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**Complainant:** "C.S." - Vermont HRC Case PA 15-0001

**Respondents:** Vermont Department of Corrections

**Charge:** Discrimination in public accommodations on the basis of disability.

**NOTE**

**On June 23, 2016, the Human Rights Commission found reasonable grounds to believe that the Department of Corrections (DOC) had discriminated against C.S. based on his disability. In light of responding counsels' concerns for the confidentiality of non-respondent, but involved parties who worked with C.S., the Commission agreed to remove the names of those employees in its public document and to refer to them only at "CCS Employee #1-5." "CCS" refers to Correct Care Solutions, the contractual vendor for mental health and medical services for the DOC during the time period covered by this report. Centurion LLC now fills this role.**



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## INVESTIGATIVE REPORT

**Complainant:** “C.S.” - Vermont HRC Case PA 15-0001

**Respondents:** Vermont Department of Corrections

**Charge:** Discrimination in public accommodations on the basis of disability.

### BACKGROUND AND SUMMARY OF COMPLAINT:

In October of 2010, C.S. was incarcerated at Northern State Correctional Facility because he did not have an appropriate guardian to take custody of him after being charged with sexually molesting his two half-brothers a year earlier when he was 17 years and 4 months old – still legally a minor. He later pled guilty as an adult while at Southern State Correctional Facility (SSCF) in March of 2013, after a judge declined to follow recommendations to sentence him as a youthful offender. He was sentenced to a term of 45 months to 7 years of incarceration and required to register as a sex offender.

His complaint alleged that he had a psychiatric disability and that the DOC kept him in segregation, isolated from the general prison population between 2011 and 2014. He alleged that DOC failed to “provide adequate staffing and supports” that would have prevented him from being held in segregation “longer than necessary.” His complaint stated that “DOC’s failure to provide me with appropriate medical and mental treatment in the most integrated setting appropriate to my needs constitutes unlawful discrimination because of disability.”

## SUMMARY OF RESPONSE

On September 19, 2014, the State submitted an answer which denied all allegations without any supporting bases. The State did not raise any special defenses.

## PRELIMINARY RECOMMENDATIONS

1) This investigation makes a preliminary recommendation that the Human Rights Commission find there are **reasonable grounds** to believe that the Department of Corrections discriminated against C.S. on the basis of his disability and violated the VFHPAA "integration mandate" in 9 V.S.A. §4201(c)(2) and the general prohibition related to denial of access to services etc. codified at 9 V.S.A. §4201(c)(1).

## DOCUMENTS

- Case Law, Law Review Articles, DOC Budgetary Data, Issue Briefs
- Complaint of Public Accommodations Discrimination – filed 7/21/14
- Court Documents – Including Mittimus, Criminal Information, Transport Orders
- Department of Corrections Policies & Procedures and Administrative Rules
- Documents generated at Southern State Correctional Facility by either the DOC or Correct Care Solutions:
  - Behavior Plans
  - Behavioral Health Psychiatric Provider Notes
  - Case note entries by caseworkers and other 2010-2014
  - Central Office Segregation Review forms
  - Complaint filed by C.S. with DRVT while at SSCF
  - Contact Notes
  - DCF Report to Court
  - Disciplinary History from 2010-2016
  - EOSRs – Alpha, Fox and Bravo Units
  - General Provider Notes
  - Health Service Requests made by C.S.
  - Identification of Special Needs
  - Incident Infraction History
  - Incident Reports – 2010-2014
  - Infirmary Progress Notes
  - Initial Needs Surveys
  - Mental Health Provider Orders
  - Mental Health Activity Therapy Notes

- Mental Health Progress Notes SFI and non-SFI – 2010-2016
  - Mental Health Provider Orders
  - Mental Health SFI and Non-SFI Progress Notes
  - Mental Health Treatment Plans
  - Medication History
  - Medical History and Physical Assessment
  - Movement History and Legal Status
  - Neurological Assessment
  - Nursing Progress Notes
  - Outside Medical Records – Bennington School, DHMC, Springfield Hospital
  - Pharmacy Notes
  - Pre-Segregation Health Assessment
  - Provider Progress Notes
  - Psychological Evaluations – Psychosexual and other
  - Psychiatry Progress Note
  - Psychiatric Evaluation Notes/Psychiatric Provider Follow-up Notes
  - Receiving and Screening Documentation
  - Segregation Inmate Daily Assessment Form
  - Segregation Logs
  - Segregation Review Paperwork – 30 and 60 days
  - Segregation Suicide Self-Harm Paperwork
  - Self-Harm Watch – Mental Health Observation Notes- Admission/Discharge
  - Special Observation Monitoring Sheet
  - Sick Call Requests
  - SSCF Offender Social History Sheet
  - Staff Referral Forms
  - Suicide Watch Notes
  - Self-Harm Watch-MH Observation Notes
  - SFI Status Referral Forms
  - VT DOC Non-Offender Personal Data
  - Weekly Non-SFI Segregation Rounds
  - Weekly SFI Segregation Rounds
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- Emails
  - Internal Memoranda
  - State's Response – 9/14/14
  - Vermont Statutes Annotated

## STAFF TITLES

(Descriptions excerpted from the SSCF Inmate Manual)

The staff at the DOC have specific facility roles, and include contracted medical/mental health providers (QHCP/QMHP). Each position is responsible for a different aspect of inmate and facility management. These include:

- Booking Officer – Does intakes and initial needs screening
- Qualified Health Care Professional (QMHP) – Mental health or medical
- Security & Operations Supervisor (SOS): The SOS oversees facility operations, all security staff and policy and procedure compliance.
- Living Unit Supervisor (LUS): The LUS oversees the operation of the living unit. He or she supervises the casework and security staff in the maintenance of security within the living units.
- Corrections Services Specialist (CSS): The CSS provides professional casework, counseling and unit program direction. He or she designs, administers and monitors services for inmates.
- Correctional Facility Shift Supervisor (CFSS): The CFSS supervises and directs security and operations of the correctional facility.

## INTERVIEWS

- Tara Clarke – Living Unit Supervisor (LUS), SSCF, 4/27/16
- Christina Granger – Caseworker II (CSS II), SSCF, 4/27/16
- Kevin Jenkins – Correctional Facility Shift Supervisor (CFSS), SSCF, 4/27/16
- “C.S.” – Complainant, 4/11/16
- CCS #1 – Social worker employed by Correct Care Solutions, SSCF, 4/29/16, qualifies as a Qualified Mental Health Professional under the Administrative Rule and directives (QMHP)
- Caroline Marsh – Assistant Superintendent of Security, SSCF, 4/27/16
- Jeff Poginy – Caseworker (CSS) II NSCF – Newport, 4/29/16
- Mark Potanas - Superintendent, SSCF, 4/27/16
- Joshua Rutherford - Former Chief of Security SSCF, now Superintendent of Marble Valley Regional Correctional Facility (MVRCF), 4/27/16
- Jay Simons – Director, The Woodside Juvenile Rehabilitation Center, email – 4/12/16
- Shawn Smith – Caseworker (CSS II) NSCF – Newport, 4/29/16

**Correct Care Solutions Employees mentioned in report via documents they authored, but not interviewed:**

CCS Employee #2  
CCS Employee #3  
CCS Employee #4  
CCS Employee #5

**ACRONYMS**

- **AS or AdSeg**– Administrative Segregation
- **CCS** – Correct Care Solutions
- **CO** – Correctional Officer
- **CRCF** – Chittenden Regional Correctional Facility
- **DOC** – Department of Corrections
- **DOJ** – Department of Justice
- **DS**- Disciplinary Segregation
- **DR** – A disciplinary report for an institutional infraction – also known as being “written up” or getting a “ticket”
- **DHMC** – Dartmouth Hitchcock Medical Center
- **DRVT** – Disability Rights Vermont
- **EOSR** – End of Shift Report
- **GP** – General population
- **MHSU** – Mental Health Stabilization Unit (Alpha unit) at SSCF
- **MHU** – Mental Health Unit staffed at the time by Correct Care Solutions staff, social workers
- **MHTP** – Mental Health Treatment Plan
- **MHTU** – Mental Health Transitional Unit (Bravo), also known as the Intermediate Mental Health Treatment Unit
- **NSCF** – Northern State Correctional Facility in Newport, VT
- **NWSCF** – Northwest State Correctional Facility in Swanton, VT
- **QHMP** – Qualified Mental Health Professional
- **SFI** – Serious Functional Impairment
- **SMI** – Serious Mental Illness
- **SSCF** – Southern State Correctional Facility in Springfield, VT
- **VTPSA** – Vermont Program for Sexual Abusers

## DEPARTMENT OF CORRECTIONS (DOC) TERMINOLOGY

- **28 V.S.A. § 701a(b): “Segregation:”** For purposes of this title, and despite other names this concept has been given in the past or may be given in the future, "segregation" means a form of separation from the general population which may or may not include placement in a single occupancy cell and which is used for disciplinary, administrative, or other reasons.

*Final Approved Administrative Rule 05-049 December 2005*

- **Administrative Segregation:** A form of separation from the general population when the continued presence of the inmate in the general population would pose a serious threat to life, property, self, staff or other inmates or to the security or orderly running of the institution. Inmates pending investigation for trial on a criminal act or pending transfer may also be included.
- **Administrative Segregation in the context of “Responses to Self-Harm”**  
**#413.11:** “Individuals who engage in self-harming behaviors may experience an exacerbation of their condition when placed in segregation. Therefore, before an inmate who self-harms is placed on administrative segregation status, a qualified mental health professional must be consulted to determine whether contraindications to that placement exist. The qualified mental health professional must document in the inmate’s medical record if contraindications to administrative segregation exist.
- **Disciplinary Segregation:** A form of separation from the general population in which inmates committing serious violations of conduct regulations are confined for short periods of time to individual cells separated from the general population. Placement in disciplinary segregation may only occur after finding of a rule violation at an impartial hearing and when there is not an adequate alternative disposition to regulate the inmate’s behavior.

### Facility Rules and Inmate Discipline #410.01

- **Major Violation:** The most serious instance of inmate misconduct, constituting violent acts or serious threats to institutional security or personal safety. They are divided into two categories, A and B, Major A being the most serious. Major violations are handled through the formal disciplinary process and referral for prosecution as needed. An inmate may receive sanctions as prescribed by

Standardized Rules and Guidelines for Recommended Sanctions (Attachment 1) for a major violation.

- **Major A:** The most serious violations - constitute violent acts or serious threats to institutional security or personal safety.
- **Major B:** violations are serious instances of misconduct of a lesser extent than Major A violations.

- **Minor Violation:** The least serious inmate misconduct injurious to order and discipline. Minor violations constitute the least serious misconduct or violation(s) of written facility rules or behaviors. Staff may attempt to resolve minor violations through an informal process that includes providing the inmate with a written statement of the alleged violation, and a decision within twenty-four (24) hours by the Shift Supervisor or a Supervisor not involved in the incident.

Placement on Administrative Segregation #410.03

- **Phase I Administrative Segregation:** Can continue for as long as the facility and other Corrections personnel, including the Deputy Commissioner think it is warranted. The Policy calls for 7, 30, and 60 day reviews, after which the Deputy Commissioner or his or her designee will do the following:
  - i. Continue on the current status;
  - ii. Modify the conditions of confinement;
  - iii. Move to Phase II Segregation (after 30 days only);
  - iv. Remove from Administrative Segregation altogether.
- **Phase II Administrative Segregation:** The inmate/offender must have been in Phase I for at least 30 days to be eligible to move to Phase II and may only do so upon approval of the Segregation Review Committee. To be eligible, the inmate/offender must have done the following:
  - a. No major A or major B disciplinary reports for the previous 30 days;
  - b. Completed any assigned Phase I in-cell programming requirements;
  - c. Have the recommendation of the Living Unit Supervisor (LUS);
  - d. Participate in a behavioral plan and adhere to conditions of confinement.

Placement on Administrative Segregation #410.06

- **Close custody** - See # 371.04 Custody / Security Assignment in A Correctional Facility: Close custody inmates are set apart from minimum and medium custody. All inmates/offenders in any form of segregation would be in close custody. There are three custody levels: minimum, medium and close. The directive states: “The custody levels are used to determine where offenders are housed, transported, where institutional work opportunities and program opportunities may be available, and what level of supervision is used with that offender.”
- **Restrictive Housing Status**: A designation which provides for closely regulated management through placement on Administrative Segregation status or by placement on Disciplinary Segregation.

Use of Restraints # 413.08

- **Restraints**: Restraints include any mechanical device used to control the movement of an inmate’s body and/or limbs. Only those restraint devices specifically authorized and disseminated by the Department of Corrections are allowable.
  - **Restraint Status I**: The securing of an inmate with handcuffs behind the back and with shackles.
  - **Restraint Status II**: Hands cuffed in front with waist chain and shackles.
  - **Restraint Status III**: Hand cuffed in front, no shackles.
  - **Black box status** – A black box is placed between the wrists over the key holes and then pulled down and attached to the waist chain making the person’s hands completely immobile.

Responses to Self-Harm - #413.11

- **Policy**: “The Department of Corrections does not punish inmates for engaging in self-harming behaviors and strives to ensure that inmates understand that confinement and uses of force are not punishment but applied to protect an inmate or others from injury.”
- **Conditions of Administrative Segregation**- An inmate in administrative segregation for self-harming behaviors shall be entitled to the same property and privileges as all other inmates in administrative segregation unless the Department of Corrections can demonstrate the need to remove an item or

curtail a privilege, consistent with the input of a qualified mental health professional.

