IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
NASHVILLE DIVISION

JOHN SMITH and SOYNIA SMITH, as survivors and next of kin of **ADDISON SMITH**, deceased, Plaintiffs, vs. **CORECIVIC, INC., DAMON T. HININGER, GRADY PERRY, EDDIE JOHNSON, JASON WHITEHEAD, ASHLEY ACKERMAN, CHRISTOPHE WILLIAMS, LOGAN KING, JOSHUA RAY, JENNY RATLIFF, LEDIA ALVA, WILLIAM LYONS, J. SCOTT LONG, MARK SIGLER, ELAINE BLOODGOOD, ANDREA STEADMAN, KEVIN TURNER, and MARCAYUS ROSE.** Defendants	**Case No. 3:20-cv-00563** **JURY DEMAND**

FIRST AMENDED COMPLAINT

NOW COME John Smith and Soynia Smith, the Plaintiffs herein, stating and alleging as follows:

Introduction

1. The Plaintiffs' 27-year-old son, Addison Smith, committed suicide on August 23, 2020, four days after he was raped by another inmate in the South Central Correctional Center ("SCCC"), a private prison in Clifton, Tennessee operated by Defendant CoreCivic, Inc. Addison had a history of mental health problems dating back to childhood, and he had threatened

suicide multiple times prior to his death. The rapist, Marcayus Rose, was sent to segregation ironically because other inmates in general population reported that Inmate Rose was harassing them for sex. Inmate Rose is a high-ranking member of the Gangster Disciples and, for reasons yet unexplained, he was assigned to the same cell as Addison despite Addison's obvious vulnerabilities.

2. After filing their Original Complaint, the Plaintiffs served a subpoena duces tecum on the Tennessee Department of Corrections ("TDOC"). On August 12, 2020 and August 18, 2020, TDOC produced records revealing the rape described above, as well as equally troubling information concerning Addison's death. The Plaintiffs incorporate by reference the investigative report of TDOC Special Agent Nicky Jordan (attached as Exhibit 1) and the internal report of CoreCivic Investigator Jessica Frakes (attached as Exhibit 2). As shown by both TDOC records and CoreCivic's own records, CoreCivic personnel repeatedly ignored Addison's stated intent to kill himself, failed to provide him with mental health care, and even failed to provide him with food. Shortly after Addison's death, at least one CoreCivic employee tampered with records in order to hide his criminal negligence. Less than three weeks after Addison's death, CoreCivic supervisors up to and including the warden signed off on a report that whitewashed many of the failures that resulted in the rape (and ultimately the suicide) of Addison.

Jurisdiction and Venue

3. This Court has jurisdiction under 28 U.S.C. § 1331 because the Plaintiff asserts federal claims under 42 U.S.C. § 1983.

4. Venue is proper in this Court because some of the Defendants reside or are located in the Middle District of Tennessee, and the acts giving rise to this lawsuit occurred in the Middle

District of Tennessee.

Parties

5. Plaintiff John Smith is the father of Addison Smith, an inmate who committed suicide at the South Central Correctional Center ("SCCC"), a private prison in Clifton, Tennessee. He asserts claims as his survivor and his next of kin.

6. Plaintiff Soynia Smith is the mother of Addison Smith. She asserts claims as his survivor and his next of kin.

7. Defendant CoreCivic, Inc. is a private prison company headquartered in Nashville, Tennessee.

8. Defendant Damon Hininger is the chief executive officer of CoreCivic, Inc.

9. Defendant Grady Perry is the warden of SCCC.

10. Defendant Eddie Johnson is an assistant warden of SCCC.

11. Defendant Jason Whitehead was a correctional officer at SCCC at all times relevant. He was the captain on duty when Addison died.

12. Defendant Ashley Ackerman was a correctional officer at SCCC at all times relevant. She was the sergeant overseeing Addison's unit when Addison died.

13. Defendant Christopher Williams was a senior correctional officer at SCCC at all times relevant. He was working in Addison's unit when Addison died.

14. Defendant Logan King was a correctional officer at SCCC at all times relevant. He was working in Addison's unit when Addison died.

15. Defendant Joshua Ray was a correctional officer at SCCC at all times relevant. He was working in Addison's unit when Addison died.

16. Defendant Jenny Ratliff was a correctional officer at SCCC at all times relevant. He

was working in Addison's unit when Addison died.

17. Defendant Ledia Alva was a correctional officer assigned to SCCC at all times relevant. She was working in Addison's unit when Addison died.

18. Defendant William Lyons was a mental health counselor at SCCC at all times relevant. He was assigned to care for Addison.

19. Defendant J. Scott Long was a mental health counselor at SCCC at all times relevant, and he also provided mental health services to Addison.

20. Defendant Mark Sigler, Ph.D., is a clinical psychologist at SCCC who was assigned to care for Addison.

21. Defendant Elaine Bloodgood, Ph.D., is a clinical psychologist who oversees mental healthcare at SCCC.

22. Defendant Andrea Steadman is a psychiatric nurse practitioner who was assigned to care for Addison.

23. Defendant Kevin Turner, M.D., is a psychiatrist who was responsible for supervising Defendant Steadman at all times relevant.

24. Defendant Marcayus Rose is an inmate currently incarcerated at Troutsdale Turner Correctional Facility who was Addison's cell mate at SCCC and who raped Addison four days prior to Addison's suicide.

Facts

25. In July of 2019, Addison was transferred from Trousdale Turner Correctional Center ("TTCC") to SCCC. Both facilities are owned and operated by CoreCivic. In the months before his transfer, Addison had a documented history of suicide attempts and hallucinations, the former dating back to childhood. On July 23, 2019, Addison was seen by an SCCC mental health

counselor, and Addison reported that he had been off his psychiatric medications for two weeks. The counselor made a referral on the date to the facility's psychiatric nurse practitioner, Defendant Steadman. Two days later, a nurse separately referred Addison to the nurse practitioner. Defendant Steadman did not meet with Addison until August 19, 2019, *i.e.*, nearly a month after he was reported to be off his medications. This caused Addison additional, needless suffering, and it likely contributed to his suicide. Defendant Turner was supposed to be supervising Defendant Steadman, but he failed to prevent her malpractice and gross negligence.

26. In mid-August of 2019, Defendant Rose was transferred to the segregation unit at SCCC because he had been harassing other inmates for sex. On August 19, 2019, Defendant Rose coerced Addison into unwanted sex acts by making threats and by telling Addison that he was a ranking member of the Gangster Disciples. Later that day, Addison reported the sexual assault to a guard, and he was transported to a local hospital for an evaluation.

27. On August 22, 2019, the day before Addison's death, he was evaluated by Defendant Sigler, a clinical psychologist and a mental health supervisor at SCCC. On the report form, Defendant Sigler did not answer questions about whether Addison had a history of suicidal behavior, whether Addison was taking psychiatric medications, whether Addison had a history of drug abuse, and whether Addison had a history of psychiatric treatment. Instead, Defendant Sigler put a question mark in between the "yes" and "no" boxes. The evaluation form was not signed until August 26, 2019, *i.e.*, four days after the evaluation and three days after Addison's death. In the notes section, Defendant Sigler claimed that he had not been able to access Addison's medical records. On August 12, 2019, however, Defendant Sigler and Defendant Long signed off on an identical form stating that the answer was "no" to the same questions. Three of the four answers in the August 12, 2019 form were wrong, because Defendant did have

a history of suicidal behavior, he did have a history of psychiatric treatment, and he did have a history of drug abuse. On July 23, 2019, the same form had yet another set of answers to the same question, but that time the answers were correct. The form was signed by Defendant Sigler and Defendant Long. The Plaintiffs allege that Defendants Sigler and Long were not even looking at Addison's mental health history and they did not familiarize themselves with his case, ergo his case was not being treated with the urgency that it required.

28. Defendant Bloodgood is responsible for overseeing mental healthcare at SCCC, and she failed to supervise Defendants Sigler and Long. A quick review of their records would have shown that they were not providing adequate care for Addison. As a result of her failure to supervise, Addison's mental healthcare was haphazard and grossly inadequate. CoreCivic's own records show that Addison was repeatedly put into disciplinary segregation rather than being treated for his severe and ongoing mental health problems.

29. Defendant Rose raped Addison on August 19, 2019, Defendant Lyons was supposed to provide mental health services related to the rape. He did not. After Addison died, Defendant Long caught Defendant Lyons fabricating records to make it appear that he met with Addison after the rape. Defendant Long was confronted by CoreCivic's internal investigators, and he was allowed to resign.

30. As set forth in Agent Jordan's report and Investigator Frakes's report, Defendants Whitehead, Ackerman, Williams, King, Ray, Ratliff, and Alva were correctional officers on duty the day that Addison died. Despite Addison's repeated statements throughout the afternoon and evening of August 23, 2020 that he was thinking about killing himself or intended to kill himself, they did not intervene. Video from the prison shows that Addison hung a towel over the window to his cell at 7:17 p.m. As a result, the Defendant guards and supervisors were unable to perform

safety checks on Addison, who had already been threatening suicide for hours. The Defendant guards did not even discover the towel until 7:52 p.m., and Addison did not respond to their verbal inquiries. Despite the clear and imminent danger, the Defendant guards and supervisors did not make entry to Addison's cell until 8:23 p.m., when he was found hanging. By then, Addison could not be revived.

