of Prisons

1990 – 2010

During my career with the Federal Bureau of Prisons, I served as a correctional officer, a GS-9 lieutenant, a GS-11 lieutenant, a GS-12 captain, a GS-13 captain, and an associate warden. My assignments have been at eight different locations at varying security levels including administrative facilities, four medium security facilities, federal detention centers, and two high security facilities in locations across the southern United States. My primary duties dealt with the safety, security, and orderly running of the institutions which included the oversight of internal audits and preparation for program review visits, American Correctional Association visits and institution character profile visits. My association with the American Correctional Association has been on six different occasions. I have participated in program review visits as an auditor and have accompanied my regional director on two occasions on institution character profile visits. I have been involved in numerous incidents of inmate violent behavior and emergency situations over the span of my career. I have been the on-scene commander for inmate disturbances and riots and have responded to medical emergencies and acts of violence

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ranging from assaults to homicides. I have been a member of after-action review teams and participated in mortality reviews.

Correctional officer at a medium security institution from 1990-1993.

GS-9 and GS-11 lieutenant at two administrative facilities from 1993-1995.

GS-11 lieutenant at a medium security facility from 1995-1997.

GS-12 captain at an administrative facility from 1997-1999.

GS-13 captain at a high security institution from 1999-2001.

I was assigned as an associate warden at three facilities from 2001-2010. During these assignments, I was responsible for several areas of the institutions and the program and operational reviews for those departments. I completed the yearly reviews of our local policy and continued to monitor changes in national policy as it affected the changes we needed to make to our local policy. I was tasked with being the re-accreditation manager for our American Correctional Association visits at two of the assignments. I utilized my experience and knowledge of national and local policy as well as the mandatory standards for correctional institutions as set forth by the American Correctional Association to prepare our facilities for the visits. Along with a team of staff I made numerous inspections and walk-thru visits of all the areas of the institution. I noted areas of concern and made on-the-spot corrections. I was selected to participate in an institution character profile review at another institution by my regional director. This process is similar to a program review, which involves touring the entire facility and noting issues which are to be included in the final report. I have also been utilized as an investigator over the course of my career. I have been involved in investigations of staff misconduct and criminal investigations ranging from assault to homicides. I have attended training in Denver, Colorado for investigation and crime scene management. I have worked with other agencies to include the Federal Bureau of Investigations, the United States Marshals Service, and the Office of Inspector General in criminal investigations of both staff and inmates. I also conducted investigations for the Federal Bureau of Prisons working closely with the Office of Internal Affairs.

SPEAKING ENGAGEMENTS

I have made public speaking appearances which included the 16th annual Criminal Justice Act Panel Training and Seminar hosted by the Federal Public Defenders Office in Lafayette, Louisiana, and the Lafayette Bar Association CLE program. My topic was The Prison Investigative Process and Your Client. The presentation included insights into prison culture and inmate behavior, the investigative process in a correctional setting, and inmate classification

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issues which include protective custody, high profile inmates, and the influence of prison gangs on the day-to-day operation of a prison.

MEMBERSHIPS

American Correctional Association

Louisiana Sheriffs' Honorary Membership Program

Louisiana Correctional Association

INCIDENT REPORT

Facility: Trousdale Turner Correctional	Incident Number: 2021-0119-269-I
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Incident Date/Time (HRS): 02/24/2021 19:12 hours

Facility Damage: None

Incident Location: Facility Property \ Section: A \ Block: C \ Cell: 215

INCIDENT PRIORITY LIST:

Priority	Priority Description
I	Death Under Investigation

Other Priority Description:

DESCRIPTION OF INCIDENT:
<p>On 2/24/2021 at approximately 1912 hours a medical emergency was called to Alpha Charlie cell 215 by C/O Harmon. Inmate Willis, Timothy #574845 stated to staff he killed his cell mate. Inmate Childress 622865 was discovered unresponsive, no pulse, and no respirations. 1914 Medical arrived, 1915 CPR initiated, 1916 EMS was called, 1925 AED applied and ventilated at 100% O2. 1930 EMS arrived at the facility, 1934 EMS assumed care. At approximately 1938 on 2/24/2021 Battalion Chief Hall pronounced inmate Childress deceased. Inmate Childress was housed with inmate Willis, Timothy #574845. TBI and OIC have been notified and are en-route to the facility to take over the investigation. Inmate Childress was COVID tested with a negative result on 12-29-2020</p> <p>Inmate Childress is a 37 year old black male serving 6 year sentence for Possession of Firearm, Felony with Prior Drug Offense.</p> <p>Medical: LOC 2, No medication, only diagnosis is adjustment disorder.</p> <p>Inmate Childress arrived at TTCC 10/27/2020 classified minimum and Inmate Willis arrived 12/27/18 classified as medium. Neither inmates are identified with a STG.</p> <p>Date and time of Notification: 2/24/21 at 1917 ADO COUM Thomas, 2/24/2021 at 1953 Contract Monitor Brun and 2/24/2021 at 1955 CCC</p>