### CONDENSED TIMELINE

- **11/25/09** - Date of alleged Lewd & Lascivious charge –17 yrs. and 4mos.
- **10/26/10** - Enters the adult corrections at NSCF – Northern State Correctional Facility in Newport – 18 yrs. 4mos.
- **1/14/11** - Transferred to CRCF - Chittenden Regional Correctional Facility
- **2/14/11**– Transferred back to Newport
- **4/26/11** - Moved to SSCF
- **4/23/12** - Assaulted in Foxtrot; found unresponsive and clinically deceased, resuscitated and transported to DHMC
- **3/1/13** - pleads guilty to Lewd & Lascivious Conduct with a Child in adult court, receives 45 months to 7 years, with credit for time served, required to register as a sex offender
- **8/6/13** – Disability Rights Vermont files a grievance with DOC on behalf of C.S.
- **8/30/13** - Moved back to Newport
- **7/21/14** – Filed HRC charge
- **8/20/14** – Approved for move to general population in Newport
- **9/19/14** – State’s Response
- **2/12/16** - current – Transfer to NWSCF in Swanton to participate in VTPSA – Vermont Treat Program for Sexual Abusers

This report is organized in the following manner: **Section I** provides a general introduction, **Section II** covers C.S.'s background and history, and **Section III** defines the term "segregation." **Section IV** discusses the terms "significant mental illness" (SMI) and "serious functional impairment" (SFI) and how a facility is supposed to manage such inmates in disciplinary or administrative segregation. This section also briefly discusses the impact of diagnosing someone with "behavior issues" versus "mental health issues." **Section V** provides an overview of the length of C.S.'s segregation and the impact of disciplinary reports – "DRs", **Section VI** discusses the behavior plans at SSCF and why they were ineffective. **Section VII** discusses the Newport behavior plans and their relative success. **Section VIII** provides a legal analysis. **Section IX** concludes the report.

## I) Introduction

C.S.'s complaint must be evaluated by taking a close look at the specific periods and facilities in which he was incarcerated, as well as his life prior to being charged with molesting his two younger half-brothers when he was 17 years old. A look at his earlier life has assisted this investigation by providing a larger context to examine the issues he faced at the DOC and whether or not the DOC violated the integration mandate of the VFHPAA. In addition, this investigation has examined progress notes from 2016 in order to get a sense of his current challenges and successes.

C.S. was first detained at Northern State Correctional Facility (NSCF) in Newport for a period of 6 months, with a brief interlude at Chittenden Regional Correctional Facility (CRCF). He was then sent to Southern State Correctional Facility (SSCF) in Springfield for approximately 2 years and 4 months. He was returned to Newport for another 18 months where he remained until February of 2016, at which point he was transferred to Northwest State Correctional Facility in St. Albans to complete sex offender education and await his release date on furlough or upon the completion of his sentence (his "max out" date).

C.S.'s complaint alleges that the DOC violated the Vermont Public Accommodations Act by failing to house him in the least restrictive environment appropriate for his needs.<sup>1</sup> His allegation is that he was continuously held in segregation from approximately March 2011, when he arrived at SSCF and for a subsequent period of time at NSCF in Newport. He further alleges that the DOC failed to "provide adequate staffing and supports" and that this failure kept him in segregation. His complaint obviously requires an analysis of where he was and

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<sup>1</sup> 9 V.S.A. §4502(c)(2).

whether he was segregated as it is defined by Vermont law, as well as whether the services he received were sufficient or insufficient to help him move out of segregation.

The longest period of incarceration at a single facility that was covered by the four corners of C.S.'s complaint, was at SSCF in Springfield. As this investigation examined records of his confinement at SSCF, it became clear that C.S. had been continuously segregated there for 2.4 years without any significant movement to general population (GP). After the 2.4 years, he was sent to Newport at the request of SSCF Superintendent Mark Potanas, who informed the then Chief of Mental Health for DOC, Dr. Meredith Larson, that staff were "at their wit's end."<sup>2</sup> After less than a year in Newport, C.S. was able to move from segregation to GP.

So the question for this investigation was, how was this accomplished? What did Newport do, that SSCF did not? There were variables to consider, some of which could not be quantified. Newport placed C.S. closer to his mother, however historically, she had not provided consistent support, and his relationship with her was complicated by the presence of his two half-brothers in her home, with whom he was to have no contact. Had C.S. suddenly matured and "grown up" so to speak? Did Newport offer him more than SSCF offered? Were the staff just "nicer" there? More innovative? It was important to look for as many objective indicators as possible to answer the question of why SSCF failed where Newport succeeded.

The answer to the question came primarily from examining mental health records, case notes, behavior plans and staff interviews. Newport has a larger population on average than SSCF,<sup>3</sup> but a lower per capita spending per inmate.<sup>4</sup> In addition, SSCF has more designated mental health resources (staff) and designated mental health units – Alpha, the Mental Health Stabilization Unit (MHSU) and Bravo,

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<sup>2</sup> The proof that there was the possibility that C.S. could be successful elsewhere – in a less restricted environment - was supported by Superintendent Mark Potanas' statement to this investigation regarding the reasons for moving C.S. to Newport. He stated that he rarely asked for anyone to be transported out of the facility. He acknowledged that SSCF staff had spent over two years with C.S. and tried "any number of approaches" and plans. Potanas said he felt that C.S. needed a new environment – "he needed to look at somebody besides my staff. I felt like it would be in his best interest." Superintendent Potanas did not feel, however, that SSCF had "dropped the ball." The opinion that C.S. could benefit from a fresh start was echoed by then facility social worker and Correct Care Solutions (CCS) employee CCS Employee #1.

<sup>3</sup> In 2016, the average daily population at Newport was 413. The average daily population at SSCF was 352. See [http://www.leg.state.vt.us/jfo/appropriations/fy\\_2016/Department%20Budgets/FY2016%20Budget%20%20-%20Corrections%20-%20Narrative.pdf](http://www.leg.state.vt.us/jfo/appropriations/fy_2016/Department%20Budgets/FY2016%20Budget%20%20-%20Corrections%20-%20Narrative.pdf), SSCF has 370 beds, not counting admissions. <http://doc.vermont.gov/custody-supervision/facilities/sscfs-folder/facts-and-information-about-the-southern-state-correctional-facility/>.

<sup>4</sup> In 2016, SSCF's per capita spending for a population of 351 was \$60,925, whereas Newport's per capita spending was \$49,794 for a population of 411. <http://www.doc.state.vt.us/about/reports/fy15-doc-annual-report/view>

the Mental Health Transitional Unit (MHTU). Mental health services at the time of C.S.'s incarceration were provided by a contractor – Correct Care Solutions (CCS).<sup>5</sup>

The records reflect that Newport succeeded because it took a more intensive, integrated approach to C.S. behavioral and mental health needs. The mental health staff at Newport and C.S.'s caseworkers accommodated C.S.'s needs in several ways. First, they recognized that C.S. was, in many ways, very young and immature and very needy and so they provided consistent emotional support and incentives for success. Second, they seemed to recognize the disabling effects of attention deficit disorder (ADHD), impulse control disorder (ICD) and post-traumatic stress disorder (PTSD), so they provided behavior plans that were manageable for him and did not set him up for failure. The plans were nimble – they were short in duration, subject to constant revision depending on his mental state, and they provided meaningful incentives for success. Third, they involved C.S. in the development of the behavior plans in a meaningful way. By doing this, they afforded him the opportunity to develop self-respect and gave him a greater incentive to “buy-in” and succeed. Fourth, there is no evidence that the behavior plans were used in a punitive fashion or that he was made to feel a failure during times he lost ground by “acting up.”

The records and interviews show that these approaches were lacking at SSCF, not because they did not exist per se, but because staff operated in a sort of vacuum. Occasionally, someone at SSCF would have a flicker of insight about what might work with him, (and did end up working with him at Newport), but the ball would get dropped. Staff seemed to approach him, more often than not, in a punitive and with exasperation and dislike, which while understandable in some respects, made things worse. Staff roles seem to have been siloed and some of their perspectives seem counterintuitive and harsh beyond necessity. His caseworker claimed no knowledge about what mental health did with him and whether or not it was successful. His frequent mental health worker, CCS Employee #1, offered no opinion about the caseworker<sup>6</sup> or even claimed to have interacted with whomever that person was at the time.<sup>7</sup> The former chief of security, Joshua Rutherford (now Superintendent at Marble Valley), felt C.S. should have been in disciplinary segregation while he was there, not

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<sup>5</sup> In 2014, 44% of the total inmate population was receiving mental health services, numbers courtesy of CCS. [http://www.leg.state.vt.us/ifo/appropriations/fy\\_2016/Department%20Budgets/FY2016%20Budget%20-%20%20Corrections%20-%20Narrative.pdf](http://www.leg.state.vt.us/ifo/appropriations/fy_2016/Department%20Budgets/FY2016%20Budget%20-%20%20Corrections%20-%20Narrative.pdf). Services are now provided by Centurion.

<sup>6</sup> This investigation interviewed Christina Granger who claimed to have an excellent relationship with C.S. but had no opinion or idea about what anyone else was doing. She would not even state affirmatively whether mental health staff were at meetings regarding behavior plans for C.S. She would only state that she “assumed” they were.

<sup>7</sup> He agreed that C.S. should have been in disciplinary segregation so he could “earn his way out” and that disciplinary segregation would have made it easier to “curb” behaviors.

the mental health unit. This was echoed by social worker CCS Employee #1. The assistant superintendent, Caroline Marsh, had no recollection of why the Chief of Mental Health for the DOC, Dr. Meredith Larson, suddenly designated C.S. as seriously functionally impaired (SFI) in January of 2013, after years of not being so designated, even though Marsh was included in meeting notes and emails on the issue and was noted to have discussed the issue with her staff. There was the sense that nobody had a “big picture” view of C.S. – just bits and pieces depending on their specific interaction with him. If one could sum up the impressions left by the SSCF records and staff into verbalizations, they would be akin to the kind of treatment one would direct at a naughty child. Interviews with staff revealed this and their attitudes are backed up by the records.

It was unclear how many of his caseworkers or mental health staff read his DCF (Department for Children and Families) files, previous psychological evaluations or case notes going back to 2010. CCS Employee #1 was surprised to learn C.S. had been given a diagnosis of Bi-Polar disorder by a psychiatrist at the Bennington School in 2010, nor did he have any idea that his IQ had tested at 73. Another assessment of his cognitive skills performed in 2011 showed his verbal ability in the “low range of functioning,” as well as his ability to process information quickly and automatically with an overall score in the low range. His CSS, Christina Granger, seems to have had little interest in his psychiatric or personal history. The fact that he had undergone an extensive psychological assessment at SSCF two times – once in September 2011 – and once in January of 2013, seems to somehow have escaped notice of line staff responsible for administering case management, behavior plans and mental health supports.

This suggested to this investigation that the significant care providers did not know who he was, or why he was the way he was or care why he was the way he was. His mental health treatment plan might have a goal of “addressing” “old trauma,” but the documented meetings with the mental health personnel sounded nearly meaningless - quick and dirty – asking how he felt, did he feel like he wanted to harm himself, why did he get a DR, could he try to do better next time. In other words, superficial, ineffective and undermined by the constant punitive environment that led C.S. to express more than once, that he felt he was in a “hole” – figuratively – that he could not climb out of. These so-called therapeutic interactions were often through a cell door, or in a room or open where confidentiality could not be assured. Furthermore, C.S. would almost always be shackled.

Evidence of the lack of effectiveness in this approach began to appear in a dire way September of 2012, when C.S. began to mutilate his penis, testicles and rectum.

His genital self-mutilation continued and steadily increased until the day he was transferred to Newport on August 30, 2013. While there were episodes of it at Newport, it essentially stopped, and there are only occasional instances of it in the present day. The DOC's official reaction was strangely muted, and the documented and agreed upon approach was to ignore him with the theory that he was just trying to get attention. From an outside perspective, it is impossible not to see these acts as evidence of severe decompensation resulting from the long period of continuous segregation along with poor casework and mental health supports. C.S. frequently voiced suicidal thoughts or would tell staff he was going to lose his mind if he had to stay in segregation. In one report he asks a CO if "they" are trying to kill him.

From September 2012 to August 30, 2013, when he was transferred to Newport, this investigation found 29 documented instances of self-inflicted harm to his penis, testicles and/or rectum at SSCF – far more than at any other facility, before SSCF, or after. He was taken to the hospital on 1/10/13 for inserting a pen into his urethra. There was one report of him tying "15" homemade ropes around his penis until it "turned black." In another instance he tied saran wrap and blanket string around his penis. He also inserted paper clips, safety pins, pieces of plastic fork, pens and pieces of black plastic from his shower flip flops in his penis and up into his urethra. In one instance, he told a nurse that he could feel the inserted object pressing against his bladder. On another occasion he cut his penis, put the blood in a cup and smeared the blood around his cell. He would insert pens and other items into his rectum, 8 in one instance. He urinated blood.

He harmed himself in other ways. On one occasion he squeezed a tube of toothpaste up his nose, making himself sick. He frequently put black window putty or toilet paper in his ears to block out sound. He bit himself and took chips of his teeth, paint or pieces of linoleum and cut himself with them. He threatened to "string up." He would bang his head against the wall or door, repeatedly. On one occasion he picked at a vein on his arm so deeply that blood covered the floor of his cell. He would disobey an order and force the COs to strip search him, literally cutting his clothes off -- and pepper spray him. In some cases, his resistance resulted in blows and kicks ostensibly aimed at subduing him.

The collective SSCF staff perspectives about these acts are very troubling. His SSCF caseworker (Granger), the assistant superintendent at SSCF (Marsh), the former chief of security at SSCF (Rutherford), his mental health providers at SSCF-- both counselors and psychiatrists (C.C.S. Employee #1, C.C.S. Employee #2 and C.C.S. Employee #3) – as well as Dr. Meredith Larson, the former chief of mental health for the DOC - took the position that C.S. did these acts to manipulate staff and "the

system” and termed his self-mutilation “choice behaviors.” Dr. Larson wrote a memo to Dee Burroughs-Biron, M.D., the medical chief of DOC, that someone should have a staff physician talk to C.S. about the permanent damage he could do to his urethra and penis. In January of 2013, Dr. Larson came up with a “plan” to combat his “acting out.” staff were instructed to “ignore” C.S. and not to engage with him when he acted out. It did not work for obvious reasons and the self-mutilation and destructive behaviors continued.