31. In the reports of Agent Jordan and Investigator Frakes, Defendants Whitehead, Ackerman, Williams, King, Ray, Ratliff, and Alva give conflicting answers about what happened on the date of Addison's death. According to prison logs, Addison had not been provided any food the entire day. Agent Jordan noted that the Defendants gave conflicting accounts about whether Addison had been provided food, but the Defendants acknowledged that Addison had been threatening to kill himself if he was not provided a meal tray. According to the autopsy report, no food was found in Addison's stomach. Defendant Ackerman, a supervisor, admitted that she thought Addison was bluffing when he threatened to kill himself, and therefore she did not take his threats seriously. She was terminated by CoreCivic, but none of the other guards or supervisors were terminated.

32. Investigator Frakes's investigative report on the rape is a clear example of the culture of deliberate indifference (and cover-up) fostered by Warden Perry at SCCC and by CoreCivic generally. The standard form completed by Ms. Frakes included a list of questions. Question 1 asked whether the rape was motivated by things such as race, ethnicity, gang affiliation, etc., and if the answer was "yes," what could be done to prevent the problem from reoccurring. Ms. Frakes simply answered "No." In reality, her own records showed that Addison, a white male, reported that he was raped by a senior leader of an African-American criminal gang. Question 2 asked, "Was any information available that should or could have alerted staff that the incident

may occur?" She answered "No" despite the fact that Defendant Rose had been put into segregation *precisely because* he was pressuring other inmates for sex. Most of her remaining answers are comparably absurd, yet the whitewash / report was approved by Defendant Johnson and Defendant Perry on September 11, 2019. Such reports are mandated by the federal Prison Rape Elimination Act, and they are designed to reduce the number of future sexual assaults, yet Ms. Frakes, Defendant Johnson and Defendant Perry treated the whole thing like a joke. In other words, Defendants Johnson and Perry are deliberately indifferent to prison rape at SCCC.

33. Agent Jordan was so appalled by what he discovered that he referred Defendants Ackerman and Lyons to Brent A. Cooper, the district attorney for Wayne County, for criminal prosecution. Unfortunately, Mr. Cooper has shown no interest in the case. CoreCivic's prisons are primarily located in rural counties, and they are often one of the largest local employers, which may explain why Mr. Cooper is not interested. Furthermore, Tennessee's small-town prosecutors generally do not care whether an inmate's death was the result of a crime.

34. Mr. Smith's death was part of a pattern. Prior to his death, CoreCivic paid millions in settlements around the United States because (1) it routinely understaffed its correctional facilities, inevitably resulting in anarchy, assault, murder, and suicide; and (2) it routinely failed to provide adequate medical and mental health care to inmates. The understaffing is particularly problematic because criminal gangs are practically running many of CoreCivic's facilities, including SCCC. Dangerous gang members like Defendant Rose are not properly segregated from other inmates, resulting in more assaults and sexual assaults. Inmates have further alleged that some of CoreCivics guards belong to the same criminal street gangs as some of the inmates.

35. In 2016, CoreCivic and its directors were sued by company shareholders because, among other things, the company misrepresented its pattern of understaffing and poor medical

care, which ultimately led the Federal Bureau of Prisons to cancel its business relationship with Core Civic. Notwithstanding these and numerous other warnings, CoreCivic continued to provide inadequate staffing, supervision and medical care at its facilities, including SCCF.

36. Under the leadership of Defendant Heninger, CoreCivic has an established history of putting profits ahead of the health and safety of inmates. According to a 2011 lawsuit filed by the American Civil Liberties Union, for example, inmates referred to CoreCivic's Idaho Correctional Center as "Gladiator School" because the understaffing led to such a violent atmosphere at the prison. CoreCivic settled the lawsuit with the ACLU, agreeing to provide minimum staff levels, but the company was held in contempt of court in 2013 because it violated the agreement and falsified records to misrepresent the number of guards on duty. In 2014, the FBI opened an investigation of the company based on its billing for "ghost employees," Idaho Governor Butch Otter ordered state officials to take control of the prison, and the company paid the state $1 million for understaffing the prison.

37. On or about February 23, 2017, a federal jury found that CoreCivic had violated inmates' Eighth Amendments rights to be free from cruel and unusual punishment by being deliberately indifferent to the serious risk posed by the company's long-standing practice of understaffing the Idaho Correctional Center. The jury did not award damages, however, because it found that the inmates' particular injuries were caused by other factors.

38. At an Oklahoma prison operated by CoreCivic, ten prisoners were involved in a fight on February 25, 2015 that left five with stab wounds. The following month, eight more were involved in another stabbing incident. In June of that year, thirty-three gang members fought with weapons and eleven prisoners were sent to a hospital. On September 12, 2015, four inmates were killed during a riot at the same facility. Inmates alleged that gangs were effectively

allowed to run the prison. According to an investigation by the Oklahoma Department of Corrections, video evidence of the September 12, 2015 incident from three cameras at the facility was recorded over or deleted by CoreCivic employees. Two guards were later indicted for bringing drugs and other contraband into the prison, including one of the guards accused of failing to act during the riot. Between 2012 and 2016, one-third of all homicides in Oklahoma prisons occurred at two CoreCivic facilities, though they held just over 10 percent of the state's prison population.

39. In August of 2016, the Office of the Inspector General ("OIG") of the U.S. Department of Justice found widespread deficiencies in staffing and medical care at facilities operated for the federal Bureau of Prisons by private contractors, including those operated by CoreCivic. As a result, the Department of Justice indicated that it would phase out its relationships with private prisons. That, in turn, led to the shareholder lawsuit described above. In a separate report released on April 25, 2017, OIG found widespread understaffing at a detention facility in Leavenworth, Kansas operated by CoreCivic for the U.S. Marshals Service, with vacancy levels reaching as high as 23 percent between 2014 and 2015. Earlier, the company tried to hide the fact that it was packing three inmates into two-inmate cells at Leavenworth, contrary to prison regulations. The following excerpt appears in the April 25, 2017 OIG report:

> In 2011, without the knowledge of the [U.S. Marshals Service], the [Leavenworth Detention Center or "LDC"] took steps to conceal its practice of triple bunking detainees. LDC staff uninstalled the third beds bolted to the floor of several cells designed for two detainees and removed the beds from the facility in advance of a 2011 American Correctional Association (ACA) accreditation audit. A subsequent CoreCivic internal investigation revealed that this may have also occurred during other ACA audits of the LDC.

The Plaintiffs restate the foregoing allegations as their own.

40. In May of 2012, a riot at a federal prison operated by CoreCivic in Natchez, Mississippi resulted in the death of a guard and injuries to approximately 20 inmates and prison staff. OIG investigated and alleged the following in a report released in December of 2016:

> The riot, according to a Federal Bureau of Investigation (FBI) affidavit, was a consequence of what inmates perceived to be inadequate medical care, substandard food, and disrespectful staff members. A BOP after-action report found deficiencies in staffing levels, staff experience, communication between staff and inmates, and CoreCivic's intelligence systems. The report specifically cited the lack of Spanish-speaking staff and staff inexperience.
>
> Four years after the riot, we were deeply concerned to find that the facility was plagued by the same significant deficiencies in correctional and health services and Spanish-speaking staffing. In 19 of the 38 months following the riot, we found CoreCivic staffed correctional services at an even lower level than at the time of the riot in terms of actual post coverage. Yet CoreCivic's monthly reports to the BOP, which were based on simple headcounts, showed that correctional staffing levels had improved in 36 of those 38 months.

The Plaintiffs adopt the foregoing allegations as their own.

41. A state audit released in 2017 found that Whiteville Correctional Facility (operated by CoreCivic) needed 79 officers to cover 17 positions during a shift, but on average the facility provided only 57 officers per shift. The same audit found systemic problems at Hardeman County Correctional Center ("HCCC") and TTCC, including understaffing and gang violence. The audit further noted that information provided by CoreCivic concerning TTCC and HCCC was so incomplete that it was not possible to determine the accuracy of staffing levels. The Plaintiff alleges that CoreCivic deliberately provided incomplete information in order to disguise the fact that it was understaffing both facilities.

42. On December 12, 2017, a former guard at TTCC testified before a legislative committee that she resigned from the company in September after witnessing two inmates die from medical neglect during the seven months that she worked for the company. Ashley Dixon told lawmakers that in one instance she pleaded with her superiors for three days to help a dying

inmate, but to no avail, and her subsequent complaints were ignored by company officials.

43. The Plaintiffs allege that suicides in CoreCivic facilities are the result of deliberate indifference, particularly because of its policies of (1) inadequate inmate supervision and (2) providing inadequate mental health care. On August 30, 2016, for example, inmate Thomas Shane Miles was allowed to hang himself in an Indiana jail operated by CoreCivic despite two suicide attempts in the previous four days. On May 3, 2017, immigration detainee Jean Jimenez-Joseph was able to hang himself at a Georgia facility operated by CoreCivic, despite the fact that he was supposed to be on suicide watch. At the same facility less than two years later, another immigrant on suicide watch, Efrain De La Rosa, was nonetheless able to hang himself. In 2018, the family of Jose de Jesus Deniz-Sahagun filed suit against CoreCivic because he was allowed to kill himself at Eloy Detention Center, an immigrant detention facility operated by CoreCivic. According to a February 24, 2018 story in the *Pinal Central* newspaper,

> His was the fifth suicide reported at the Eloy facility since the mid-2000s, a high number compared to other detention centers across the country.
>
> The detainees who preceded Deniz-Sahagun hanged themselves with bed sheets or shoelaces.
>
> An analysis by National Public Radio in 2016 determined that the prison had the highest number of deaths in the country. The *Arizona Republic* made the same determination in 2015.