Inmates/Residents Involved? Yes
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INVOLVED PEOPLE:

Inmate/Resident Name(s) & Number	Jurisdiction	Witness or Participant	5-1C Attached or Refused?	Injuries

Employee Name(s) & Number	Employee Title	Witness or Participant	5-1C Attached?	Injuries



Offender Attributes



Links Suspend

TOMIS ID **00574845** Willis, Tymothen B. Status ACTV Location RMS

Emergency Notf Military/Child Suprt License/ID Issuance

Physical Info Social Info Offender Summary Offender Location Offender Other ID

Reset key fields

Inquire

Modify

Alerts

Marital Status	<input type="text" value="Single"/>	Religion	79	Muslim - Sunni
DL Number	133859985	DL State	TN	Tennessee
County of Birth	060 Maury	State of Birth	TN	Tennessee

Citizenship

Place of Birth		Alien ID	
Jurisdiction	TN Tennessee		

Actual Site	RMSI	Unit 1A1	Cell 01	Bed A
Assigned Site	RMSI	Unit 1A1	Cell 01	Bed A

Custody Level	MAX Maximum	PREA Aggressor	N
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RNA Level	High Risk: Violent	Date	07/31/2018	Site	NWCX
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Street	REDACTED	State	TN	Zip	REDACTED
City	REDACTED	Alternate Phone	REDACTED		

Home Phone

Email Address

FastPath Go

HOLMAP01

TENNESSEE DEPARTMENT OF CORRECTIONS
CLASSIFICATION CUSTODY ASSESSMENT FORM

DATE: 12/08/2020
TIME: 13:56:58
PAGE: 1

TOMIS ID: 00574845 WILLIS, TYMOTHY B.
SITE NAME: TROUSDALE TURNER CORRECTIONAL CENTER
COUNSELOR: CURTIS, SHAWNA
CAF DATE: 12/08/2020

HISTORY OF INSTITUTIONAL VIOLENCE

	0	
ASSAULT. NO WEAPON, NO SERIOUS INJURY (LAST 18 MONTHS)	3	-----
ASSAULT. WITH WEAPON, NO SERIOUS INJURY (LAST 18 MONTHS) ...	5	SCORE
ASSAULT. WITH OR WITHOUT WEAPON WITH SERIOUS INJURY OR DEATH	7	
(LAST 42 MONTHS)		
ASSAULT. WITH OR WITHOUT WEAPON WITH SERIOUS INJURY OR DEATH	5	
(43 THROUGH 60 MONTHS)		

ASSAULT OCCUR WITHIN LAST SIX MONTHS

	0	
NO	0	-----
YES	3	SCORE

SEVERITY OF CURRENT OFFENSE

	0	
LOW	0	-----
MODERATE	1	SCORE
HIGH	3	
HIGHEST	4	

PRIOR ASSAULTIVE OFFENSE HISTORY

	0	
LOW	0	-----
MODERATE	1	SCORE
HIGH	3	
HIGHEST	4	

SCHEDULE A SCALE (SUM OF ITEMS 1 THROUGH 4)

	0	
CLOSE 10-14.		
MAXIMUM 15 OR MORE.		

ESCAPE HISTORY

	- 2	
NO ESCAPES OR ATTEMPTS	- 2	-----
ESCAPE OR ATTEMPT FROM MINIMUM CUSTODY, NO ACTUAL OR	0	SCORE
THREATENED VIOLENCE: OVER 1 YEAR AGO		
ESCAPE OR ATTEMPT FROM MINIMUM CUSTODY, NO ACTUAL OR	1	
THREATENED VIOLENCE: WITHIN THE LAST YEAR		
ESCAPE OR ATTEMPT FROM MED OR ABOVE CUSTODY, OR FROM MIN	5	
CUSTODY WITH ACTUAL OR THREATENED VIOLENCE: OVER 1 YEAR AGO		
ESCAPE OR ATTEMPT FROM MED OR ABOVE CUSTODY, OR FROM MIN	7	
CUSTODY WITH ACTUAL OR THREATENED VIOLENCE: WITHIN LAST YR		

HOLMAP01

TENNESSEE DEPARTMENT OF CORRECTIONS
CLASSIFICATION CUSTODY ASSESSMENT FORM

DATE: 12/08/2020
TIME: 13:56:58
PAGE: 2

TOMIS ID: 00574845 WILLIS, TYMOTHY B.
SITE NAME: TROUSDALE TURNER CORRECTIONAL CENTER
COUNSELOR: CURTIS, SHAWNA
CAF DATE: 12/08/2020