January of 2013 was a strange month for conceptualizing approaches to managing C.S. As noted, he was taken to the hospital for the first time for inserting a pen into his penis and urethra. On 1/18/13, Dr. Larson’s “ignore him” directive came down. In that memo she noted she would ask one of his psychiatrists, CCS Employee #3 about any possible remaining pharmacological avenues for treatment. Four days later, on 1/22/13, CCS Employee #3 wrote a memo stating that in his opinion, C.S.’s main diagnosis was borderline personality disorder, which was a sort of death knell for further treatment since, as CCS Employee #1 put it, “sadly” there was not much to be done for persons with BPD. He advocated deference to DOC and a plan that primarily assured “safety” and “security” rather than any substantive mental health treatment or other accommodations. CCS Employee #1 thus legitimized an approach that supported the withdrawal of any possible efforts at treatment. The disappearance of the bi-polar diagnosis, the PTSD diagnosis, the impulse control and attention deficit disorders were not discussed or do not appear in the notes.

Paradoxically however, Dr. Larson provisionally designated C.S. as “SFI,” however, Dr. Larson continued to defend her approach which promoted “ignoring” C.S.: “[S]cant evidence suggests that this approach is at least not making things worse and may be useful.” In another strange collision of circumstances, C.S. underwent a Psycho-Sexual Evaluation at the order of the court by Dr. Kathleen Kennedy. She combed through C.S.’s social and psychological history and concluded with a recommendation that he needed an updated psychological profile and “significant mental health supports,” which CCS Employee #3 had concluded were nearly useless for a person with borderline personality and which may well not have included “ignoring” someone who has significant mental health issues. There is no evidence that either

Dr. Larson or CCS Employee #1<sup>8</sup> were thoroughly familiar with C.S.'s history even though there were two substantive and fairly recent evaluations from 2011 (Connelly) and 2010 (Bennington School). Their (what seems now to be) limited insights reinforced the siloed approach to C.S. This led to increased acts of self-mutilation and an accumulation of DRs from the resultant behaviors associated with the anger and anxiety of prolonged segregation.

There is no doubt that C.S. could be manipulative and attention seeking. On at least one occasion he voiced satisfaction over costing the state money for having to send him to the hospital for placing a pen in his penis. But behind this kind of manipulation, there seemed to be the deepening madness and despair of a person who was already seriously damaged from childhood. This was a one of the last forms of control he had. The self-loathing this implies, the willingness to experience that kind of physical pain and the humiliation that comes with it are deeply troubling. The facility was unable to stop it and in the opinion of this investigation, made it worse, especially in light of the fact that it eased up at Newport. The typical response to his acts of self-injury was put him "on full precaution status: smock, mattress, finger food, no utensils, no shower shoes, no other property"<sup>9</sup> and to pepper spray<sup>10</sup> him if necessary to make him stop. His cell was searched randomly and he was moved from cell to cell at times, without notice. During the plan to ignore him, staff was to engage him only on "pleasant topics" and not discuss or to react to outbursts. No outside resources were called in; no consultations were made - there is no evidence of collective reflection - of taking a step back to assess what could be done to halt his dangerous abuse of his body. C.S. seemed to stop caring - and voiced this more than once.

C.S. was chronologically young when he entered corrections - almost 18 and-a-half years old and even younger mentally. He was described by those interviewed at SSCF and Newport as "childish," "attention seeking," "immature," "very immature,"

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<sup>8</sup> The only caveat to this is a follow-up Psychiatric Progress Note by CCS Employee #3 on 12/22/11: "Has had a traumatic life starting from having been repeatedly sexually and physically abused starting at age 5, having lived in numerous foster homes and residential treatment facilities. Consider prodromal schizophrenic spectrum illness." It is not clear whether this came from records or from interviewing C.S. A records release request was sent to Bennington School in 2010 and 2011 but it is unclear when they were received. No other mention of "prodromal schizophrenic spectrum illness" was mentioned in any of the records this investigation found. Dr. Connelly performed his evaluation on September 30, 2011, so it could have been ready by 12/22/11, although one would like to think that CCS Employee #3 might have approached C.S.'s care differently had he read it.

<sup>9</sup> Memorandum from Meredith Larson, Chief of Mental Health for DOC to Dee Burroughs-Biron, Director of Medicine, DOC, 1/18/13.

<sup>10</sup> DOC Policy # 413.08 - Use of Restraints - Also known as "oleoresin capsicum" - "OC spray" or "pepper spray").

“childlike,” “goofy,” and “confused.” Early case note records describe him as “very needy,” “confused” and without any comprehension of why he was there. His mental age was evident in a Health Service Request he submitted at SSCF on 10/31/12 for pictures of “dragons,” “teddy bears,” “cartoons,” and “fairies.”<sup>11</sup> (See Exhibit 1 for a Health Services Request). There is a progress note reporting that he jumped up and down with happiness on his cell mattress due to the arrival of a staff person. As is sometimes typical for youth, he thought it was fun to jump out and scare the nursing staff. He was often victimized in the early days – one staff person reported seeing him being beaten up by another inmate and doing nothing to defend himself. He was nearly killed by another prisoner who took advantage of his naiveté by luring him into a cell and then beat him and strangled him from behind to the point that he was found clinically dead by the COs who just barely managed to resuscitate him.

His IQ had tested out at 73 and he had been documented as being below average in his verbal and cognitive abilities. However there were varying reports about his ability to process information.<sup>12</sup> Christina Granger, his SSCF caseworker, said it was clear he would need more help than others. Another early case note from a different CSS reported him being nearly unable to read in an early group called “Habits of Mind” and getting teased for it. He told one of his caseworkers at SSCF that although he could not read well, he liked to collect books because it was “cool.” On the other hand, one of his caseworkers at Newport said he was a good reader and thoughtful writer and read science fiction. His written requests for Health Care assistance (attached Exhibits 1 and 2) revealed significant problems with writing, spelling and mental processing. His requests are for items both below and at his chronological age and also reflect a sense of disorientation and disconnect from reality. For instance, he repeatedly asked for condoms and HIV/STD tests even though he had no sexual contact with others and this was noted by nursing staff in response to his requests. On 7/2/13, about a month and half prior to his transfer to Newport, he put in a Health Services Request that he feared he had “mad cow

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<sup>11</sup> Health Service Request from C.S. on 10/31/12 and 9/22/12. A note from a recreational therapist on 11/1/12 also records him asking for pictures of dragons “so he could keep busy in his cell.”

<sup>12</sup> Clark v. State, 739 F.Supp.2d 1168,1184 (N.D.Cal.2010). “Prisoners with developmental disabilities are not always easy to distinguish from non-disabled prisoners. According to Dr. Nancy Cowardin, only a small percentage of people with developmental disabilities have identifying physical characteristics or impairments in physical or motor skills.... In addition, many developmentally disabled people work hard to mask their disabilities...Masking behavior is even more common among developmentally disabled people who are considered to be higher functioning with only “mild” support needs — the majority of developmentally disabled prisoners.... Masking results in compensatory behaviors such as wearing a broken watch to provide a reason to ask another person what time it is or carrying a book to pretend to be literate Thus, plaintiff class members may appear to have skills in areas in which they actually require help.” (Citations omitted).

discuse” [sic]. He again asked for a condom and a sex change and wrote he was seeing “little red smerfs” [sic] and other undecipherable content. (See Exhibit 2).

This investigator is not an apologist for C.S.’s actions - towards either his brothers or the many corrections and contractual employees who worked with him and towards whom abuse and profanity were directed. He went to Newport for the second time having accrued 153 disciplinary reports (DRs), at SSCF - major and minor. He could be violent and incredibly vulgar - stubbornly resistant and crudely insulting towards male and female staff. He is reported to have learned the names of a staff person’s daughter from other inmates and threatened to assault them or “date” them upon release. He spat at staff and threw urine at them on at least two documented occasions. On another, he threw a bag of feces out of his cell. He agitated other inmates. He flooded his cell and destroyed fixtures. He made weapons out of socks and broom straw or toothbrush handles. He wore handcuffs so much he was able to fashion a “key” to unlock himself, which resulted in his placement on “black box status.” He was an accomplished “fisher”<sup>13</sup> and stole prohibited items such as pens, paper clips, staples, razor blades, small springs, window putty and other items – even a radio at one point. On one occasion, he managed to steal a tray of 300 bars of soap and was found lathering up in his cell. He was not at all averse to interfering with the “smooth operation of the facility” and creating significant stress for staff and other inmates.

There is no way to account for or measure the stress, anxiety and fear that correctional staff experience in coping with difficult inmates. The psychology of corrections is a complex and peculiar one. It has been studied fairly extensively by those outside and inside of the correctional system starting most famously with the Stanford Prison Experiment.<sup>14</sup> Vermont is not alone in its struggle around the use of forms of segregation of inmates with mental health and behavior issues – many other

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<sup>13</sup> Using a string or threads from sheets with a weighted object tied to one end used to pass items to inmates in other cells.

<sup>14</sup> See <http://www.prisonexp.org/>; The impact of prison conditions on staff well-being Blerie, Int. J Offender Ther. Comp Criminol. (International Journal of Offender Therapy and Comparative Criminology) 2012 Feb;56(1):81-95. (originally published Nov. 2010 online); Individual and Environmental Sources of Work Stress Among Prison Officers, Steiner & Wooldredge, Criminal Justice and Behavior August 1, 2015 42: 800-818.

states have struggled with this issue for years - and still do- with similar difficulties.<sup>15</sup> This is not a report about segregation as an issue, but only about C.S.

However current staff attitudes perhaps reveal more about the effects of working in an environment where depredation is the norm.<sup>16</sup> The Assistant Superintendent, Caroline Marsh,<sup>17</sup> told this investigation that the behavior plans and staff had actually “saved” C.S.’s life (instead of arguably making him worse) and that he might otherwise be dead. She opined that he had benefitted from having “good staff role models” at SSCF and that he had learned “new skills,” although she could not point to any. She stated that she believed that the sanctions that he received and the behavior plans were sound “because he’s still alive.” When challenged about the facility helping him, she stated that they had saved his life because they had resuscitated him when he was brutally attacked by another inmate in 2012 and found without any vital signs by staff.<sup>18</sup> Her distorted perspective and her emotional disconnect is jarring.<sup>19</sup> However these attitudes are born out by the facility’s records and the contrast with Newport’s approach and the success C.S. achieved there results in this investigation’s reasonable grounds recommendation.

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<sup>15</sup> See “Expert Report: Mental Health Care in the Alabama Department of Corrections: *Bradley v. Hightower*,” Kathryn Burns, M.D., M.P.H. & Jane Haddad, Psy.D.; “Tennessee ACLU joins lawsuit over teen solitary confinement,” *The Tennessean*, Anita Wadhvani, April 28, 2016; “Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies,” <https://www.aclu.org/files/assets/Administrative%20Segregation,%20Degrees%20of%20Isolation,%20and%20Incarceration.pdf>

<sup>16</sup> Dr. James DeGroot, Ph.D., who has been the Director of Mental Health for Georgia’s Department of Corrections for 16 years along with a panel of three other corrections practitioners (one of whom, Sharen Barboza, PhD, CCHP-MH is affiliated with Centurion, LLC, the present mental health provider for the DOC) did a presentation and had panel discussion at the Georgia Department of Corrections called “It’s Not Mental Illness, It’s Just Behavior”: Identifying and Treating Personality Disorders Rather than Dismissing Them.” The presentation had a segment on the effect of working in Corrections called “What are the Risks of Working with People who Have Personality Disorders?” It identified impacts on staff such as changes to personality and mental status, including difficulty “identifying vulnerabilities, using projective identification, blurring boundaries,” and stress secondary to having limits pushed, being manipulated and having lawsuits filed. It also discussed being aware of “cracks” in a corrections employees own mental health status.

<sup>17</sup> Assistant Superintendent Marsh was recognized with a 2014 DOC Staff of the Year Award.

<sup>18</sup> When told he had been able to make it to GP at Newport, she replied, “That’s wonderful.”

<sup>19</sup> Although all staff interviewed regularly had opportunities to observe and evaluate C.S., several, when asked questions about delivery of services, tried to confine their answers by statements like “that’s not my area,” “that’s not my role,” “that’s not in my area of expertise,” “that was not included in my duties,” or “you should ask so-and-so.” This does not mean that staff are incompetent. They may have great successes with other inmates, but they failed to work effectively as a group/team with respect to C.S.

## II) C.S.'s BACKGROUND

[C.S.] was 13 years old in July of 2005 when the excerpt below was written by an examining psychologist, Dr. Phillip Kinsler, Ph.D., at the request of the court in order to evaluate whether C.S. was competent to stand trial as a juvenile charged with Disorderly Conduct. He had already been in DCF custody for 5 years at that point:

Emotionally, [C.S.] is a severely impaired individual. His models of safety and trust violated him and he was abused within a "home" environment. [C.S.] is sad, immature, reactive, and unable to react in a prosocial manner. [C.S.] has poor self-esteem and has exhibited suicidal ideation. Behaviorally, [C.S.] is aggressive, impulsive, oppositional, disorganized, easily frustrated, and unable to sustain attention. [C.S.] is prescribed a complicated cocktail of medications and even this does not fully help him maintain control. It would be expected that [C.S.] gets quickly overwhelmed by situations, predicts a negative outcome and then reacts in a hostile manner. ***Overall, [C.S.] is a severely damaged child. Even without opposition to testing (from his attorney), his history would prevent him from being able to perform at higher levels or appropriately advocate for himself. He is not able to focus for extended periods of time, nor make sense of complicated verbal information. If he realized what was being said, it is likely he would react poorly, as he can easily be disinhibited, further complicating his situation... Certainly [C.S.] should be under court/DCF supervision with a goal of becoming a viable, productive adult.... [C.S.] should remain in a heavily structured environment under close supervision. Any and all therapeutic interventions need to be tried....*** (Emphasis added).

This excerpt is striking in that the young boy described in 2005 seemed to have changed very little from 2010 until the present when he was interviewed by this investigation in April of 2016. It is an eerie foreshadowing and explains so much about his struggle in DOC custody and why he needed accommodations.

When C.S. came to SSCF, he was a little over 18 years old and he was still legally in the custody of DCF. He had not been adjudicated for the Lewd & Lascivious charge, meaning he still possessed the legal presumption of innocence as to all charges when he was first placed in the custody of the DOC. Additionally, the alleged acts of sexual abuse of his younger half-brothers occurred when he was still a juvenile, so it was unclear whether his case would be heard in an adult or juvenile court. Records show he believed it would be heard in Juvenile Court and that he would be returned home. The former belief was not an unreasonable one. Two examining psychologists - one requested by his counsel, one by the State, as well as a DCF Supervisor recommended that he be treated as a youthful offender. Furthermore, he had been detained for no other reason than lack of a guardian who could care for

him while he awaited trial or some other disposition of his case. In his order, the Judge asked that he be housed away from the general population in light of his age.