On December 6, 2018, Ross Hamilton Anderson was found hanging in his cell at Trousdale-Turner.

44. The Plaintiffs allege that the foregoing incidents actually understate the problem. A scathing audit released by the Tennessee Comptroller on January 10, 2020 found that CoreCivic had not properly recorded information about accidents, illnesses, and traumatic injuries at two of its facilities in Tennessee. Likewise, nurses at two CoreCivic facilities failed to monitor inmates

to insure they were taking their medications, increasing the likelihood that mentally-ill and suicidal inmates would skip their medications. The same audit found that Whiteville Correctional Facility, which is operated by CoreCivic, was missing nearly one-third of its medical and mental health personnel during two different audit periods, and that homicides were two times more likely in CoreCivic facilities than in state-operated facilities.

45. The foregoing incidents – and others like them – demonstrate that CoreCivic, its wardens, its senior officers, and its directors adopted and enforced a corporate policy of deliberate indifference to inmate health and safety, specifically illustrated by inadequate inmate supervision and inadequate medical and mental health care for inmates, all for the purpose of increasing the company's profits, and notwithstanding the fact that such practices consistently led to riots, rapes, assaults, suicides, murder, and mayhem. The rape and suicide of Addison Smith were predictable consequences of this corporate policy.

46. The directors and senior officers of CoreCivic knew that inadequate supervision, inadequate mental health and medical care, inadequate training, and improper inmate segregation practices were rampant at the company's facilities, and they did not make reasonable efforts to change corporate policies, supervise offending employees, or counteract the threats to inmate safety. This is evidenced by the fact that most of the employees who played a role in Addison's death were not terminated.

Claims

Count 1: Civil Rights Violations

47. All prior paragraphs are incorporated herein by reference.

48. The Plaintiffs bring claims against all Defendants except Defendant Marcayus Rose under 42 U.S.C. §1983 because they violated Addison Smith's Eighth Amendment right to be

free from cruel and unusual punishment. Specifically, they failed to protect him from rape and self-harm, and they failed to provide adequate treatment for his mental illness.

Count 2: Wrongful death

49. All prior paragraphs are incorporated herein by reference.

50. The Plaintiffs bring claims of wrongful death against all of the Defendants.

Count 3: Medical malpractice

51. All prior paragraphs are incorporated herein by reference.

52. The Plaintiffs bring claims of medical malpractice against all of the Defendants except Defendant Marcayus Rose.

Count 4: Gross Negligence

53. All prior paragraphs are incorporated herein by reference.

54. The Plaintiffs bring claims against all of the Defendants except Defendant Marcayus Rose for gross negligence leading to the death of Addison Smith.

55. The Plaintiffs bring claims against Defendant CoreCivic for gross negligence leading to the rape of Addison Smith.

Count 5: Negligence

56. All prior paragraphs are incorporated herein by reference.

57. The Plaintiffs bring claims against all of the Defendants except Defendant Marcayus Rose for negligence leading to the death of Addison Smith.

58. The Plaintiffs bring claims against Defendant CoreCivic for negligence leading to the rape of Addison Smith.

Count 6: Assault

59. All prior paragraphs are incorporated herein by reference.

60. The Plaintiffs bring claims against Defendant Rose for sexually assaulting Addison. Defendant CoreCivic is also liable for the sexual assault insofar as placed Defendant Rose in the same call as Addison despite the known danger.

Request for Relief

61. The Plaintiffs respectfully pray that upon a final hearing of this case, judgment be entered for them against the Defendants, for actual and punitive damages together with pre-judgment interest at the maximum rate allowed by law; post-judgment interest at the legal rate; costs of court; attorney fees; and such other and further relief to which the Plaintiffs may be entitled at law or in equity.

THE PLAINTIFFS DEMAND A JURY TRIAL.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that I filed a copy of the Plaintiffs' First Amended Complaint with the Court's ECF system on August 19, 2020, resulting in automatic notification to Nathan Tilly (ntilly@pgmfirm.com) and James Pentecost (jpentecost@pgandr.com), counsel for the Defendants.

/s/ Janet H. Goode
Janet H. Goode

Exhibit 1

Investigative Report of Nicky Jordan

INVESTIGATIVE REPORT

Case #:	**Case Agent:**	**Activity Date:**	**Prepared Date:**
PRI 19-192	Nicky Jordan, Special Agent	August 23, 2019	October 28, 2019

Prepared by:	**Supervisor Name, Title**
Special Agent, Nicky Jordan, September 11, 2019	Joseph Frye, Acting SAC

Report Re:
On August 23, 2019 Tennessee Department of Correction inmate **Addison SMITH #571191** was discovered by South Central Correctional Staff; hanging inside his single man cell. An investigation was initiated due to automatic jurisdiction protocol by the Tennessee Department of Correction Office of Investigations and Compliance. TDOC Special Agent Nicky Jordan was assigned the case.

SYNOPSIS:

On August 23, 2019, at approximately 10:00 PM TDOC Special Agent (SA) Nicky Jordan was notified of a possible suicide of TDOC inmate **SMITH #571191** at the South Central Correctional Facility (SCCF) (operated by Core Civic) located in Clifton, Tennessee. SA Jordan made notifications and went to the SCCF to conduct an investigation. SA Jordan proceeded to the Wayne County Medical Center to conduct a visual examination of the body of **SMITH**. SA Jordan noted no injuries consistent with a fight or struggle. There was noted bruising around the neck consist with a ligature mark. SA Jordan took (12) photos of the body (**Exhibit 1**). There were no puncture wounds or slashes found on the body.

SA Jordan went to the SCCF and took (24) photos of cell A107 (**Exhibit 2**) assigned only to SMITH. SA Jordan noted the cell did not have a sign of a fight or struggle, no suicide notes were discovered. A ligature made from what was identified as a torn bed sheet was discovered tied to a ventilation vent above/ to the left facing the toilet.

SA Jordan reviewed several hours of videos of Skylab "A" pod in which **SMITH** was assigned; the video does not contain audio (**Exhibit 3**). SA Jordan noted **SMITH** inside his cell alive which can be viewed by the video, there was no one noted entering the cell prior to him being discovered hanged. Video review supports staff witnesses accounts of events where as **SMITH** covers his cell door window to obstruct anyone's view.

SA Jordan obtained eleven written statements from staff and two from inmate witnesses. Ashley **ACKERMAN** provided a written statement she was notified **SMITH** was making statements he was going to hang himself. **ACKERMAN** stated she reported

another inmate in cell 104 claiming he was going to commit suicide but neglected to report **SMITH** (**Exhibit** 4).

SA Jordan obtained a written statement from Officer Logan King who stated on 8-23-2019 at 1900 hours he performed a security check at which time **SMITH** told him he wanted to kill himself. King stated he reported this to the Senior and was told she knew this and it had been reported to her by Senior Williams he (**SMITH)** had been doing this all day. King stated later he went back to cell A-107 and **SMITH** had covered his cell door window and was not talking. This was reported to Senior **ACKERMAN** who stated to have **SMITH** take the blind down. Officer Ray and King went to the cell and **SMITH** would not answer. King stated he looked over the blind and saw **SMITH** unresponsive and a rope around his neck, this was reported.

SA Jordan obtained a written statement from Officer Joshua Ray who reported on August 23, 2019 at approximately 19:10 hours inmate **SMITH** told him he was going to kill himself, Ray stated he reported this to Sergeant **ACKERMAN.** Ray stated at approximately 20:00 hours officer King and Ratliff and himself (Ray) knocked on **SMITH's** cell door and there was no response. Ray stated he peered through the pie flap (an opening at the midlevel door where food is passed) and saw **SMITH** hanging. Ray stated he immediately informed Sergeant **ACKERMAN** and she told the officers to post outside the cell door.

SA Jordan obtained a written statement from SCCF Acting SORT Commander Colton Wilkerson. Who went to Cell A-107 and found **SMITH** hanging in the cell and SORT opened the cell door, began chest compressions and placed **SMITH** on a stretcher whom was taken to medical.

SA Jordan obtained a written statement from SCCF SORT member Abioaum **ARE IBRAHIM** who stated on 8/23/2019 at approximately 20:20 hrs SORT was called to A-107 and found **SMITH** hanging. The cell door was opened , medical was called and CPR was started.

SA Jordan retrieved the TDOC Segregation Unit Record (Form CR-2857-2) and noted on Friday August 23, 2019 there were no entries for Breakfast, Dinner, Supper, Showers, Exercise Time, Supervisor Signature or Programs notes, medical staff did note they saw **SMITH** on first shift. (**Exhibit 5**). SA Jordan retrieved **SMITH's** recorded phone calls and preserved them on disc (**Exhibit 6**).