DISCIPLINARY REPORTS - GUILTY

		- 1
NONE IN LAST 18 MONTHS	- 4	-----
NONE IN LAST 12 MONTHS	- 2	SCORE
NONE IN LAST 6 MONTHS	- 1	
NEW ADMISSION/PAROLE VIOLATOR.....	0	
ONE IN LAST 6 MONTHS	1	
TWO OR MORE IN LAST 6 MONTHS	4	

MOST SEVERE DISCIPLINARY RECEIVED

		5
CLASS C	2	-----
CLASS B	5	SCORE
CLASS A	7	

DETAINER/NOTIFICATION/CHARGE PENDING

		0
MISDEMEANOR	3	-----
FELONY	5	SCORE

PRIOR FELONY CONVICTIONS

		0
ONE	2	-----
TWO OR MORE	4	SCORE

SCHEDULE B SCALE (SUM OF ITEMS 5 THROUGH 9)

2

CUSTODY LEVEL SCALE FOR TOTAL A + B (CAF SCORE)

		2
CLOSE 17 OR MORE.		-----
MEDIUM 7-16.		-----
MINIUMUM 6 OR LESS.		

CAF CUSTODY LEVEL: MINIMUM



TENNESSEE DEPARTMENT OF CORRECTION
CLASSIFICATION CUSTODY ASSESSMENT

TCC
INSTITUTION

DATE: 5-20-19
TIME: 1024

NAME: Willis, Timothy TOMIS ID: 574845
CAF DATE: 5-20-19

1. HISTORY OF INSTITUTIONAL VIOLENCE (Jail or Prison, Rate Most Serious)		
ASSAULT – no weapon, no serious injury (last 18 months)	3	
ASSAULT – with weapon, no serious injury (last 18 months)	5	
ASSAULT – with or without weapon, with serious injury or death (last 42 months)	7	
ASSAULT – with or without weapon with serious injury or death (43 through 60 months)	5	<u>5</u> SCORE
2. ASSAULT OCCUR WITHIN LAST SIX MONTHS		
No	0	
Yes <u>ASW 2-6-19</u>	3	<u>3</u> SCORE
3. SEVERITY OF CURRENT OFFENSE (Rate Most Serious)		
Low	0	
Moderate	1	
High	3	
Highest <u>Reckless End (Deadly Weapon), Lawrence, 2017</u>	4	<u>3</u> SCORE
4. PRIOR ASSAULTIVE OFFENSE HISTORY (Rate Most Serious)		
Low	0	
Moderate	1	
High	3	
Highest	4	<u>0</u> SCORE
SCHEDULE A SCALE (SUM OF ITEMS 1 THROUGH 4)		
Close 10-14		
Maximum 15 or More		
(9 OR LESS, COMPLETE SCHEDULE B)		
5. ESCAPE HISTORY (WITHIN LAST 5 YEARS OF INCARCERATION)		
No escapes or attempts	-2	
Escape or attempt from minimum custody, no actual or threatened violence: over 1 year ago	0	
Escape or attempt from minimum custody, no actual or threatened violence: within the last year	1	
Escape or attempt from medium or above custody, or from minimum custody with actual or threatened violence: over 1 year ago	5	
Escape or attempt from medium or above custody, or from minimum custody with actual or threatened violence: within last year	7	<u>-2</u> SCORE
6. DISCIPLINARY REPORTS – GUILTY		
None in Last 18 Months	-4	
None in Last 12 Months	-2	
None in Last 6 Months	-1	
New Admission / Parole Violator	0	
One in Last 6 Months <u>ASW 2-6-19</u>	1	
Two or More in Last 6 Months <u>F26 2-6-19</u>	4	<u>4</u> SCORE
7. MOST SEVERE DISCIPLINARY RECEIVED (last 18 months)		
Class C	2	
Class B	5	
Class A <u>ASW 2-6-19</u>	7	<u>7</u> SCORE
8. DETAINER / NOTIFICATION / CHARGE PENDING		
Misdemeanor	3	
Felony	5	<u>0</u> SCORE
9. PRIOR FELONY CONVICTIONS		
One	2	
Two or More	4	<u>4</u> SCORE
SCHEDULE B SCALE (sum of items 5 through 9)		
CUSTODY LEVEL SCALE FOR TOTAL A + B (CAF SCORE)		
Close 17 or More		
Medium 7 – 16		
Minimum 6 or Less		
CAF Custody Level:		<u>Close</u>