1. Psychosexual Evaluation - **Dr. John Connelly, Ph.D., M.P.A., M.A., PLLC**  
(September 30, 2011)

As part of the effort to have C.S. tried a youthful offender, C.S.'s DCF worker, Cori Shimko, referred C.S. to Dr. John W. Connelly, Ph.D. for a Psychosexual Evaluation. In the introduction to his report, Dr. Connelly noted that Ms. Shimko made the referral for two reasons: 1) DCF needed to understand the risk he might pose, but also, 2) to determine the best system to meet his needs. Dr. Connelly further noted that Ms. Shimko "*detailed that there were worries that his limited skills and low functioning could lead to victimization in jail.*" (Emphasis added).

In his evaluation of C.S., Dr. Connelly noted that in February of 2005, when C.S. was 12 and 1/2, a forensic examination (partially quoted above) of his competency to stand trial had resulted in a determination that C.S. was incompetent to stand trial in juvenile court for an alleged Disorderly Conduct. The evaluator, Dr. Phillip Kinsler, Ph.D., reviewed C.S.'s history:

There are reports of physical abuse at the hands of [C.S.]'s father, as well as by his older brothers. One report alleges sexual abuse at the hands of his older brother. Several reports raised the question of sexual abuse by his father with no details or substantiation. [C.S.] engaged in highly sexualized behaviors over a considerable period of time.

Dr. Connelly noted that C.S. had "blown out of every placement" and:

... shown severe acting out behavior including violence, fire-setting, killing of a puppy by strangulation over a matter of days, suicide attempts, attempts at self-mutilation, temper tantrums, rages, victimizing other children and intimidating his mother and foster parents.

Dr. Connelly also assessed C.S. as having a General Intellectual Ability Score of 79 (range 1-100) which is in the "low range of cognitive functioning." Further details of the fire setting revealed that C.S. set fire to his father's bed and witnessed his father commit acts of violence against his mother.

Dr. Connelly finalized some of the background review by noting that, just prior to incarceration at SSCF, C.S. was discharged from the Bennington School in 2010, where he spent a total of 4 years and 7 months. The school noted that "[C.S.] had difficulty within the residential setting. At times, this escalated into periods of sustained dyscontrol, during which [C.S.] engaged in aggressive behaviors, property

damage and attempts at going AOL.” C.S. was prescribed a number of psychiatric medications at his discharge, including Abilify, Depakote ER, Loratadine and Seroquel. He was diagnosed with PTSD, Bi-Polar, and rule/out ADHD. He had a number of Axis IV stressors, including lack of primary support group, “many losses, physical and sexual abuse, and academic difficulty.”

Dr. Connelly’s own evaluation began with an interview with C.S.’s then caseworker at SSCF, Monique Sullivan. At that time, C.S. was in administrative segregation for having picked up numerous DRs, which Dr. Connelly noted, meant that “[C.S.] spends most of his time alone in his room, including eating meals alone.” C.S.’s caseworker told Dr. Connelly that “[C.S.] was prescribed several medications. She indicated that he rarely read anything due to his low reading ability and dislike for reading...[she] reported that for the past three months, [C.S.] has not had conduct-related issues. She also reported that he has had no visitors since arriving at [SSCF].” (Emphasis added).

Upon meeting C.S. in person, Dr. Connelly noted that C.S. seemed “a bit younger in appearance than his chronological age. His mannerisms and style were more consistent with a 15-16-year-old adolescent. He reported a height of 6’1 inch [sic], 140 pounds, appearing very thin and unhealthy. [C.S.]’s speech was marked by articulation errors, intermittently orating via poor grammatical structure.”

Dr. Connelly performed several tests on C.S. derived from the Woodcock-Johnson Psycho-Educational Battery – III (WJ-III). The test showed that C.S.’s “overall intellectual ability is estimated to fall within the low range of cognitive functioning.” Dr. Connelly found that,

[C.S.’s] verbal abilities fall within the low range of functioning suggesting that his fund for knowledge and ability to communicate that knowledge is developed much less than men his age. His thinking abilities fall within the average range of functioning, yet with this cluster, his scores were extremely fragmented. *[C.S.’s] cognitive efficiency which refers to his ability to process information quickly and automatically is at the low end of the low average range.* (Emphasis added).

Dr. Connelly also found that C.S.’s understanding of sexual norms was impaired. He reported that C.S. “has a skewed understanding regarding sexual rules, boundaries, etc. This is obviously in part due to his orientation within his family and the fact that as a young child, he was exposed to severe chaos, including his own sexual victimization.” C.S. could not name the President of the United States or the Governor of Vermont. He stated that he “spent limited time reading and had

essentially no access to television, or the radio due to being in administrative segregation.”

In making his findings and recommendations, Dr. Connelly noted further testing might be warranted to see if his “cognitive profile is low enough to receive adult services and agency support, as well as discuss whether or not he will be assigned a Guardian to help him with his legal, financial, medical and other affairs.” He opined that:

...early childhood experiences coupled with his compromised cognitive profile, limited interests, limited skills and reported frequent masturbation and uncertainty about his sexual orientation, collectively suggest a significant at-risk profile for future sexual behavior problems as well as he himself being taken advantage of sexually by more sophisticated, mature or physically stronger adults.

Of significance to this investigation are Dr. Connelly’s observations about the effects of being in a segregated environment without any kind of treatment. Those observations have bearing both on the determination of whether C.S. is a person with a disability, and if he is, whether placement in prolonged segregation, particularly at SSCF, was the “least restrictive environment appropriate for his needs” pursuant to the VFHPAA. In Dr. Connelly’s opinion,

...it is unfortunate that [C.S.] has spent the first year of his adult life incarcerated and not receiving any treatment. *He is currently placed in an environment where he is unstimulated and not engaged in any goal-directed behaviors. As noted in the text of this report, [C.S.] is developmentally immature and many of his behavioral infractions since being incarcerated are due to this immaturity, impulsivity, and poor judgment versus that of Psychopathy.* (Emphasis added).

Dr. Connelly recommended a “soon as possible” release from the DOC:

...placement in a residential therapeutic milieu where he can receive focused treatment for his sexual victimization, sexual-offending patterns, as well as attempts to strengthen his academic abilities (e.g. improve his reading) and identify future employment-related opportunities.

He also added a cautionary note:

...[C.S.. needs] close monitoring, as he is sexually indiscriminate and is apt to engage in casual sexual contact with others. It is hoped that [C.S.] can be placed in a program serving young men between the ages of 16 and 21 where he can receive the necessary supervision, mental health support, directed

treatment, etc. to better position him to achieve his stated goals of wanting to matriculate in society.

Dr. Connelly's also incorporated an assessment of C.S. performed by Dr. Robert Hemmer, Psy.D., in July of 2005. Dr. Hemmer believed that C.S. needed "intensive treatment" for anger issues and that C.S. "most likely suffers from Bipolar Disorder, Post-Traumatic Stress-Disorder and Attention Deficit/Hyperactive Disorder." Dr. Hemmer determined that C.S.'s full scale IQ was 73 and noted that "...this estimate of...IQ indicates that [C.S.] may not be able to fully appreciate his situation and thus may not be competent to stand trial." The record does not fully reveal whether Dr. Larson and CCS Employee #3 took any of these evaluations or findings into account.

**B. Department of Children and Families (DCF) Report – Supervisor Cori Shimko - October 2011**

Supervisor and Social Worker Cori Shimko – Department for Children and Families (DCF) (October 2011) - Ms. Shimko was clearly concerned for C.S.'s well-being in the adult system and was critical of her own agency's management of his care: In recommending that he be treated as a "youthful offender" she wrote:

[C.S.] presents as a young adult who's [sic] maturity is not reflective of his chronological age and whom [sic] has a history of being traumatized from perhaps pre-birth. It is important to recognize the bulk of research that suggests that children who experience domestic violence from the womb can be affected prior to birth. [C.S.] has experienced domestic violence, abandonment, significant loss, sexual abuse and likely a lack of appropriate care and nurturance all well before the age of 5. Brain development has likely been severely impacted. *From a very young age, [C.S.] has demonstrated significant and severe mental health and behavior problems which have placed him in unsafe situations over a long period of time. Twice residential treatment was recommended, however providers did not follow through with recommendations at the time for reasons that now cannot be fully understood.... When [C.S.] did obtain treatment in residential care, he was removed and returned to foster care, despite clear information from the provider...that what he required was a higher level of care and treatment.... In hindsight one could ask why he was not placed in a secure psychiatric facility...If [C.S.] stays in the correctional system, in this social worker's experience, he will likely victimize others and be victimized by others...If he stays segregated until discharged, there is even less hope for [C.S.] as what he needs the most is skill development.* (Emphasis added).

Ms. Shimko provided an extensive examination of C.S.'s background and mental health history and recommended to the court that C.S. "be given youthful offender status on one count of Lewd & Lascivious with a child under the age of 16." She recommended intensive around the clock supervision, "active engagement in treatment for sexually harmful behaviors" and active "engagement in mental health treatment" to include individual and group therapy, as well as "psychiatric treatment and consultation." She recommended that C.S. enroll in educational and vocational training and "transitional life skills programming." She suggested placement in a "developmental home" run by the Sterling Area Services which would provide specialized care such as:

...access to the community to learn real world life skills while he receives specific treatment for his mental health and sexually harmful behaviors while assuring that the community is safe, though [sic] one on one [sic] supervision, support, and structure. Sterling has much experience in providing services to highly dangerous and challenging youth and adults who would otherwise be institutionalized in staff secure or locked facilities.

She also recommended the other standard terms of probation and that the court review his progress in 6 months so it could monitor or sanction him if necessary.

Ms. Shimko's report contained other information important to this investigation's determination of whether C.S. is a person with a disability. Ms. Shimko noted that C.S. had been placed 10 times since being committed to DCF at age 8 in 2004. She noted that while C.S. "lacks social skills...he does show empathy and remorse for his behaviors and the ramifications regarding his sexual abuse of his brothers. He also has over time displayed empathy for others."

Lack of sufficient and appropriate treatment was the norm as C.S. was moved from one placement to another, or considered for placements which then fell through due to lack of funding or infrastructure as well as his continuing behaviors. On Thanksgiving of 2009, he was released from the Becket School to return home for the holiday. It was during this visit that C.S. sexually abused his two younger brothers. In response, his mother sent him to his father's house, who in turn sent him to his (father's) sister's home where there were young children without telling her what had happened. There is no indication that C.S. abused those children but DCF and the police were informed and C.S. was sent to the Woodside Juvenile Facility. In general, his parents were only sporadically supportive and kept in contact with him on an irregular basis, sometimes not even returning calls having to do with basic health care issues.

Ms. Shimko reported that three months after his 18th birthday, C.S. left Bennington “with no transition plan developed to transition into the community, no consistent and sustaining relationships with family or anyone else...” He moved around aimlessly, “couch-surfing,” and seeking out short-term shelters. He sought help from DCF but they could not find housing due to his pending charges and behaviors. DCF was able to put him in a motel for three days and tried to gain him access to food, but C.S. did not follow through with appointments.

He was finally cited for the Lewd & Lascivious charges and went to Newport briefly. As she led up to the conclusion of her report and her recommendations, Ms. Shimko wrote that, “[C.S.] has remained incarcerated for the last 14 months. He has received no treatment specific to his needs. He has been on administrative segregation or close custody most of that time...” She noted some deficiencies in his IEP and “questioned how [C.S.] could have met his transitional goals [and been awarded his high school diploma] as he then possessed minimal self-care and life skills.” She noted that he had been failing all of his classes. Ms. Shimko noted that while C.S. wanted to work, he “does not have realistic ideas about his own skills, what training and skills he needs to obtain sustaining employment to be self-supportive, and has a lack of employability and job skills.”

Her observations about C.S. support a determination that he is a person with a disability: “[C.S.] *can sometimes identify problem behaviors or situations, but cannot think of, or apply solutions*” and is “*sometimes confused about the outcome of his behavior, and not always able to see the logical connection between action and consequence.*” She noted he often failed to take responsibility for his actions and “*consistently fails to identify triggers that cause problem behaviors.*” (Emphasis added).

Ms. Shimko recommended Youthful Offender status for C.S. on the grounds that he had missed out on services even when the services had been strongly recommended, noting three separate occasions when residential services were recommended but without any follow through by his “legal team and the State.” She recommended sex-offender specific treatment and “intensive mental health treatment in a program where consultation with an expert treatment provider would take place, or a one-to-one community placement to teach C.S. specific life and other skills while ensuring community safety.

The court form posed the question of whether “the youth [is] amenable to treatment or rehabilitation as a youthful offender.” Ms. Shimko’s response took a long view to this question. She analyzed the question from the point of view of looking at long-term community safety and opportunities for C.S. since he would one day be

released from prison. She wrote *"If [C.S.] remains incarcerated, especially in segregation, and then is eventually released, he does not have the skills to adequately provide even basic care for himself. Inevitable [sic] he will be drawn toward...persons who will take advantage [of him] and victimize him in multiple ways. [C.S.'s] lack of boundaries and emotional needs will also likely lead him to violate the boundaries of others who are more vulnerable than he."* (Emphasis added).

C. Psychosexual Evaluation – Dr. Kathleen Kennedy - 1/18/13

On 1/18/13, Katherine Kennedy, Ph.D., then at the University of Vermont, performed a "Psychosexual Evaluation" of C.S. per order of the sentencing court. Much of the report included a review of his personal history, much of which has already been included. The new findings and observations Dr. Kennedy made include the way C.S. acted at the assessment, as her findings with respect to his amenability to treatment and likelihood of re-offending. She was retained to "determine his level of risk to reoffend and the appropriateness of sex offender treatment." She summarized her report by noting the "Problem Formulations" first:

[C.S.] clearly has mental health issues that are significantly impacting his functioning. Based on information reviewed for the PSI, they appear to have initially emerged when he was preschool-aged and included assaultive and self-injurious behavior. [C.S.] was reportedly sexually and physically victimized as a child.