"B" shift segregation supervisor **Ashley ACKERMAN provided** a statement it was reported to her inmate **SMITH** was going to kill himself if he did not get a food tray. **ACKERMAN** stated Senior **Christopher WILLIAMS** was present and stated **SMITH**

had been saying this all day and had received his food and not to give him a tray. **ACKERMAN** stated she continued to get reports from her staff **SMITH** was going to kill himself (no notifications or referrals were made by **ACKERMAN** in accordiance with TDOC policy 113.88) **(Exhibit 7). ACKERMAN** reported **SMITH** had covered his door to Captain **Jason WHITEHEAD** because he wanted a food tray. It was ordered by Shift Commander **WHITEHEAD** that **SMITH** was to be given a food tray; however **SMITH** had now placed a towel over the window of his cell door. Staff reported this to **ACKERMAN,** whom was never seen on video going to **SMITH's** cell to defuse or check on the reported situation.

ACKERMAN called the shift commander requesting SORT come to the unit to open the cell door of **SMITH.** Shift Commander **WHITEHEAD** stated **ACKERMAN** called him requesting SORT to deal with a covered cell door window, but never mentioned **SMITH** was making suicidal threats. Video reviewed noted at 7:17 PM, **SMITH** places a window covering over the cell window door. At 7:52 PM while conducting security checks staff notice **SMITH** has a covered cell door window.

Staff reported multiple attempts were made by correctional staff to have **SMITH** remove the window covering beginning at approximately 7:52 PM until 8:23 PM when the cell door is finally opened (See **EXIBIT 8**- Timeline) there was no verbal response from **SMITH**. **SMITH** was discovered hanging inside his cell; he was placed on a stretcher at 8:28 PM with medical staff performing life saving measures.

SA Jordan secured a copy of the medical and mental health records of **SMITH.** It was noted there were self-reported multiple suicide attempts since age 10. It was reported in 2018, **SMITH** was found hanging and cut himself reportedly because of his fiancé passing away. Multiple suicidal intentions beginning in 2019, documented statements were discovered in **SMITH's** mental health file where he stating he was unable to do 14 years in prison.

It should be noted on August 21, 2019, SA Jordan interviewed **SMITH** after he claimed he had been sexually assaulted by TDOC inmate **Marcayus ROSE** #426230. SA Jordan ordered Core Civic to transport **SMITH** to the Jackson Madison County General Hospital for a sexual assault collection kit to be collected. SA Jordan conducted a follow up interview the following morning at the South Central Correctional Facility and had **SMITH** placed in a single man cell until the investigation was completed. Inmate **ROSE** was transported from South Central Correctional Facility to TTCC the same day. This case was/is being investigated as a Prison Rape Elimination Act (PREA) by the Tennessee Department of Correction Office of Investigations and Compliance at the time of the suicide. This investigation discovered (TDOC Policy 502.06 was not followed

and false information was being attempted to be entered into a mental health file by Core Civic Mental Health Worker **William LYONS;** (concerning mental health intervention). A copy of Core Civic disciplinary actions against employees or those allowed to resign was requested by SA Jordan but at the time of this report not provided.

A copy of this report will be provided to the District Attorney's office for review for any potential criminal charges against any employee or Core Civic.

DEFENDANT(S):

ACKERMAN, Ashley – 110 Lake Circle, Savannah, Tennessee

Lyons, William- Mental Health Specialist- 2106 Covenington Drive, Florence Alabama

VIOLATION(S):

TDOC Policies 113.88

TDOC Policies 506.02

JUDICIAL DISTRICT(S):

DATE/TIME/PLACE

EXHIBIT(S):

Exhibit 1: [12 photos taken of Addison **SMITH** at the Wayne County Medical Center]

Exhibit 2: [24 photos taken of cell A-107 assigned to Addison **SMITH** at the time of the incident]

Exhibit 3: [Video of Sky Lab A Pod]

Exhibit 4: [Written Statements] ASHLEY ACKERMAN
Exhibit 5- Segregation Unit Record
Exhibit 6- Smiths Phone calls
Exhibit 7- Policy 113.88
Exhibit 8- Time line
Exhibit 9- medical - Mental health Records
Staff

Addison Smith Summary

This summary is being provided to the Medical Examiner's Office. This summary is not all inclusive nor is the final work product. This summary is preliminary findings and the investigation is ongoing.

On August 23, 2019, I (Tennessee Department of Correction Special Agent) Nicky Jordan responded to the South Central Correctional Facility (SCCF) in Clifton, Tennessee to investigate a suicide. I initially went to the Wayne County Medical Center, located in Waynesboro, Tennessee where I performed a visual examination and photographed the body of TDOC inmate Addison Smith. During the visual examination , I did not note any injuries consistent with a fight or assault. I did observe what appeared to be a ligature marks around his neck.

The body was sent to the Medical Examiner's office for an autopsy. I proceeded to the South Central Correctional Facility to conduct an investigation. The cell was examined and photographed. A ligature was tied to a vent above the toilet. Smith was assigned to a single occupant cell. The cell did not contain a suicide note nor was a letter discovered in outgoing mail. Multiple statements were taken from staff concerning SMITH making suicidal statements during their shift he was going to kill himself over a food tray.

I reviewed video and found SMITH moving about his cell and covering his cell door window. I observed staff outside his cell door at times they relate in their statements attempting to have him remove the door- window covering. I observed staff eventually open the cell door and remove SMITH.

A review of the medical-mental health files of SMITH found multiple suicide attempts beginning at the age of 10 which were reported by SMITH. I spoke to SMITH's mother who confirmed at a young age SMITH drew pictures of himself hanging. Previous to this a few days prior SMITH claimed he was sexually assaulted by another inmate- that investigation was ongoing at the time of the death. This investigator found any injuries inflicted to SMITH was inflicted upon himself whether intentional or attention seeking. The investigation is ongoing concerning staff negligence however SMITH at this time is responsible for the injuries he received.

STATE OF TENNESSEE
DEPARTMENT OF CORRECTION
INTERNAL AFFAIRS
100 BOMAR BOULEVARD
NASHVILLE, TENNESSEE 37209-1100
TELEPHONE (615) 741-7144
FAX (615) 741-0758

Crossville Office
53 N. Main Street, Suite 106
Crossville, TN 38555
Telephone (931) 707-0024
FAX (931) 707-5242

Jackson Office
3004 Greystone Square
Jackson, TN 38305
Telephone (731) 661-6284
FAX (731) 661-6288

MEMORANDUM

TO:
Director of Internal Affairs
Tennessee Department of Correction

FROM: NICKY JORDAN, Special Agent

DATE: 12/06/2019

SUBJECT: Primary Investigation Evaluation Concerning

Name: MARCAYUS ROSE - Inmate 00426230

Investigation Number: PRI-19-191

Date Initiated: 8/30/2019

1. **ALLEGATION(s):**
   PREA , It is alleged on August 21, 2019 SCCF inmate Addison SMITH #571191 was sexually assaulted by TDOC inmate Marcayus ROSE #426230 inside their cell at segregation.
2. **INVESTIGATIVE ACTIONS TAKEN:** See Appendix A
3. **INVESTIGATIVE RESULTS:** See Appendix B

RECOMMENDATION:

Core Civic better manage suspected sexual aggressive inmates. A review of the SART team to ensure they are in compliance and not pencil whipping reports. Inmate Smith was not seen by mental health after making his claims as per the SART protocol. Smith later committed suicide, after claiming he was suicidal staff did not take him serious, it is recommended shift commanders make personal rounds and observations during each shift to ensure inmates are being properly cared for.

APPENDIX B

INVESTIGATIVE RESULTS:

This Investigation was authorized

Inmate Addison Smith # 571191 claimed his cell partner Marcayaus Rose #426230 forced him to perform oral sex on him on or about August 19, 2019. Rose had just been segregated from the annex with claims he was sexually approaching inmates. This claim was through unknown inmates who sent a unsigned note to the administration. Smith was interviewed by SA Jordan and taken to the Jackson Madison County General Hospital where a sexual assault kit was collected.

On the following day SA Jordan interviewed inmate Rose who denied the allegation. Rose was moved to TTCC during the investigation Smith maintained his claim and was placed in a single man cell. During the time in the single man cell Smith hung himself. The DA was contacted and stated there was no victim to testify and the case can not be prosecuted.

See Case File.

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FAX (731) 661-6288

MEMORANDUM

TO:

Director of Internal Affairs
Tennessee Department of Correction

FROM: **NICKY JORDAN, Special Agent**

DATE: **11/01/2019**

SUBJECT: Primary Investigation Evaluation Concerning

Name: **ADDISON SMITH - Inmate 00571191**
ASHLEY N. ACKERMAN - Staff ID ACKEAS01
WILLIAM M. LYONS - Staff ID LYONWI01

Investigation Number: **PRI-19-192**

Date Initiated: **8/30/2019**

1. **ALLEGATION(s):**

   (2) Suicide, On August 23, 2019 SCCF inmate Addison SMITH #571191 was found hanging in his single cell in segregation at the SCCF.

2. **INVESTIGATIVE ACTIONS TAKEN:** See Appendix A

3. **INVESTIGATIVE RESULTS:** See Appendix B

RECOMMENDATION:

Core Civic provide all requested information to TDOC when requested.

APPENDIX B

INVESTIGATIVE RESULTS:

This Investigation was authorized.

SCCF inmate Addison Smith #571191, was found hanging in his single man cell at SCCF on August 23, 2019. Tennessee Department of Correction Special Agent Nicky Jordan investigated the incident. The investigation discovered multiple violations by Core Civic Employee Ashley Ackerman who was in charge of staff and the segregation unit on the evening of August 23, 2019. Ackerman failed to follow up on reports and report to mental health staff inmate Smith was stating he was going to kill himself. Ackerman failed to act when advised by staff Smith refused to remove a covering from his cell door. Ackerman failed to render aid after being told by her staff Smith was hanging in his cell; and waited several minutes for the SART Team to arrive.

In a related note it was discovered Mental Health Specialist William Lyons had failed to provide mental health intervention to Smith who had alleged he was a sexual assault victim. Lyons attempted to falsify documentation into Smith's mental health file after the death of Smith. SA Jordan has requested multiple times for William Lyon's and Ashley Ackerman dismissal files and Core Civic has not provided either. Lyon's who lives in Alabama has not been interviewed.

See Case File

TENNESSEE DEPARTMENT OF CORRECTION
CHAIN OF POSSESSION
CONTRABAND

Date: 8-24-19 Control Number:

Time: 3:00 A.M. / P.M. Disciplinary Report # _____

Recovered from:

Name: _____ Number: _____
(last) (first) (mi) (if applicable)

Check One: ☐ Offender (see 504.01) ☐ Visitor
☐ Employee ☐ Other

Description of Evidence and Recovery:

2 Copies of footage of incident with (4 Disc) I/m Smith, Addison 571191

Contraband Discovered By:

Jennie Roberts (Full name – signature)

Jennie Roberts (Full name – type or print)

FINAL DISPOSITION OF CONTRABAND

Date: _____ Time: _____ A.M. / P.M. Location: _____

Disposing Official: _____

Witness: _____ Witness: _____

Method of Disposal _____
(incineration, flushing, etc.)

DATE	RELEASED BY	RECEIVED BY	REASON FOR CHANGE
8/24/19	Jennie Roberts Signature Jennie Roberts STS Name & Title (print)	Signature Name & Title (print)	

DATE	RELEASED BY	RECEIVED BY	REASON FOR CHANGE
	Signature Name & Title (print)	Signature Name & Title (print)	

CR-3255 (Rev. 5-00)

Exhibit 2

Investigative Report of Jessica Frakes

CoreCivic

November 11, 2019

TO: Special Agent Nicky Jordan
Tennessee Department of Correction
Office of Investigations and Compliance
37 Executive Drive
Jackson, TN 37305

FROM: Mandy Ellis
Senior Director, Investigations
General Counsel Office of Investigations, CoreCivic

RE: Facility Investigation number 2019-0108-015 TDOC Inmate Addison Smith #571191

SA Jordan:

Per your request, here is the information related to the investigation conducted by South Central Correctional Center Investigator Jessica Frakes related to the suicide of TDOC inmate Addison Smith #571191, which occurred on August 23, 2019.

EXECUTIVE SUMMARY[1]:

On August 23, 2019, a medical code was called in HA107 in the segregation unit due to Tennessee Department of Correction (TDOC) Inmate Addison Smith 571191 being found hanging and unresponsive in his cell.

On August 24, 2019, Warden Grady Perry authorized Facility Investigator Jessica Frakes to investigate this allegation.

The investigation consisted of interviewing multiple staff members, one inmate interview, reviewing Milestone video footage, monitoring the GTL inmate phone system, reviewing the inmate's medical file, TOMIS (Tennessee Offender Management Information System) review, and a review of the 5-1 incident reporting system.

[1] *This is an investigatory document pertaining to a correctional institution, and is exempt under the Tennessee Open Records Act pursuant to T.C.A. § 10-7-504(a)(2)(A) and (a)(8).*

CoreCivic

The investigation concluded that Senior Correctional Officer Ashley Ackerman failed to respond timely to staff reports of Inmate Smith's threats of self-harm on August 23, 2019. This is supported by her own admission as well as the statements of multiple staff.

CONCLUSION SUMMARY:

Based on the review of Milestone and the statements from multiple staff members, Senior Correctional Officer Ashley Ackerman failed to appropriately respond to Inmate Smith's threats of self –harm on August 23, 2019. Ackerman stated during an interview on August 24, 2019, that she did not take inmate Smith's threats of self-harm seriously because she believed he was "playing a game" to obtain an extra food tray.

CoreCivic

November 11, 2019

TO: Special Agent Nicky Jordan
Tennessee Department of Correction
Office of Investigations and Compliance
37 Executive Drive
Jackson, TN 37305

FROM: Mandy Ellis
Senior Director, Investigations
General Counsel Office of Investigations, CoreCivic

RE: GCOI #2019-8-1177 case summary

SA Jordan:

Per your request, here is the information related to the investigation conducted by South Central Correctional Center Investigator Jessica Frakes on behalf of the General Counsel Office of Investigations regarding former Mental Health Coordinator William Lyons. If you have any questions, please let me know.

EXECUTIVE SUMMARY[1]:

On August 25, 2019, Mental Health Coordinator (MHC) Jeremy Long reported to Internal Affairs Jessica Frakes that he believed Mental Health Coordinator (MHC) William Lyons wrote a mental health note for Inmate Addison Smith TDOC# 571191, but did not actually meet with the inmate.

On August 27, 2019, the allegation was escalated to the General Counsel Office of Investigations (GCOI) by Facility Investigator Jessica Frakes. On August 28, 2019, a formal investigation was directed by GCOI and assigned to Investigator Frakes. The investigation included the review of CR-3431 (Institutional Health Services Referral Form), email printout, and milestone video footage, as well as staff interviews.

[1] *This is an investigatory document pertaining to a correctional institution, and is exempt under the Tennessee Open Records Act pursuant to T.C.A. § 10-7-504(a)(2)(A) and (a)(8).*

CoreCivic

Based on the investigation, the allegation that MHC William Lyons wrote a mental health note for Inmate Addison Smith, but did not actually see him in medical, was supported. Milestone review showed that Inmate Addison Smith exited the Medical Building at 0722 and was secured in his assigned cell (HA107) at 0725, while the medical note was signed for 0730. Additionally, Milestone review showed that MHC William Lyons did not come into South Central Correctional Facility checkpoint until 0726.

BACKGROUND INFORMATION:

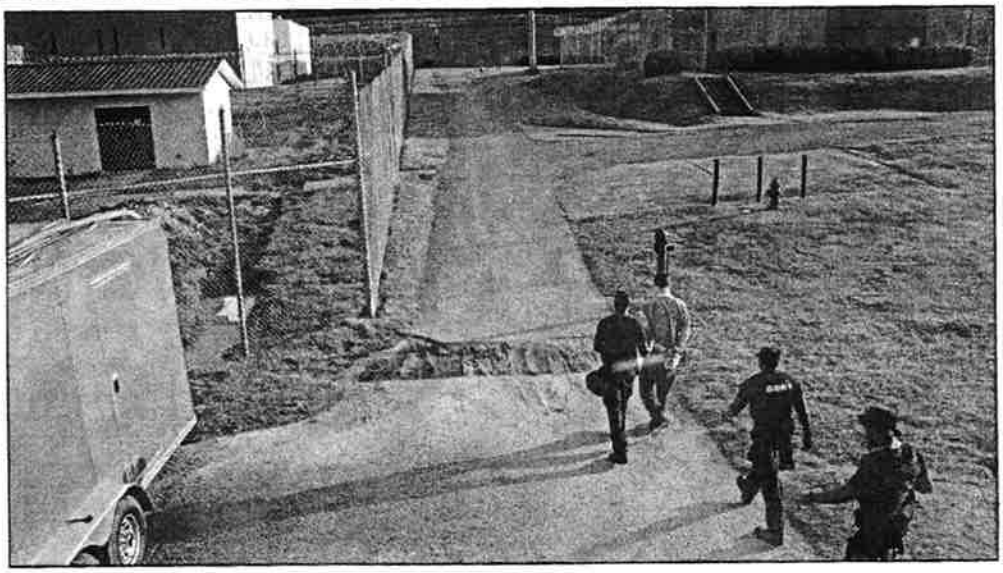
On August 21, 2019, Inmate Addison Smith #571191, who was housed in segregation, made a PREA allegation against his cellmate Marcayes Rose #426230. Inmate Smith alleged that Inmate Rose forced Inmate Smith to perform oral sex on him, due to Inmate Rose being a high ranking me...ber of his affiliation (Gangster Disciple). As a result of t... PREA allegation, a mental health referral was filled out by the facility nursing staff and placed in mental health coordinator Lyons' mailbox, so that Inmate Smith could be evaluated by Mental Health at a later date; due to no mental health staff being onsite. Inmate Smith was escorted to the SCCF medical building and later transported offsite to Jackson Madison General Hospital in Jackson, Tennessee to be evaluated by the Sexual Assault Nurse Examiner (SANE). On August 22, 2019, Inmate Smith was returned back to South Central Correctional Facility and taken back to the Segregation Unit. On August 23, 2019, Inmate Smith successfully committed suicide in the Segregation Unit. On August 24, 2019, MHC Lyons sent an email with a mental health referral attached to an email, stating that he had the mental health note in his office to be filed, because he could not find the chart the day he made the note. This note did not come into question until August 25, 2019, when MHC Jeremy Long reported to Internal Affairs Jessica Frakes that MHC Lyons was acting like he was searching for the mental health note. On August 27, 2019, after his investigation interview, MHC Lyons resigned from South Central Correctional Facility.