As to "Risk" she wrote:

[C.S.'s] risk of reoffense was conducted using the Static-99R, the Vermont Assessment of Sex Offender Risk-2 01 ASOR-2), and the Sex Offender Treatment Intervention and Progress Scale (SOTIPS). [C.S.'s] combined risk to reoffend... falls within the Moderate-low risk group, with an estimated sexual recidivism rate of 4.8% within five years upon release into the community. The dynamic, or potentially changeable, factors that are also linked with criminal behavior were assessed...Based on the information provided for this evaluation, [C.S.] possesses some of these risk factors, including sexual behavior problems, poor emotion management skills, poor problem-solving ability, rule-breaking behavior, unemployment, and limited social support. On the positive side, a factor that may contribute to a lower likelihood of reoffending that is demonstrated or possessed by [C.S.] includes the fact that he admits to his sexual offense. These factors are not exhaustive, and [C.S.] may possess other risk or protective factors.

With respect to “Treatment and Supervision Needs” she opined that C.S.” will require treatment to address his sexual offending behavior and any associated attitudes.” With respect to his Responsivity Issues (to treatment), she wrote that “[C.S.’s] mental health issues will likely interfere with his ability to effectively participate in treatment. His cognitive ability was assessed in 2010 and yielded an overall score falling within the borderline range of intellectual functioning, which will also probably affect his ability to participate.” Her assessment ended with her Recommendations:

1. It is recommended that [C.S.] participate in a specialized sex offender treatment that uses a cognitive behavioral and psychoeducation-oriented group approach.
2. It is recommended that at some point [C.S.] participate in an updated comprehensive psychological evaluation in an effort to specifically identify and treat his mental health needs. Treatment would likely include a combination of psychological interventions and psychotropic medication.

### **III. What does the term “Segregation” mean?**

Since C.S. claims he was segregated and that segregation would have been unnecessary had he been provided better services, “segregation” must be defined:

For purposes of this title, and despite other names this concept has been given in the past or may be given in the future, "segregation" means *a form of separation from the general population which may or may not include placement in a single occupancy cell and which is used for disciplinary, administrative, or other reasons.*<sup>20</sup>

None of the DOC staff interviewed by this investigation defined segregation according to the statutory meaning when asked to do so. Instead, they described custody statuses and specialized units however those descriptions still matched the statutory definition of segregation. This contributed to the difficulty of determining how restricted inmate actually are. Every definition or matrix seems to have some variation, exception, or allowable exercise of staff discretion that makes distilled definitions difficult. For instance, the matrixes found in *Conditions of Confinement* #410.06 are labeled as “Samples” only. The matrixes for Disciplinary Segregation and Administrative Segregation, Phase I and Phase

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<sup>20</sup> 28 V.S.A. § 701a(b).

II determine what one can have in their cell according to their segregation status, how often one can come out of their cell; how often an officer must document observing them, how often they can shower, etc. but may be subject to “tweaking” by facility staff.

For instance, “Restraint Status I” is mentioned in *Conditions of Confinement* #410.06. However records often mention Restraint statuses II and III for which no definition can be found. Similarly, the directive term “close custody” is defined as minimum, medium and close, but each can be a universe in and of itself. Thus the term “close custody” is self-referential without discrete definition. An inmate can also be in “close custody by points” which is not defined and the point system is subject to staff discretion. The multiplicity of cross references between policies and directives adds to the confusion. This issue is not peculiar to Vermont.<sup>21</sup> While the facility certainly benefits from this definitional obscurity, the frustration of tracking down clear-cut answers in a DOC investigation can be likened to chasing down drops of mercury loosed from a broken thermometer.

The nature of particular units contributes to this. The 11-cell Alpha Unit at SSCF is an example of unit fungibility. While Alpha is designated as the Mental Health Stabilization Unit (MHSU), it can house inmates on four different “statuses:” a) Close Custody [see #371.04]; b) Mental Health Treatment [see APA Rule #05-049]; c) Administrative segregation [see #410.01, #410.03 and #410.06], and d) Disciplinary Segregation [see 410.01, 410.03, APA Rule 05-049]. Nonetheless, per the statutory definition, it is impossible to classify placement in Alpha as anything but segregation and that certainly was the case with C.S.

Similarly, staff described the Bravo Unit, also known as the Mental Health Transitional Unit (MHTU), as a general population unit, however when C.S. was placed there, the nature of his confinement also fit the statutory definition of segregation. For instance, his “Bravo Close Custody Behavior Plan” required that he be “confined to his cell.” He was to eat all meals in his cell, not leave the unit, not have a TV, only come out for recreation alone, at which point the plan read in caps: “THE REST OF THE UNIT WILL BE LOCKED DURING HIS REC PERIODS.”

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<sup>21</sup> The authors of the Linman Project stated in their 2013 report: “...the challenges in compiling and comparing policies are significant. As noted, correctional systems do not standardize the terms related to segregation, nor provide the same levels of detail, and many jurisdictions employ more than one kind of administrative segregation. Because of the different forms of administrative segregation, the divergent criteria, the array of processes for the initial and for ongoing placement, and the varying conditions and degrees of isolation, this overview necessarily generalizes and excludes some details of policies.” Administrative Segregation, Degrees of Isolation, and Incarceration: A National Overview of State and Federal Correctional Policies: A Project of the Linman Public Interest Program at Yale Law School, June 2013, at 3.

This is a form of separation from the general population in spite of the misconception on the part of staff and inmates, (including C.S.), that being in Bravo is being in general population.<sup>22</sup>

While the statute and implementing regulations distinguish between administrative and disciplinary segregation, all segregation ends up having a punitive aspect, regardless of what it is called. There is no privacy, no dignity, nothing that cannot be taken away – no freedom of movement, little to move time faster. C.S. also spent considerable time in segregation before coming to SSCF and after he left SSCF for Newport a second time, but the qualitative difference during his second Newport stay provides an astonishing contrast to SSCF. His time in segregation at Newport was coupled with an aggressive and achievable behavior plan with an embedded mental health component that allowed him to contribute to its creation to enough of an extent that there was buy-in and success.

#### **IV. What do the terms “SMI” and “SFI” mean, how does that affect segregation, and why does diagnosis matter?**

There are several issues with respect to the term “Serious mental illness” - SMI<sup>23</sup> - and the designation of serious functional impairment - SFI<sup>24</sup> - in C.S.’s case. First, C.S. was not designated SFI until January 22, 2013, coincidentally, on the day of his assessment with Dr. Katherine Kennedy although every indicator shows he should have been so designated immediately in 2010 upon entry to the facility. Second, the DOC violated its statutes, rules and the VFHPAA by not designating him as SFI immediately in 2010 and making accommodations for him. However even once he was designated as SFI, there is no evidence that his life at SSCF changed for

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<sup>22</sup> On 8/6/13, C.S. filed a grievance through DRVT and asked to be moved to Bravo Unit which he equated with general population. This investigation does not agree that Bravo Unit fits the description of general population, particularly under the circumstances that he was placed in while there. The grievance was filed pursuant to DOC Policy #320.01. It stated that C.S. had been in segregation since 2010 without receiving “adequate mental health treatment and that my behavior plan has goals that – given the lack of my mental health treatment – are unrealistic for me to achieve, as evidenced by the 150 DRs I have received and the on-going self-harm during this time. I am grieving the fact that I had a diagnosis of Bi-Polar Disorder in community, and was evaluated just prior to my incarceration, but DOC removed that diagnosis from my records. There is no documentation that DOC discussed my complex treatment needs with my community provider to offer continuity in care. I am currently designated SFI.”

<sup>23</sup> DOC APA Rule 05-049: “Serious Mental Illness: Substantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. This includes, but is not necessarily limited to, diagnoses of schizophrenia, schizoaffective disorder, psychotic conditions not otherwise specified, bipolar disorder, and severe depressive disorders.”

<sup>24</sup> Vermont DOC Directive 410.01: SFI-designated Inmate: An inmate designated by the Chief of Mental Health Services to be severely functionally impaired, based on an inmate’s diagnosis and functioning during incarceration and the recommendation of DOC medical and mental health providers.

the better – in fact, if one uses the genital mutilation as an indicator – it got worse, although he could no longer be held in disciplinary segregation more than 14 **consecutive** days.<sup>25</sup> However staff could always change his status for a day into some other form of segregation, then put him right back in DS in if they felt it was warranted.

Third, although C.S. clearly had mental health diagnoses (that varied somewhat over time) and developmental delay issues, the prevailing opinion was that C.S. was choosing to behave the way he behaved –and that he could change anytime he wished. Fourth, the “secure and orderly running of the facility” were terms that could trump anything an inmate wanted - access to a job, library, gym, etc. This could occur on a macro level (murder or suicide with resulting facility lockdown) or a micro level (change of shift, someone acting up, officer doesn’t feel like it – justifiably or otherwise). The “security needs of the facility” were built into every behavior plan and was the repeated justification for the segregation review committee decision to keep C.S. in segregation when such documentation could be found.<sup>26</sup>

The perspective that C.S. could “choose” his behaviors and could stop them at will was completely simplistic. It bespoke an ignorance of C.S.’s particular background and to the impact of significant developmental delay. These attitudes also ignored the knowledge and understanding of mental illness and developmental delay challenges embedded in the rules and in statutes. Vermont DOC APA Rule 05-049 defines “SMI” as:

[A] [s]ubstantial disorder of thought, mood, perception, orientation or memory, any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life. This includes, but is not necessarily limited to, diagnoses of schizophrenia, schizoaffective disorder, psychotic conditions not otherwise specified, bipolar disorder, and severe depressive disorders.<sup>27</sup>

The term “Serious functional impairment” – “SFI” is defined as:

...(A) a disorder of thought, mood, perception, orientation or memory as diagnosed by a qualified mental health professional which substantially impairs the ability to function in the correctional setting; or (B) a development disability, traumatic brain injury or other organic brain disorder, or various

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<sup>25</sup> Id.

<sup>26</sup> See Turner v. Safley, 482 U.S. 78, 84–85, (1987) (noting deference to administration regarding prison management is appropriate).

<sup>27</sup> Vermont DOC APA Rule 05-049.

forms of dementia or other neurological disorders, as diagnosed by a qualified mental health professional, which substantially impairs the ability to function in the correctional setting.<sup>28</sup>

One other significant aspect of the APA rule is that it recognizes the impact of “concurrent disabilities” which had a tremendous impact on C.S.’s ability to adjust to the correction’s environment. The rule defined “concurrent disabilities” as:

Inmates with serious mental illness may also suffer from cognitive impairments, developmental disabilities, and traumatic brain injury (TBI), as well as an assortment of health conditions. Additionally, *functional problems such as very low reading level, communication problems, and poor adaptive living skills* may complicate the management, assessment, and treatment of seriously mentally ill inmates. *Since these conditions may not be readily apparent to correctional staff who supervise inmates, QMHPs and other clinical staff will assess these or refer for specialized assessment as needed and will assist in the development of both treatment and custody plans which accommodate these conditions. This includes not only diagnosis, but also recognition of the interaction between serious mental illness and other disabilities, and how this interaction manifests itself in the correctional environment.*<sup>29</sup>

The definition highlights the impact of concurrent disabilities on the development of case plans:

If the QMHP has reason to believe an inmate is unable to comply with behavioral requirements due to a concurrent condition or complication, *the treatment plan will include accommodations to minimize confusion and allow alternative approaches to gaining the inmate’s cooperation.* An example is to provide verbal explanations of rules and expectations, rather than rely on written handbook instructions. Another is the use of positive reinforcement for successes.<sup>30</sup>(Emphasis added).

The staff at SSCF – casework, mental health, security and administrative never seemed to fully explore or understand and therefore embrace the definition or the necessary accommodations C.S. needed.

There is also no evidence that C.S. benefitted from the other so-called “safeguards” offered by the rule’s policy. This included the due process considerations that must be followed when someone is placed in either administrative

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<sup>28</sup> 28 V.S.A. §906(1).

<sup>29</sup> *Id.* at 6

<sup>30</sup> *Id.*

segregation (AS)<sup>31</sup> or disciplinary segregation (DS).<sup>32</sup> Alternatives to segregation can be considered and the Superintendent has the authority to not segregate someone if he or she believes it is contraindicated.<sup>33</sup> There are variations between AdSeg and DS with respect to the due process components, but C.S. was not consistently treated as an SMI inmate or designated as an SFI inmate for the majority of his time at SSCF, so the rules did not appear to mean much.

Segregated inmates were to get daily visits from nurses or mental health workers and mental health was to ensure three weekly visits. Restraints and the use of pepper spray were also limited with SMI inmates and safeguards were supposed to be built in. In *Restrictive Housing* #410.06, provides for a segregation review committee that is directed to review the propriety of the particular segregation.<sup>34</sup> According to the paperwork reviewed by this investigation, up until C.S. went to general population, the committee approved his segregation over and over again - in some form or another. A problem arises when an inmate is continuously in segregation - that is, the demarcated procedures begin to fall by the wayside and documentation suffers because events begin to run together. It is nearly impossible to determine the discrete reason why someone might be in segregation on a Tuesday, since an event from that day, or the day before, or the month before or even two months before might have resulted in such placement. In C.S.'s case, this investigation would review

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<sup>31</sup> Id. at 4. "A form of separation from the general population when the continued presence of the inmate in the general population would pose a serious threat to life, property, self, staff or other inmates or to the security or orderly running of the institution. Inmates pending investigation for trial on a criminal act or pending transfer may also be included." Inmates could be placed in administrative segregation "only after due process and assessment by a QMHP and upon approval of a physician." "The Superintendent shall make reasonable efforts to accommodate the behavioral and mental health needs of the inmate in a setting other than segregation, consistent with the safety and security of the institution. These options include, but are not limited to, removal from programs or activities, change in living unit, restriction to living unit, early lock-in, restriction to cell or room, or intermittent segregation." There was no documentation connecting Potanas to such alternatives.

<sup>32</sup> Id. at 3.