CONCLUSION SUMMARY:

Based on the investigation, the allegation that MHC William Lyons wrote a mental health note for Inmate Addison Smith, but did not actually see him in medical, was supported. Milestone review showed that Inmate Addison Smith exited the Medical Building at 0722 and was secured in his assigned cell (HA107) at 0725, while the medical note was signed for 0730. Additionally, Milestone review showed that MHC William Lyons did not come into South Central Correctional Facility checkpoint until 0726. Lyons resigned his employment with CoreCivic on August 27, 2019.

XProtect Smart Client 2016 R3 Surveillance Report

Surveillance Report

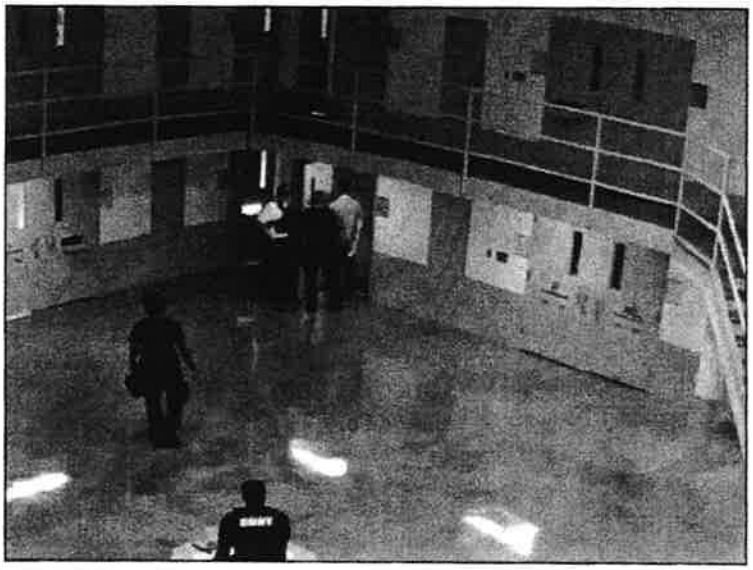


Camera name:	Medical Rear - Camera 2
Image capture time:	8/22/2019 7:22:28 AM (UTC-05:00)
Report print time:	8/25/2019 8:59:42 AM (UTC-05:00)
User:	CORRECTIONSCORP\FRAK0253
User's note:	ADDISON SMITH Being moved To Restrictue Housing Upon Return From Jackson General Hospital 7:22:28 AM NJ

CONFIDENTIAL

XProtect Smart Client 2016 R3 Surveillance Report

Surveillance Report



Camera name:	Skylab A Pod
Image capture time:	8/22/2019 7:25:15 AM (UTC-05:00)
Report print time:	9/11/2019 10:24:45 AM (UTC-05:00)
User:	CORRECTIONSCORP\FRAK0253
User's note:	Inmate Smith being placed inside HA107 after returning from the outside hospital

I/M Smith Being Placed
in His Cell
7:25:15 AM
NJ

CONFIDENTIAL

XProtect Smart Client 2016 R3 Surveillance Report

Surveillance Report

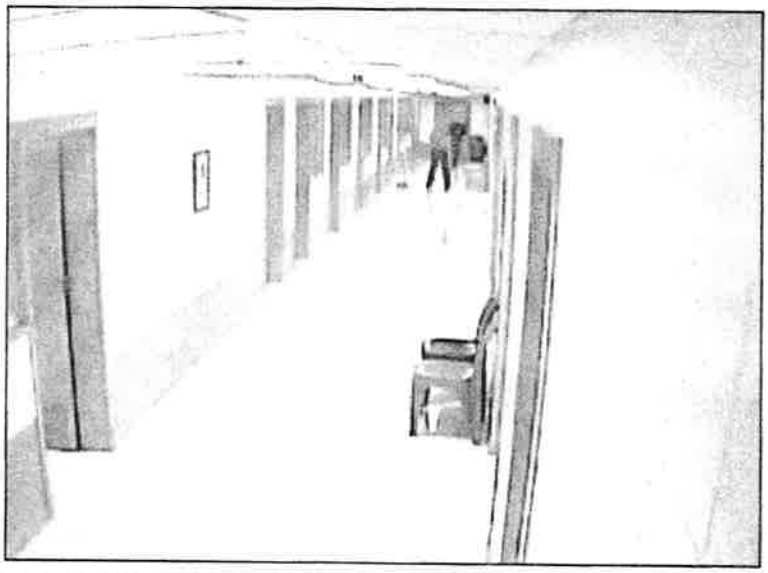
Camera name:	Admin Front Lobby
Image capture time:	8/22/2019 7:26:33 AM (UTC-05:00)
Report print time:	8/25/2019 9:06:29 AM (UTC-05:00)
User:	CORRECTIONSCORP\FRAK0253
User's note:	Lyons at Checkpoint

7:26 AM
William Lyons Arriving
at work and AT
Check Point
NJ

CONFIDENTIAL

XProtect Smart Client 2016 R3 Surveillance Report

Surveillance Report



Camera name:	Medical Hall
Image capture time:	8/22/2019 7:33:15 AM (UTC-05:00)
Report print time:	9/26/2019 10:32:41 AM (UTC-05:00)
User:	CORRECTIONSCORP\FRAK0253
User's note:	Lyons entering the medical building

7:33 AM.
Medical Hall

INCIDENT STATEMENT

Facility	SCCF	Incident Number	
Incident Date	~~08-25-19~~ JS 082419	Incident Time (HRS)	Approx 0900 0930

Person Name	ID Number (Employee #/Inmate #/Civilian ID)	Person Type (Employee/Inmate/Civilian)	Person Role (Witness or Participant)
J. Scott Long MA MHC	G40957384	EMPLOYEE	WITNESS

Housing Location (For Inmates/Residents Only)	

Based on your own knowledge, what did you see, hear, and do?

IN MEDICAL, IN Shared office Space W/ MH/BHA LYONS. This Writer spoke W/ BHA LYONS on this date about paperwork related to a deceased Inmate, Smith, Addison. LYONS came in to present paperwork related to the YM's PREA upon return from the hospital. BHA LYONS searched through his desk as he claimed to be looking for a note related to the event. At Jsc Eventually, he stopped searching and stated that he "would have seen" the YM on the day of his return and then stated that he was trying to imagine what time he saw this YM. This left me with the impression that LYONS did not see/interview the YM in question. The note left in record utilized past tense verbage and reenforced this impression. This writer approached LA with the concern that paperwork had filed fraudulently and that LYONS had not met with the YM in question at all.

Did you receive any injuries? YES or NO (If YES, Explain Below)

Were you evaluated by medical? YES or NO N/A

Printed Name:	J. Scott Long MA MHC		
Signature:	J. Scott Long MA MHC	Date:	8-25-19
Typed By:	J. Scott Long, MA MHC	Date:	8-25-19

This section to be completed by CCA staff if the civilian/other or inmate/resident refused to complete the 5-1C.

Place an "X" in the appropriate box:

	Inmate/Resident refused to complete this 5-1C
	Civilian/Other refused to complete this 5-1C

Employee/Witness Printed Name		Date:	
Employee/Witness Signature			

Employee/Witness Printed Name		Date:	
Employee/Witness Signature			

CONFIDENTIAL

10/3/13

Frakes, Jessica

From: Lyons Jr, William
Sent: Saturday, August 24, 2019 10:21 AM
To: Perry, Grady; Garner, Jammie; Frakes, Jessica; 'Robert.Turman@tn.gov'; Bloodgood Grandy, Elena
Subject: Inmate 571191, Smith
Attachments: Smith 571191.pdf

Here is a copy of the note I made when I saw him. It was not in the chart because I could not find the day I made the note. It was in my office to be filed. If you have any questions, please contact me.

William (Mike) Lyons, MS, ALC
Mental Health Coordinator / Behavioral Health Administrator
South Central Correctional Facility
555 Forrest Ave, Clifton, TN 38425
(931) 676-5346
William.LyonsJr@corecivic.com

CONFIDENTIAL

TENNESSEE DEPARTMENT OF CORRECTION
INSTITUTIONAL HEALTH SERVICES REFERRAL

SCCF
INSTITUTION

☐ MEDICAL
☒ MENTAL HEALTH

INMATE: Smith, Addison — 71191
Last

PRESENTING PROBLEMS: 8.2 in Skylab - no IN is on lamictal for Borderline PD/O also has SZ d — inst collimate for eval

FALSE DOCUMENTATION
LYONS NEVER SAW
I/M SMITH

REFERRED BY: Lyons MC — 0051
Sign — Time

SEND REFERRAL FORM I — ☒ MHA ☐ HSA

RECEIVED BY: Lyons MSE BHA — 8/22/19 — 730pm
Signature/Professional Title — Date — Time

REFERRAL DISPOSITION (Course of Action): P/T dorm post returned from ER hospital. He stated that he overdosed & wanted to go to sleep. "I don't want to talk about it" "I told the investigators" He denied any current suicidal or homicidal thoughts. Will see on 8/27/19 for follow up. He denied the need for counseling, but he is on LOCT.

DATE: 8/22/19 TIME: 730pm

Lyons MSE BHA
Signature/Professional Title

CR-3431 (Rev. 05-15) — Duplicate as Needed — RDA 1100

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PREA CALL – Date 9-3-19 / Time _____ Outcome unsub.

Would Have Remained Open until DNA Labs Back. As well as Follow up interviews. (NJ)

PREA INCIDENT PHONE CALLS

1) **Warden/designee introduces all staff in the room**

2) **Specify the Incident Number and Priority Classification**

Inmate on Inmate Sexual Abuse (IOI SA) Contact between mouth and penis, vulva, or anus 2019-0108-338

Provide summary of the reported incident

On 08/21/2019 at approx. 2116 SCO Laurin, Trevor took inmate Smith #571191 out of his cell to take him to the shower. Once the inmate was removed from his cell he advised SCO Laurin, that he had been sexually assaulted. Inmate Smith alleged his cellmate, inmate Rose, Marcayes #426230 from HD106 forced ...nate Smith to perform oral sex on him. SCO Laurin immediat..., took him to the VG non-contact room, and C/M Dickey notified myself, S/S Warner at 2117. He was escorted to medical by myself S/S Warner and C/M Dickey. Nurse Cynthia McQueen, RN completed the health assessment on inmate Smith #571191. Once the assessment was completed he exited the facility to Jackson General Hospital at approx. 0005 to have a rape kit completed. Sco Mchorris, David and C/O Gregory, Adam were the transporting officers.

Interviewed Smith this evening at EXIT 126 (NJ)

All prea notifications made and protocols followed.

1) **Go through the checklist (14-2 C) to identify all protocols have been followed**
   Attached

2) **Provide investigation activities completed and also whether another jurisdiction is completing an investigation**

Both TDOC OIC and Clifton PD were notified and OIC Jordan did participate

Inmate Smith was interviewed and stated that Inmate Rose made him perform oral sex on him and told him that he was a high ranking gang member and that he would hurt him if he didn't do it. He stated that he kept saying that he was the number 4 in his affiliation. Smith said that he wasn't trying to go anywhere because he liked it at SCCF and he just wanted to let someone know what happened.

PREA CALL – Date _____ / Time _____. Outcome _____

Inmate Rose was interviewed and denied the allegations that had been made against him. He said that he wouldn't do that because he had 5 kids.

Milestone Review

There is no Milestone inside the cell where the allegation took place.

Phone System

Inmate Smith last utilized the GTL phone system on 8-12-19 where he talked to a female who he calls his mother and she told him that his grandfather put $50 on his books and said to tell him not to ask about money. He tells the female to please have the man answer the phone because he need to talk to him abc... some mail.

Inmate Smith utilized the GTL phone system on 8-11-19 where he talks to him mom and she asks him if he is okay and he told her that he was fine and just wanted to tell her goodnight before he gave the phone up. She asked again if he was okay and he tells her that he is just homesick and misses things at home and wishes that he would have done things different. They talk about protective custody and he tells her that he is trying to get PC and that he is currently in the hole. He tells her that he has been thinking about her and that he really misses them. He gets on the phone and talks to a male telling him that he appreciates him for taking care of his mom and that it means a lot. He says he wishes that he could have done things different and he will be around soon enough maybe. He tells him again that he appreciates him taking care of her and tells his mom to take care of herself and that she is going to be okay because she is strong and that she is tough. She tells him that she misses him and he tells her he misses her too and he is fine and he is good. She tells him that he doesn't sound good and he tells her that he promises he is and he is just worried about her and they both sound like they are crying. He tells her to please have grandad answer the phone and that he isn't going to bug him about money he just really wants to talk to him.

Inmate Rose last utilized the GTL phone system on 8-21-19 where he talks about being sent to the hole for nothing. He said that he has done nothing to be locked up and he thinks that someone dropped a kite on him because he hasn't done anything. He tells the female that he is up there for pending investigation and asks her to call Warden Perry or Warden Bryant. He talks about the PREA line and how an inmate can just call and make up some stuff and get you crossed out. He says that he isn't giving anyone a chance to write him up.

PREA CALL – Date _____ / Time _____ Outcome _____

PREA Scores/Incidents

Inmate Smith was last scored at TTCC on 11/14/18 where he scored NA/NA

Inmate Rose was last scored at SCCF on 5/23/19 where he scored NA/NA

Involved Inmates History (TOMIS)

Inmate Smith is a 27 year old white male who is serving a 14 year sentence for contraband in a penal facility, vandalism $1,000-$10,000, Kidnapping, Theft of property $1,000-$10,000, and burglary- other than habitation. He has no documented STG and 7 disciplinary infractions in 2019 for possession of a deadly weapon (2), refusing cell assignment (3), defiance, and refusing/attempt to alter a drug test. He has no PC history and arrived to SCCF on 7-11-19.

Inmate Rose is a 31 year old black male who is serving a 9 year sentence for evading arrest (flight), attempt tampering with evidence, and schedule II drugs: cocaine. He is a confirmed Gangster Disciple and minimum direct custody level. He has had no disciplinary infractions in 2019 and no PC history. He arrived to SCCF on 10-10-18 from BCCX.

3) Medical/Mental Health information based on contacts during incident response
Mental health part

4) Provide information regarding Risk of Sexual Victimization (14-2B or similar tool) completed at intake and/or 30 day reassessment for both the alleged victim and alleged perpetrator

5) Discuss challenges of the case and any corrective actions that may need to be addressed to eliminate future incidents or enhance response.

INCIDENT REPORT

Facility:	South Central	Incident Number:	2019-0108-338-PREA

Incident Date/Time (HRS):	08/21/2019 21:17 hours

Facility Damage:	None

Incident Location:	Facility Property \ Skylab \ Pod: D \ Cell: 106

INCIDENT PRIORITY LIST:

Priority	Priority Description
PREA	Inmate on Inmate Sexual Abuse (IOI SA) Contact between mouth and penis,vulva, or anus

Other Priority Description:	

DESCRIPTION OF INCIDENT:

On 08/21/2019 at approx. 2116 SCO Laurin, Trevo[illegible]ook inmate Smith #571191 out of his cell to take him to the showe[illegible]. Once the inmate was removed from his cell he advised SCO Laurin, that he had been sexually assaulted. Inmate Smith alleged his cellmate, inmate Rose. Marcayes #426230 from HD106 forced inmate Smith to perform oral sex on him. SCO Laurin immediately took him to the VG non-contact room, and C/M Dickey notified myself, S/S Warner at 2117. He was escorted to medical by myself S/S Warner and C/M Dickey. Nurse Cynthia McQueen, RN completed the health assessment on inmate Smith #571191. Once the assessment was completed he exited the facility to Jackson General Hospital at approx. 0005 to have a rape kit completed. Sco Mchorris, David and C/O Gregory, Adam were the transporting officers.

Victim: Inmate Smith, Addison #571191. White/MIR No Confirmed STG- Inmate is segregation for PH-PDW scheduled End Date: 08/27/19
Aggressor: Inmate Rose, Marcayus #426230. Black/MID Confrimed GADI- Inmate is segregation for PIN-WAD Scheduled End Date: 8/23/19

Tdoc Turman and Ado Bryant was notified at 2149. CCC was notified at 2325.(Ticket #AS03)

Inmates/Residents Involved?	Yes

INVOLVED PEOPLE:

Inmate/Resident Name(s) & Number	Jurisdiction	Witness or Participant	5-1C Attached or Refused?	Injuries
ADDISON SMITH (00571191)	TN DOC	Participant	Attached	No

Employee Name(s) & Number	Employee Title	Witness or Participant	5-1C Attached?	Injuries

INCIDENT REPORT

Medical Evaluation Completed?	Yes

HEALTH SERVICES PERSONNEL CONDUCTING EXAMINATIONS:

Name	**Title**
McQueen, Cynthia	Registerd Nurse

Weapons Discovered?	No	**How Many?**	

Weapon Description	**Weapon Location**

Cell Phones Discovered?	No	**How Many?**	

Inmate/Resident Disciplinary Charges Filed?	No

Inmate/Reside... Name(s) & Number	**Segregation and/or PHD**	**Property Inventory Completed**

Incident Videotaped?	N/A		
Name/Title of Camera Operator:			
If Not Recorded, Explain:			
Photos of injuries, contraband, or property?	No	**How Many?**	
If No Photos, Explain:	Inmate was sent out to medical		
Name/Title of Photo Taker:			

EVIDENCE INFORMATION:

Evidence recovered during incident?	N/A
Chain of Custody Maintained:	No
Evidence Description:	
Evidence Current Location:	
Name/Title of Person Discovering Evidence:	
Criminal Charges:	No

Notifications:

Facility Notifications:

INCIDENT REPORT

Person Notified	Date/Time Notified	Notified By	ADO?
Assistant Warden Bryant	08/21/2019 @ 2149	S/S Tonya warner	Yes

FSC Notifications:

Person Notified	Date/Time Notified	Notified By

Contracting Agency Notifications:

Person Notified	Date/Time Notified	Notified By
Cole Turman	08/22/2019 at 0503	S/S Tonya Warner

Outside Agency Notifications:

Person Notified	Date/Time Notified	Notified By
CCC	08/21/2019 at 2325	S/S Tonya Warner

Referred for Investigation by Warden/Administrator or ADO?	Yes

Prepared By:	Tonya Warner	Title:	Shift Supervisor

Completed Date/Time:	08/22/2019 00:00hours

Name	Job Title	Date and Time Signed
Tonya R Warner	SHIFT SUPERVISOR	08/22/2019 04:58 hrs

Sexual Abuse or Assault Incident Review Form

PREA § 115.86 *Sexual Assault Incident Reviews*, requires facilities "to conduct a sexual abuse incident review at the conclusion of every investigation of sexual abuse and, where the allegation was not determined to be unfounded, prepare a written report...recommending whether the allegation or investigation indicates that a change in policy or practice could better prevent, detect, or respond to sexual abuse." Further, "the facility shall implement the recommendations for improvement, or shall document its reasons for not doing so in a written response."