<sup>33</sup> Id. at 3-4. "If contraindications exist, the QMHP will recommend alternatives to segregation. All alternative options shall be considered prior to placing an inmate with serious mental illness in segregation. These options include, but are not limited to, other disciplinary actions such as loss of privileges, removal from programs or activities, change in living unit, restriction to living unit, early lock-in, point fines, temporary loss of use of personal property, institutional community service/reparation, reprimand, apology, written essay, monetary restitution, restriction to cell or room, or intermittent segregation. The consideration of alternatives must be documented. The Superintendent shall make reasonable efforts to accommodate the behavioral and mental health needs of the inmate with a serious mental illness in a setting other than segregation, consistent with the safety and security of the institution."

<sup>34</sup> Vt.DOC Directive 410.06. "A committee comprised of three (3) or more individuals from the ranks of custody operations, casework and medical or mental health. The purpose of the committee is to 1) determine the needs and requirements of an inmate assigned to segregation and 2) to assess the progress of individuals prior to a phase advancement or release from segregation status to determine whether the conduct of the inmate placed on segregation warrants further segregation."

documents generated in December of 2013 which noted that C.S. had been segregated since, say, 8/29/13. However, when this investigation looked back to see where whether C.S. was segregated on 8/29/13, one day before his segregation “started on 8/29/16, it would find he was. So it was a continuous, rolling segregation without clear margins. Distinctions without differences.

Per the rule, SFI inmates are to have QMHPs assess them prior to a DR hearing to determine if the behavior which resulted in the DR is the result of a SFI, if there is any contraindication to segregation and to make any recommendation for a sanction to the hearing officer.<sup>35</sup> Available records show that mental health providers almost never pushed back. There are a few other SFI provisions in 410.01 that pertain to SFI inmates but they need not be further discussed here.<sup>36</sup> In general, while the statute sets out mandatory directives for DOC with an SFI inmate, C.S. went through the system experiencing a lot of pinch-hitting and an ineffective hodge-podge of approaches. The SFI designation did nothing to jump start a fresh approach.

The statute and APA rule emphasize the importance of extensive staff training as to how to deal with inmates who have significant mental health issues or co-occurring disorders, however in another public investigation performed by this investigator, staff at SSCF, including Christina Granger, did not recall having any training. The State later claimed that the training had occurred, however this investigation finds it significant that neither Ms. Granger nor the four other COs who were interviewed for that case, (at least one of whom worked with C.S. in Bravo), recalled the trainings.

There have been studies documenting the difficult adjustments that mentally ill inmates with co-occurring disorders, (such as developmental delay), face. This issue exists and has existed in many places in nearly identical form. During the year 2000, Kathryn Burns, M.D., M.P.H. and Jane Haddad, Psy.D.,<sup>37</sup> were retained to review various parts of the Alabama Department of Corrections.<sup>38</sup> Their conclusions are

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<sup>35</sup> Vt. DOC Directive 410.01. As noted later in the report, the QHMPs never found the behaviors due to a SFI or found any contraindications to segregation and only twice recommended anything other than segregation.

<sup>36</sup> 28 V.S.A. §907 has directives that are extensive and mandatory, not discretionary. It sets forth a method for screening inmates who have a “serious functional impairment” (SFI) and directs the DOC to develop and implement an “individual treatment plan” for those inmates who have an SFI. Persons with SFI are to be screened within 24- hours of arrival. The statute also requires a “thorough trauma informed evaluation” conducted in a timely and reasonable fashion by a [QMHP].” The statute requires that SFI inmates have access to follow-up evaluations, crisis intervention, crisis beds, residential care within a correctional institution, clinical services provided within the general population of the correctional facility, and services provided in designated special needs units – presumably Alpha and Bravo.

<sup>37</sup> Dr. Haddad also works for MHM Services, Inc., who operates as Centurion, LLC in Vermont.

<sup>38</sup> Kathryn Burns, M.D. and Jane Haddad, Psy.D., “Mental Health Care in the Alabama Department of Corrections,” *Bradley v. Hightower*, Civ. No. 92-A-70-N (N.D. Ala., June 30, 2000), p.4.

similar to some of the findings of this report with respect to SSCF and the problems with accommodating inmates with mental health and development delay issues, including:

...2) Inmates with serious mental illness report that they frequently must violate rules, hurt themselves or cause property damage to gain the attention of staff. Often even this destructive behavior does not eventuate in treatment; only further disciplinary action and segregation result.

...6) Therapeutic programs and counseling are wholly inadequate. Some claims as to providing psychotherapy, both in terms of frequency and what this clinical activity entails, are transparently false.

... 8) Based on inmate reports and medical record documentation, some mental health staff have demonstrated a general distrust of and contempt for individual inmate-patients.

... 10) here is little or no evidence of effective training of staff on the rudiments of mental illness and medication.<sup>39</sup>

Furthermore, Dr. Burns and Dr. Haddad also found “treatment plans” at ADOC subpar in much the same way that this investigation has found SSCF’s plans subpar in C.S.’s case:

The type and level of individual and group treatment available to the MHU inmates is seriously deficient. The psychiatrist and psychologist provide only cursory individual reviews of the inmates. Individual treatment plans are developed but they are generic and provide very limited information about the inmate. A typical treatment plan, for example, lists the following goals: optimize psychopharmacotherapy (medication); participate in group therapy (156007).<sup>40</sup>

They also characterized mental health rounds as “drive-throughs” with very little therapeutic value.<sup>41</sup> With respect to the lack of staff training, the authors note, “Without training, behavior associated with serious mental illness is likely to be treated as willful misconduct and such behavior associated with an illness becomes an occasion for a disciplinary proceeding.<sup>42</sup> These same issues presented significant hurdles in the effective treatment of C.S. and resulted in what appears to have been an intensified deterioration of his mental health while at SSCF.

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<sup>39</sup> Id. at 4-5.

<sup>40</sup> Id. at 31.

<sup>41</sup> Id. at 23.

<sup>42</sup> Id. at 65. This certainly describes C.S.’s circumstances.

## V. Time in segregation at SSCF and the effect of DRs in general

The amount of time C.S. spent in segregation was determined partially by examining forms generated by Correct Care Solutions (CCS) such as, (but not exclusively), Mental Health Non-SFI (and later SFI) Weekly Segregation Rounds, Self-Harm Watch/Mental Health Observation Summaries, Staff Referral Forms and Nursing Progress Notes. Forms and notes generated by the DOC supplemented CCS's forms. The DOC records that might reveal whether or not C.S. was in segregation include, but are also not limited to, end of shift reports (EOSRs), Segregation Confinement Logs, Incident Reports, Meeting Notes, Disciplinary Reports, caseworker notes and Behavior Plans.

Since forms were sometimes missing, this investigation plotted the days of incarceration that could be accounted for by documents and then tried to account for the gaps by assuming that logically speaking it was highly unlikely that C.S. had been in administrative segregation for 5 days, went to GP on the 6<sup>th</sup> and was back in Adseg on the 7<sup>th</sup>. In other words, it is highly reasonable to assume that the gaps can be accounted for because someone forgot to fill the data. For instance, a segregation log may show that C.S. was in administrative segregation May 18 through May 23. On May 24, the column is blank, but on May 25, the recording in AdSeg begins again. It would make no sense to think C.S. moved to GP for a day and came back the next, thus, this investigation accounted for missing days using this common sense approach. His allegation is of continuous segregation and the records bear this out.

All told, using the method of multiple document examination, C.S. was in segregation for every day of the 2.4 years he was at SSCF. He was either in Foxtrot, Alpha Unit or briefly, in Bravo unit and his "status" in each of these locations qualifies as segregation. He was usually segregated because he picked up "DRs" – disciplinary reports – either majors or minors. Major infractions ranged from serious, such as an assault on staff or purposefully flooding his cell, to minors (any number of things). DRs could result in anything from being sent to disciplinary segregation or Phase I administrative segregation, or being placed in Alpha unit in a safety smock if he made threats of suicide or other self-harm. On top of, or in addition to those sanctions, he could also be denied such privileges as phone calls – none, for 30 days (or less), or put on "crayon status" – i.e. have to write with a crayon, (**see Exhibit 3**), or denied personal items in his cell such as coloring books or magazines or even clothes with the exception of boxer shorts, or having his mattress and blanket removed from early morning to the evening, every day for 30 days (or less). The sanctions run according to policy and permissible items are awarded according to custody status.

A pattern of assignment to segregation emerged from an examination of documents: C.S. would “mess up” he would get a “DR” and get time in segregation, then more time, then even more time. The isolation and sheer boredom inherent in segregation caused attention seeking behaviors, negative or otherwise which led to DR after DR.<sup>43</sup> Then, the sanctions associated with the DRs strip what little someone has away - literally. In addition to formal sanctions, there were informal sanctions because staff got tired of writing formal DRs. This was recognized in an email by the shift supervisor at SSCF who instructed staff to write DRs so that an inmate’s possible years in segregation could be justified if inquired about by Central Office.<sup>44</sup> DRs pose significant issues for inmates with disabilities:

Mentally ill prisoners are routinely punished under prison disciplinary systems for rule infractions arising from their illness without regard to their actual culpability. Unless an infraction is minor, it will be adjudicated in a formal hearing. In theory, prison disciplinary hearings can lead to a finding of “not guilty....” however, this ... rarely occurs...the real purpose of the hearing is to determine punishment... [H]earings provide a modicum of due process...Nevertheless, they typically do not recognize incompetence...the hearing goes forward regardless of whether the prisoner is capable of either understanding the charge or presenting a defense. Nor do [the]... hearings permit an insanity defense.... Hearing officers may not even take mental illness into account as a mitigating factor in determining a sentence. They do not consider whether the prisoner’s conduct reflected significant cognitive or volitional impairments. The imperative of punishment supersedes any potential recognition that a mentally ill prisoner may not have been meaningfully able to control his behavior. Prison officials... fear that accommodating mental illness will provide excuses for prisoner misconduct, encourage others to engage in similar misconduct, and promote a general breakdown in order. Particularly strong is the concern about malingering—that inmates will fake mental illness to avoid punishment for misconduct.<sup>45</sup>

Even when staff would “clear” or override his DRs, the failure to change the facility problems embedded in his mental health and behavior plans came right back and resulted in a repeat of a vicious cycle.

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<sup>43</sup> Hans Toch & Kenneth Adams, *Am. Psychological Ass’n, Acting Out: Mal-Adaptive Behavior in Confinement* 106–10, 112 (2002); discusses “periods of high disciplinary involvement overlap with symptomatic behavior seriously disturbed inmates.” See also Kenneth Adams, *The Disciplinary Experiences of Mentally Disordered Inmates*, 13 *Crim. Just. & Behav.* 297, 304 (1986).

<sup>44</sup> 7/5/13 email, CSSF Kevin Jenkins to SSCF staff.

<sup>45</sup> Jamie Fellner, *A Corrections Quandary: Mental Illness and Prison Rules*, 41 *Harvard Civil Rights-Civil Liberties Law Review* 391, 398 (2006).

## VI. SSCF: Behavior Plans, Mental Health Services and Staff

Just prior to his arrival at SSCF in March 2011, C.S. was incarcerated in Newport and was in "closed custody by points."<sup>46</sup> On 3/15/11, there is a significant entry in the case notes from then Superintendent Jay Simons. In the entry, Mr. Simons noted that he sent the following message Deputy Secretary of AHS Patrick Flood regarding C.S.:

I hope this message finds you well. I am writing regarding the case of the young man we spoke about during your visit to the NSCF. I've attached a sample of a plan he has put forward. I believe when you read the plan, a few of his needs will become evident. He is the young man who was incarcerated for the lack of a court appointed guardian. That seems simple enough, and we have tried but have so far been unsuccessful getting him one. He has significant sexual behaviors that get in the way of his being successful with the "average responsible adult." It is these very behaviors that make him vulnerable in the prison and general population. As result he bounces between restrictive housing and a holding cell. ***This is a case that needs close supervision no matter where he lives. Are there any services that you can point me towards? I'm afraid that he is falling between the cracks.*** Any assistance you can provide will be greatly appreciated. (Emphasis added). (See Exhibit 4 for the letter Mr. Simon referred to).

There was no indication that Assistant Secretary Flood responded to Mr. Simons in the massive amount of material provided by the state. Mr. Simons indicated to this investigation that he did not recall making the case note entry and did not recall whether Assistant Secretary Flood responded.

Collectively, records show that the DOC certainly could have and should have designated C.S. as an SFI inmate and almost certainly would have but for multiple failures to follow-up, not just in 2010, but in 2011 and 2012. As a result, C.S. was not designated as SFI until 1/22/13 and then only provisionally. At that point, he had been in some form of segregation continuously for nearly 3 years. There was one final case note entry from the Newport caseworker indicating that C.S. continued to "have a difficult time relating to staff" and had a tendency to hoard items and a difficult time with hygiene. During his time in Newport, C.S. received 21 DRs, plus one at Chittenden. A week later, on 4/26/11, C.S. was moved to Southern State Correctional Facility where he would remain for 2 years and 4 four months.

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<sup>46</sup> This is an amalgam of elements like DRs received, program completions, attitude, etc. It is subject to arbitrariness.

## A. Overview: SSCF Behavior Plans and Mental Health Treatment

As noted in the Introduction, while behavior plans evolved out of team meetings, there is little evidence of communication or coordination between different staff with respect to development and implementation. They would devise a plan, it would not work, the staff would reconvene and revise the plan. CSS Granger, as well as Assistant Superintendent Marsh insisted to this investigation during interviews that the plans had worked. However, on 8/15/13, only two weeks before C.S. left for Newport, CSS Granger made a case note entry acknowledging that none of the plans worked. She was not alone. CCS Employee #2, the Director of Mental Health in a Mental Health Recommendation for C.S. dated 8/27/13 wrote: "The treatment team has constructed many treatment plans with the hopes of effectively engaging [C.S.] and helping to shape more positive behaviors, but these have not been very successful, often failing at the point of implementation."

While C.S. clearly needed a change, it is troubling is that it took so long for this to happen. Dr. Larson put the brakes on this idea on 1/18/13, for several reasons, including the fact that 1) he had just been to Newport without behavior changes, that 2) SSCF staff had had a break while he was there, 3) that SSCF was the "most experienced with dramatic and inflammatory behaviors and the Alpha Unit is well staffed," 4) that "other facilities cannot provide housing with the same capacity for close observation."

SSCF staff gave C.S. boilerplate Behavior Plans that he may not have been able to read or comprehend very well given the concerns expressed in the reviewed evaluations.<sup>47</sup> CSS Granger acknowledged she had not been trained how to write behavior plans. She stated she learned by reading her predecessors' plans which were certainly not worthy of emulation. For instance, one of her ('the teams') behavior plans called for C.S. to go 45 days DR free. However, this expectation was without any commensurate accommodations for and consideration of what it would take to make him successful. Superintendent Potanas also acknowledged that he had no training writing behavior plans. These staff deficits set C.S. up for failure and then he was blamed for the resultant outbursts the failures produced. The CSS and mental health team are the central players in the crafting and implementation of the plan, thus when there is an extremely difficult inmate for whom the plans are not working, it would make sense to ask for outside consultation, but this did not happen. Instead, the

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<sup>47</sup> One of the recreational therapists described him as often having difficulty with his attention span, focus and ability to concentrate. This is consistently described throughout the years by staff.

records show a slow “giving up” on C.S. and a willingness on the part of mental health to let the DOC dictate the rules of his custody in all respects.

One of the more troubling documents was from one of his treating psychiatrists, CCS Employee #3. CCS Employee #3’s note comes on 1/22/13, four days after Dr. Larson’s memo to Dr. Burroughs-Biron and the same day that Dr. Katherine Kennedy’s evaluation was performed, calling for an updated psychological analysis – which obviously CCS Employee #3 could not have seen due the timing. CCS Employee #3’s note read as a justification for providing only nominal mental health support to C.S. from that point on, because he had then determined that C.S. had Borderline Personality Disorder:

Sadly, treatment for Personality Disorders is a long and complicated process of intensive psychotherapy which requires that the patient be engaged with the therapist. No medication outcome studies exist that might help us in initiating yet another medication trial. . . .Initiating any type of psychotherapy treatment plan would not be affective due to the milieu and [C.S.’s] very concrete thinking and inability to approach any issue from a psychological view. Our treatment must be directed solely at assuring his safety. His symptomatic medications help to reduce impulsivity and explosiveness which is the most direct and productive way to medically address safety issues. Based upon its evaluation and set of safety procedures, the Department of Corrections has place [sic] [C.S.] in the safest type of security available at this facility. Mental Health will continue the present treatment plans. It is my recommendation that we take our lead from Corrections to the best way to assure [C.S.’s] safety.

It assumed that meaningful psychotherapy would not work – and that there were no other diagnoses which might have been playing significant roles and might have required accommodations such as the ADHD, PTSD, Impulse Control issues. It assumed a previous level of psychological support that is not backed up by the records. It also misses a major point – a point recognized by an earlier caseworker at SSCF, and later in at least one instance by CCS Employee #2 and later implemented successfully at Newport – that C.S. *did* deal with concrete ideas better. He responded better to the calendar on the door. He responded better to concrete examples. He responded better when people paid attention to him, since, to put it colloquially – he was still very much a kid. He responded better to goals with *short* time spans – 7 days DR free, not 45 days. Basic building block approaches would provide him with the increasing ability to manage himself and attain goals once at Newport. CCS Employee #3’s memo seems very much like an effort to legitimize a systemic decision to “wash its hands” of C.S. and any further pretense of treatment.

## B) History of the SSCF Plans

There were significant missed opportunities to accommodate C.S. Despite what seemed to be at the very least an obvious developmental delay, it took the first caseworker Judith Brileya from April 2011 until July of 2011 to develop the first behavior plan.

On 7/8/11, the first behavior plan was entered into the case notes. Brileya also noted he had not received a Major DR in 33 days. She noted he was to start a reading group, but noted no supports that might be provided to avoid the prior experience. Her plan was vague and it boiled down to "follow the rules of the facility." For instance, it said he was to "remain minor and major DR free." He was to be "pro-social" and not assault staff, not possess weapons, not be disruptive. If he was able to do this for 30 days, he would get an override for his DRs. The plan noted "will work with assigned CSS and mental health *as needed*." This was completely insufficient. It was too broad and too vague in terms of both prohibitions and lack of meaningful rewards that had fleshed out parameters. Furthermore, by 7/19/11 he had a new caseworker. By 9/12/11 he had yet another.

Meanwhile, on 8/23/11, the first mental health treatment plan (MHTP) was issued by CCS Employee #1. Treatment foci were reduction in frequency of impulsive behaviors with a goal of less DRs for impulsive behaviors. The interventions were identified as an exploration of "pros & cons" of compliance with rules and prescriber's recommendations. Progress measurements were to get "no disciplinary reports for 2 months" i.e. 60 days. The second focus of treatment was to reduce the negative impact of traumatic life events on daily functioning through learning to "implement calming and coping strategies to manage stress." The progress measurement was difficult to read but it included "subjective self-report of something and lessening of stress related trauma." The first focus had an anticipated completion date of 10/23/11 and the second focus had a completion date of 11/23/11. The only indicator about how often CCS Employee #1 would meet C.S. was the reference in the behavior plan of 7/8/11– as needed. Had C.S. had any desire to discuss "stress related trauma" with CCS Employee #1 or anyone else, he would have had to do so on a Restraint 1 status, likely with a black box, and with no privacy.

Documents show that C.S. was placed in disciplinary segregation on 8/27/11 although the case notes reference this only because CSS Sullivan noted she talked to him on Fox. The two documents were Segregation Review Evaluations – a 30-day and 60-day review. The 30-day review was done by CCS Employee #1 on 9/27/11. The 60-day review was unsigned. At 30-days the review recommended continued segregation and revealed that C.S. had been seen three times in 30 days by mental

health – once every ten days, plus a weekly segregation round which is akin to a drive-by. There was no mention of the MHTP or the behavior plan or having talked to the CSS. The note stated that C.S. had been working on “decreasing impulsive behaviors.” CCS Employee #1 checked a box which noted “No psychotic symptoms, suicidal ideation or mental deterioration noted during interview.”

The 60-day review took place on 10/26/11. This time, continued segregation with no mental health restrictions was again recommended, but with no review date. The form said “Next review – Unknown.” Otherwise, the form stated that C.S. was on psychotropic meds and that he was compliant with them, and was not experiencing psychosis, suicidal thoughts or mental deterioration. The note added that he has been working on “affect regulation and impulse control.” Also noted was that he has been seen on an individual basis 7 times in 60 days as well as on weekly segregation rounds.

A cross-reference with the CSS’s notes during the 30 and 60-day review period, and after 9/20/11 when he requested a unit job and complained about the reading class, showed little affirmative action by case work staff or interface with mental health staff. On 9/24/11 he told his CSS that he was upset he could not have the cleaning job. She told him he could not have it if his own cell was dirty; it is clear he did not have the same definition of cleanliness that others had. She offered to get him a calendar to have the unit officers check off on the days his cell is clean to standards. She wrote: “He liked the idea because it is something tangible that he can see every day.” On 9/28/11, she told him that the team would not discuss his having a job until he could show that he can “maintain proper personal hygiene. So far he has not.” He also attended his first anger management class that day. He picked up a DR on 10/10/11 for having commissary items he was not allowed to have. He complained that one CO had let him have the items but a different CO took them away and wrote him up. Whether intentional or not, both COs were figures of authority and these kinds of situations clearly felt unjust as reflected in the comments recorded by CSS Sullivan.

The lack of interventions and missed opportunities, in spite of all the red flags that got raised on a regular basis, continued throughout his stay at SSCF. It was clear that C.S. was very childish, immature and young for his age and that he had obvious developmental and social delays. It was clear that even at that point, after having been incarcerated for well over a year at SSCF that C.S. did not “get it.” He could not read well; he did not understand basic concepts of personal cleanliness. He did not understand why he could not just be moved from Fox. He did not have social skills and did not know when not to talk to other inmates in a sexual manner. One CO broke

the rules by allowing him items in his cell that another CO would not allow and he got in trouble for it - which he very reasonably resented -- he did not grasp the code of behavior that said "I should not have anything in my cell because that is the rule" regardless of what someone else said or did. In his mind, a figure of authority allowed him to break the rule -- why should he be held accountable?

"Behavioral Treatment Plans" were put together for 12/9/11 and 1/14/12. There was also a MHTP that was done on 12/8/11 and authored by the same person. It was to run until 6/8/12. The behavioral components were integrated with the mental health components, which seemed promising until it became clear that the plans all lacked the level of support and remediation that C.S. needed.<sup>48</sup> Each had a component that noted that "the caseworker will meet for 15 minutes each week" and was to write a note to MH. MH was to review the weekly "Behavior Log" each time he or she visited, but it was not clear how often MH was to meet with C.S. In December, journal use was called for, but in January it was eliminated in favor of a word puzzle or Sudoku. Exercise in his cell and appointments with a recreation therapist were added.

On 7/17/12, C.S. was seen by CCS Employee #2 the Mental Health Supervisor and supervisor of CCS Employee #1 and all of the CCS mental health staff at SSCF, who, after speaking with C.S. wrote in his Mental Health Progress Note: "This pt. appears to be seeking some sort of structure to his time on the Alpha Unit to help him focus on working toward an identified goal. He seeks to know what he has to do to get rewarded and what that reward will be. The plan is to speak to his caseworker about a possible behavior plan that is very simple and very clear about goals to work for and timeframes to attain those goals (this write spoke with his caseworker just after talking with [C.S.])."

On 7/19/12, C.S. told Granger he was taking a plea. He asked her for a treatment plan. She wrote "I advised that MH and I are working on something for him" so at least it was clear that CCS Employee #2 had contacted her. However, no plan can be found up until 8/28/12 -- more than a month later and it is milquetoast plan. There are no names on it and it is unclear who the CSS was since it appears that CSS Granger was out for a period of time and another CSS substituted.

The plan of 8/28/12 can be boiled down to a few pieces -- obey the rules, take your meds, meet with your MH health worker twice a week, follow orders. This in no way even remotely resembles what CCS Employee #2 described, so the disconnect continued and there were more lost opportunities for intervention. C.S. got a unit job

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<sup>48</sup> There actually was a MHTP done 12/8/11 which is reflected in the Behavioral Treatment Plan and authored by the same person. The MHTP provides no information on how often treatment is to take place.

cleaning, then he lost the job due to his behavior. He earned a radio then he lost the radio. He flooded his cell. He lost time with the rec therapist. He got the job back. He asked to go to the gym. He asked to go to the library. There is no indication he got to go.

When CSS Granger returned, she developed an incentive plan for C.S. which he signed on 9/18/12. The plan is still vague: remain DR free (both major and minor), keep your cell clean, don't make sexual comments, be pro-social, and if you do all this, you will get a radio [Walkman]." This plan is also a perfect example of using the plan as a form of punishment. She adds that if he receives the radio, but you get convicted of either a major or minor DR, you lose the radio and have to go 30 days DR free to get it back. In addition, she adds "Failure to comply with the specifications listed above will result in...1) you will not receive more allowable property, and 2) you will lose the personal property you already have." The combination of reward and punishment in the same document – without the plan having other significant strengths - was less than ideal.

On 10/10/12, Granger was out again on leave and CSS Peter Bouleri stepped in for her and asked C.S. why he kept picking up Major DR's. C.S. responded that it was easier to be bad than good and that he no longer cared. CSS Bouleri noted that "he is regressing" and that a new plan would be drafted with MH "so he has some attainable goals to get to a better place physically and mentally." There was no evidence of any plan in the records. On 10/16/12 Granger returned and told C.S. she was working on an incentive plan, but there is no evidence of a plan until 10/26/12 when he is moved to the Mental Health Transitional Unit – Bravo – to see how he would do.

The Bravo Behavior Plan was the best of all the poor plans that the team developed to that point and better than the Bravo Close Custody Plan of May of 2012. It was clearer, incentive based, and had more manageable increments for success. However, while C.S. was moved to a different environment, he was still segregated, with more "normalcy" than he had been exposed to just beyond his reach. In Bravo, most inmates can move within the very small unit, but not out of it. They can talk, play games, watch the unit TV, come and go from their cells and eat communally. However, C.S. was locked in his cell unless he came out for recreation which he did alone, or for a meeting with a mental health worker or rec therapist. Otherwise he was confined to his cell, was not allowed to leave the unit and had to eat all meals in his cell. He had a TV for the first time and he was allowed a surprising number of items. His rules were to remain Major DR free and get no more than two minor DRs a week, plus the usual "follow all facility rules" component. He had a contact structure and

was required to work with his CSS two times a week and MH as determined by MH. The "carrots" were set out in increments. If he got no DRs at all for 7 days, he would get different magazines. If he got no DRs for 14 days, he would get a Walkman. If he remained DR free for 21 days he would be allowed to eat with the others in the unit. If he made it to 28 days, he could go to the gym or library. A month of no DRs meant he could walk to medical or MH appointments without an escort.

C.S. only made it until 11/9/13 when a CO found what she believed to be a weapon in his cell. So of course the question is: what went wrong? In the opinion of this investigation, it was too little too late. Staff had failed to establish relationships of trust and good will with C.S. and there were too many uncoordinated moving pieces. The plan itself was still too vague – for instance, it required that C.S. work with his assigned CSS a minimum of three times a week. But work on what? There was no content to that – nothing tangible to help him understand what those meetings would consist of. Would it be lecture time? Would it be "fun" time? Recreation time? Which days of the week? When could he count on the CSS being there? Similarly, what did it mean to work with mental health "as determined in the mental health treatment plan?" Were there meaningful "rewards" attached?

There was no mental health treatment plan associated with the move to Bravo that this investigation found. Only one from 9/12/12 which was about as generic as a plan could be and it boiled down to: "Increase positive interaction with peers." In addition, it is unclear how much C.S. valued the incentives offered. There are two hand-written plans from C.S. himself in the records, both written about a year later after he had moved to Newport. In those plans, he cared most about getting a video game and earning the right to have it in his cell at all times rather than an hour or two a day. He wanted his newspapers, gym trips, a job, a storage bin and a Walkman.