An incident review team must complete the review within thirty (30) days of the conclusion of any law enforcement or administrative investigation with a finding of **substantiated or unsubstantiated**.

Completed forms should be sent to the CCA Facility Support Center (FSC) PREA Compliance Coordinator.

Incident Date: 8/21/19 Incident Time: 2117

Facility Name: South Central Correctional Center

Incident Location: Skylab D 106

Lead Reviewer Information

First Name: Eddie Last Name: Johnson

Phone Number: (931)676-5346 ext. 2203 Title: Assistant Warden

Report Date: 8/21/19

Review Team Members

#	Name *(First and Last)*	Title and Role *(e.g. Investigator)*
1	Click here to enter text	Click here to enter text
2	Click here to enter text	Click here to enter text
3	Click here to enter text	Click here to enter text
4	Click here to enter text	Click here to enter text
5	Click here to enter text	Click here to enter text

Incident Details

Brief Summary/Nature of Incident:

On 08/21/2019 at approx. 2116 SCO Laurin took inmate Smith #571191 out of his cell to take him to the shower. Once the inmate was removed from his cell he advised SCO Laurin, that he had been sexually assaulted. Inmate Smith alleged his cellmate, inmate Rose, Marcayes #426230 from HD106 forced inmate Smith to perform oral sex on him. SCO Laurin immediately took him to the VG non-contact room, and C/M Dickey notified myself, S/S Warner at 2117. He was escorted to medical by myself S/S Warner and C/M Dickey. Nurse Cynthia McQueen, RN completed the health assessment on inmate

Sexual Abuse or Assault Incident Review Form

Smith #571191. Once the assessment was completed he exited the facility to Jackson General Hospital at approx. 0005 to have a rape kit completed. Sco Mchorris, David and C/O Gregory, Adam were the transporting officers.

	Victim Info	Alleged Perpetrator Info
Name *(First & Last)*	Addison Smith	Marcayes Rose
Country of Birth	USA	USA
Inmate Number	571191	426230
Date of Birth	7/27/92	11/28/87
Gender	Male	Male
LGBTI identification, status or perceived status	Unknown	Unknown
Language Spoken	English	English
Known Disabilities	None	None

Criminal Investigation Details

Was a criminal investigation conducted? No IN Progress But TDOC (NJ)

Investigation Finding Select findings Date of Findings Select a date

Law Enforcement Name (agency) Click here to enter text

Administrative Investigation Details

Was an administrative investigation conducted? Yes

Investigation Finding Unsubstantiated On Going (NJ) Date of Findings Select a date

Administrative Name (conducted by): Click here to enter text

Incident Review Findings

	Group Dynamics	
1	Was the incident or allegation motivated by race; ethnicity; gender identity; lesbian, gay, bisexual, transgender, or intersex identification, status or perceived status; or gang affiliation; or motivated or otherwise caused by other group dynamics at the facility? If yes, describe and detail any remedial information to prevent such occurrences in the future.	No

Sexual Abuse or Assault Incident Review Form

Click here to enter text		
	Staffing	
2	Was any information available which should or could have alerted staff that the incident may occur? E.g. information from inmate/resident risk assessment, past issues between inmates/residents, history of fighting, prior incidents, etc. Describe.	No
Click here to enter text		
3	At the time of the incident, did staffing in that area meet levels required by staffing plans, post orders, etc.? Describe oversight at the incident location.	Yes
Click here to enter text		
4	Are there any changes or additions to current staffing that may help prevent similar incidents or allegations in the future?	No
Click here to enter text		

	Physical Plant	
5	Have any prior substantiated allegations of sexual abuse or assault occurred in the same area of the facility? If yes, describe and provide dates.	No
Click here to enter text		
6	Consider whether physical barriers or layout within the area may have in any way facilitated the abuse. If yes, explain and discuss what changes can be made.	No
Click here to enter text		
7	Would monitoring technology, or augmented monitoring technology, have been useful in preventing or responding to this incident? If so, how?	No
Click here to enter text		
	Incident Response	
8	Once the incident was detected, was staff response timely and appropriate?	Yes
9	Were policies and procedures followed in this case (protection duties, responder duties regarding preservation of evidence, reporting, coordinated response, etc.)?	Yes
10	Describe the staff response to the incident and any deviations from established policies or procedures.	
Responded per 14-2		
11	Were appropriate medical care, mental health counseling and/or other health services offered to the victim after the incident was reported? Describe the services offered.	Yes
Medical, Mental Health and SANE		
12	Were appropriate victim advocacy services offered to the victim after the incident was reported? Describe the services offered.	Yes
Medical and Mental Health		
13	If any of the alleged victims or perpetrators has a disability (including a mental illness) or is limited English-proficient, were appropriate steps taken to ensure the inmate/resident(s) had access to all aspects of the facility's efforts to prevent, detect, and respond to sexual abuse? Explain what services or accommodations were provided.	Yes
Click here to enter text		
14	Describe reclassification and housing decisions for both the victim and alleged perpetrator following the allegation.	

Why was Rose in Segregation?

? SART?

Medical yes Mental Health ?

? JMCGH?

Sexual Abuse or Assault Incident Review Form

Victim(s): _____

Alleged Perpetrator(s): _____

15	Were any additional measures necessary to protect staff, contractors, volunteers, or detainees against retaliation for reporting or complaining about the incident, or participating in the investigation? Please describe and, if retaliation occurred, describe how the facility responded.	No
Click here to enter text		
16	Are there any other changes in policies or practices at this facility that might help better prevent, detect, or respond to incidents of this nature in the future? If yes, please describe.	No
Click here to enter text		
17	Did this incident result in the review or revision of any facility policies or procedures? If so, what policies or procedures were reviewed and/or revised as a result, and how were they implemented?	No
Click here to enter text		

Recommendations

List all recommended changes in policies, procedures, and/or practices identified through the questions above, and describe exactly how each recommendation was implemented.

#	Recommendation Description	Method of Implementation
1	Click here to type recommendation	Click here to enter text
2	Click here to type recommendation	Click here to enter text
3	Click here to type recommendation	Click here to enter text
4	Click here to type recommendation	Click here to enter text

If any recommended changes were *not* implemented, please explain why.

#	Recommendation Description	Justification
1	Click here to type recommendation	Click here to enter justification
2	Click here to type recommendation	Click here to enter justification
3	Click here to type recommendation	Click here to enter justification
4	Click here to type recommendation	Click here to enter justification

Original – Warden
Copy – Facility PREA Compliance Manager
Copy – FSC PREA Coordinator

CoreCivic FACILITY EMPLOYEE PROBLEM SOLVING NOTICE

CONFIDENTIAL: THIS FORM IS TO BE MAINTAINED IN ACCORDANCE WITH POLICY 3-9, EMPLOYEE RECORDS

Facility: South Central

Employee: Ackerman, Ashley NICOLE **Title:** SR CORRECTIONAL OFFICER

PSN Number: 2019-PSN-10087

Name of Supervisor initiating Problem Solving Notice: Bryant, Eric

Rules Violation:

1. Failure to Follow Policy/Procedures

1.2. Violating CoreCivic Code of Ethics and Business Conduct and any supplements thereto

5. Misconduct Related to Job Performance

Date of Incident: 09/11/2019 **Date of Notice:** 09/12/2019

Description of Incid...

Based on the investigation it can be concluded based on the review of Milestone and the statements from multiple staff members that Senior Correctional Officer Ashley Ackerman failed to appropriately respond to an emergency situation. This can be concluded by her own admission as well as multiple witnesses. Senior Ackerman stated she did not take inmate Smith's threats of self-harm seriously because she believed he was "playing a game" to obtain an extra food tray.

Corrective Action Taken:

Action: Termination

Primary Approver Signature: Eddie Johnson 09/11/2019

Release Approver Signature: Grady Perry 09/11/2019

Service Supervisor Signature: Eric Bryant 09/12/2019

Service Witness Signature: Shannon Boyd 09/12/2019

Employee Signature:

(Signature does not indicate agreement or disagreement with the information contained on this document. By signing, the employee is acknowledging receipt of this Problem Solving Notice and his/her option to grieve such action.)