As a result of not making it in Bravo, C.S. was sent back to Alpha and that evening he engaged in genital self-mutilation. Everything he had been allowed in Bravo, apart from any of the incentives he was supposed to work toward, was taken away. This included his glasses, a deck of cards, six books or magazines, candy bars, pen, paper, personal photos, personal mail and clothing/hygiene items.

The acting out and penalties kept coming, and finally, Superintendent Potanas asked for him to be moved for 8-12 weeks, first to Newport then to St. Albans then back to SSCF. Prior to the move to Newport, CCS Employee #3 made a written Mental Health Recommendation which essentially acknowledged the failure of SSCF to manage his mental health and associated behaviors. He wrote: "Mental Health, Casework, and Security staff at SSCF appear to be at an impasse in efforts to engage [C.S.] more effectively and helping him realize a less restrictive

living environment.” He overplayed staff requests for C.S.’s input into the plans. There is no evidence of much input. CSS Granger noted she asked for input and said she would pass his requests along, but the plans were usually so bland it was impossible to tell what he might have recommended.

Ironically, CCS Employee #2 prescribed an approach for success with C.S. at other facilities which boiled down to: 1) ignore negative behaviors, but respond with appropriate consequences; 2) when positive behavior occurs, provide more staff attention; 3) slowly reduce safety measures to prevent self-harm so there would be no yo-yo effect; 4) look for activities or rewards he finds more valuable than “acting out.” 5) Consider the possibility that “other staff” and “cultures” might result in a “new treatment direction.” His recommendation acknowledged staff “frustration” in working with such a “difficult patient” and characterized C.S. as having grown “comfortable” in the “rut of behavior” he was in at SSCF. Thus, the plans at SSCF came to an end and a new chapter opened for C.S. at Newport.

## **VII. Newport (NSCF) Behavior Plans**

As noted in the Introduction, Newport succeeded in its efforts to move C.S. to GP in under a year for four reasons all of which took into account and accommodated his intellectual disability and mental health issues. First, the staff recognized they were dealing with a very emotionally immature and needy young person – no matter his chronological age - and so they provided consistent emotional support and incentives for success even when he was in segregation there. Second, they provided behavior plans that were manageable for him and did not set him up for failure. The plans reflected a recognition of and accommodation for the disabling diagnoses of attention deficit disorder (ADHD), impulse control disorder (ICD) and post-traumatic stress disorder (PTSD). Third, they involved C.S. more in the development of the behavior plans which encouraged him to be more invested in the plan. Finally, they did not use the behavior plans as forms of punishment and reward. If C.S. failed to meet some aspect of a behavior plan because he picked up a DR, there was still the sense that he had not lost everything and unlike the staff at SSCF, staff did not ignore him in the same manner. They continued to reach out to him and tell him they wanted him to be successful, while also being firm and holding him accountable.

C.S. made a symbolic gesture on the day he arrived at Newport. A caseworker he had had during his first stay at Newport met with him to go over information. C.S. told the caseworker that he wanted to stay at Newport and not be returned to SSCF. The caseworker told C.S. that this up to him to some extent and that he needed to stop harming himself and picking up DRs. At this point, the caseworker’s notes read, C.S.

“gave me a piece of wire approximatelt [sic] 2.5 inches long that he had in his mouth. He again stated he would not self-harm anymore.”

While it was a gesture of a willingness to engage, the road to GP was not without significant difficulties. For every step forward, C.S. would often take two or even three steps back. However, staff engaged him in a dynamic process, even when he was in segregation for having committed one or more DRs. He left SSCF in segregation and arrived at Newport and continued in segregation there for several months.<sup>49</sup> He periodically continued his negative, assaultive, and destructive behaviors although his genital mutilation slowed and then halted except for periodic episodes with long gaps in between.

At the Newport facility, C.S. had a Mental Health Treatment Plan that was integrated into his Behavior Plan and a caseworker and mental health provider who frequently met with him together to provide support.<sup>50</sup> His first meeting with his caseworker, Shawn Smith, resulted in what Smith described as a lengthy discussion about C.S.’s past behaviors and C.S. acknowledged that he did things to get out of his cell. Smith then made a contract for safety with him and let him wear his “normal attire.” The next day he was allowed utensils, a normal food tray and a book. Such simple things in light of the last two-and-a-half years would have been priceless.

In those first few days he was also given an assignment to “write when he was successful and why he was unsuccessful and ...also asked to write about when he has made poor choices and what allowed him to make those choices.” Smith noted that C.S. completed those assignments “thoroughly and thoughtfully.” C.S. was also asked to “come up with some short term goals that he would like to achieve and how he will go about meeting those goals.” Another contract for safety was made. The incentive to buy-in was being created.

On 9/11/13, Smith and CCS Employee #4, an employee from Mental Health met with C.S. to come up with a Behavior Plan. The case note indicated that C.S. had “maintained pro-social behavior for the past 7 days.” On 9/12/13 the Plan was approved by staff and on 9/13/13, C.S. agreed to the Plan. The plan was focused on where C.S. stood and where he needed to move. Importantly, it was for a period of 7

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<sup>49</sup> His arrival was preceded by an email from then SOS Joshua Rutherford that set forth every single negative piece of information he could come up with about C.S. and apologized to the facility for having to send him there. His final words offered the opinion that C.S. should have been in disciplinary segregation so that something could be accomplished with him. Rutherford’s supervisor, assistant superintendent Caroline Marsh, characterized the email as an appropriate warning on the one hand but did not recognize that it could have set C.S. up for failure by deeply prejudicing staff before he got there. Fortunately, it did not.

<sup>50</sup> On 9/9/13, CCS Employee #4 wrote a Mental Health Progress Note. She has gone to see C.S. and check on his mental state. He “denied any intention to self-harm but stated ‘I’m always thinking about it.’ CSS Shawn Smith was also visiting w/inmate at this time. CSS smith was getting inmate to laugh. ‘I hate to smile,’ he said.”

days only – this allowed him to not be overwhelmed with the periods of time that had been the components in the SSCF plans. It required him to write in his journal which would be processed with his caseworker each day. It provided a simple technique to de-stress through the use of a rubber-band, the provision of which in and of itself – would not have been allowed at SSCF.

There were expectations of staff with respect to C.S. and this had been missing at SSCF. The plan required that staff submit daily reports to Smith on how C.S. was doing. The plan also required that staff document his positive and negative behaviors. Then there were “the carrots:” success would result in 2 phone calls a week, 2 hours of access to a newspaper per day, an hour of supervised recreation with another inmate. These incentives were significant.

On 9/20/13, as promised, the second Plan came. It added or allowed C.S. to work per request of one of the officers and if he completed the duties, he would be allowed “1 canteen item from the recreation fund” in addition to the other goals (calls, newspaper and recreation). On 9/26/13, C.S. told Smith he had banged on his cell door over the weekend but had realized it was wrong and had written the officer an apology, which was self-reflective progress. On 10/3/13 he was moved to Phase II AdSeg having completed the 30-day plan which was not couched as a 30-day plan, but again, a plan in small, achievable increments. As a special reward, Smith wrote: “Because of [C.S.’s] pro-social behavior, myself [and the SOS] brought [C.S.] outdoors for a walk as he has not been outside for an extremely long time.”

The next behavior plan allowed for a limited time with a video game and a unit job. However suddenly, C.S.’s behavior deteriorated, as it often seemed to do when he was doing well. He threatened an officer with bodily harm and went back segregation status. He lost the newspaper and the calls for the time being. However instead of losing everything, which seemed so often to be the way it was at SSCF, he got 1 hour of structured recreation with Smith and the recreation coordinator. Records show that Smith reported meeting with C.S. 3x per day. While a new plan was needed, the staff was persistent. A Mental Health Progress note illustrated the firm but constructive approach taken by casework and mental health cooperatively. While noting that C.S.’s behavior had caused him to lose the privileges he had accrued, they decreased, but did not take away access to his hand-held unit altogether. Even more importantly, together they presented him with a new plan to get him moving and told him “that this writer [sic] and Mr. Smith are still committed to supporting him in reaching his goals and to make good choices. When asked if [he] was committed to the [plan], [he] responded “I don’t know” and had earlier remarked “I’m gonna shut down after this.”

The following days and months were much like this - steps forward and steps back. However the constant was the structured, consistent staff support and small, but meaningful and obtainable goals. For the first time, C.S. experienced staff who actually seemed to care about how he felt and wanted to understand – and mostly to have him understand – why he acted the way he did, although he acknowledged that the support made him uncomfortable and that he was more comfortable around people who “holler[ed]” like his father.<sup>51</sup> Notes from 11/1/13 reflect that C.S. showed CCS Employee #4,

...a list of good and bad things that he does. he [sic] said he wants to work to increase the good and get rid of the bad. C.S. said that he accepts the DR and seg time and wants to re-engage with the Behavior Plan...because he thought the Behavior Plan was working. *“This is the best I’ve done anywhere.”* This writer assured [him] that once his DR sanction stuff was over that we would certainly restart the Behavior Plan. We discussed yesterday’s incident that resulted in [him] being OC sprayed. [He] agreed that when things deviate fro [sic] what he believes it should be he gets irritated and that when things aren’t exactly how he think [sic] it should be he doesn’t accept anything. [C.S.] said he would like to process the work that he did on the Change reports. This write [sic] will email his caseworker, Shawn Smith, and notify him of [his] request. (Emphasis added).

By 11/26/13, Smith reported that although his behavior was deteriorating, he had not been harming himself, which was an enormous achievement. Slowly, bigger incentives were added. Workout time in the gym, and more workout time overall, beginning an education course, steps towards more socialization and freer movement. Mental Health put together relaxation techniques for him to use in his cell and were integral part of each Plan from all appearances. At all times he worked in his journal but not in isolation – he was expected to process it. On one occasion when he had gotten a DR, he showed it to CCS Employee #4 who read it and remarked he needed to add more detail – in other words – think about your part in this more deeply – own it.<sup>52</sup>

On 1/6/14, CCS Employee #4 and Smith met with C.S. CCS Employee #4’s note stated: “We reviewed the Behavior Plan and acknowledged the progress. [C.S.] has completed the first 5 tasks. He has been over 30 days DR free and has been moved to Phase II.... [C.S.] talked about programming and said he want to participate if it happens at this facility. [C.S.] says that if he goes to Springfield again he would

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<sup>51</sup> Mental Health Progress Note, 11/4/15, CCS Employee #4.

<sup>52</sup> Mental Health Progress Note, 11/13/13, CCS Employee #4.

kill himself. "They don't like me." By 1/8/14, C.S. the official count of DR-free days was 44 – a big achievement. A week later he picked up a minor DR, however he was allowed a visit with his mother which went well and she was apparently impressed with the changes she saw.

The staff seemed to know when to make "a big deal" out of an infraction and how to handle it creatively when possible, rather than using the "piling on" method popular at SSCF. C.S. received a laundry job and was given books he ordered on 1/23/14. On 1/29/14, he completed all major goals on the latest Behavior Plan which was a huge achievement and moved him ever closer to the goal of moving to GP. The process got started, then, on 2/10/14, Smith's notes indicated that C.S. had received 3 major DRs over the weekend. Thus, the ups and downs continued. On 2/6/14, Smith and CCS Employee #4 met with him together to discuss a near miss on a DR for banging on his door. Together they spoke with telling him "this incident was an opportunity to review his skills and techniques for 1) managing conflict, 2) reducing his impulsivity and 3) to respond to conflictual situations on [sic] a positive and constructive manner."

A memo from CSS II Shawn Smith to Superintendent Shannon Marcoux on 6/6/14 illustrates the hard work it took to reach C.S. and how carefully the staff needed to be about moving him too quickly. In the memo, Smith notes that he has been working with C.S. for 7 months. The memo sets forth C.S.'s issues in practical detail – it is clear that Smith has real concern for C.S. and is invested in his success. Smith documents his concerns about not moving C.S. to GP too quickly. He writes:

He has several issues that will make it extremely difficult for him to be successful in general population as his behavior needs to be closely monitored all time [sic]. Because of [C.S.'s] sexual charges and his desire to be liked by others he has shown over and over that when other offenders treat him nicely he will do whatever they ask to include sexual favors, breaking facility rules by making phone call for them, putting on a show for the amusement of others by breaking sprinklers and giving officers a hard time, passing contraband etc. [C.S.] and I have spoke [sic] at length about this and he understands this is an issue and he continues to work on it but with some difficulty. I visit [C.S.] and speak with him a couple [sic] times a day to help him remain on track and it takes a lot of time and effort but it is possible when he is residing in a smaller unit with less outside factors and stimulation.

Smith continued by noting the effects of segregation: "[C.S.] has been isolated from others for the most part since he entered the correctional system because of his sexualized, self-harming [sic] and assaultive behaviors.... During his supervised

recreation with other offenders it is apparent that he is overwhelmed by all the outside stimuli and he starts acting up to impress others and it needs to be addressed in the moment by staff. Smith states that this instant “nip-it-in-the-bud” approach had been working well, but he feared that moving C.S. to GP too quickly would result in a loss of those gains because there would be more stimuli and less attention from staff for purposes of intervention.

Smith pointed out that C.S. had been designated a “predator” and “victim” by the PREA screening tool, which was also a concern. Smith opined that a gradual transition to GP was necessary in order to allow C.S. to “become accustomed to all that happens in general population and he needs to continue to practice intervening on his thoughts and feelings and make the safe choice (which he has shown that he can do).” Smith also noted that C.S.’s plan at the time involved working in the gym and cleaning the upstairs of Echo building which would allow slow exposure to GP and thus vicarious absorption of the culture there while also being supervised. The goal would be to allow more time there if he could demonstrate “pro-social” behavior for an extended period of time. Smith also revealed that C.S. had undergone an education assessment and that he and the educator on site would work on “using his strengths to help him succeed and working on his weak areas [sic]. Smith also stated that the search for an appropriate cell mate was underway and that he was looking for someone willing to help C.S. and encourage him.

Finally, on August 21, 2014, one day after C.S. moved to GP, Mental Health staff person and social worker CCS Employee #5, wrote in her Mental Health Progress Notes:

[C.S.] seen for f/u after going to general population from SMU. ***This is a big step for this young man.*** [C.S.] reports he “didn’t sleep all night.” He admits he knows it was “because of the newness and all.” [C.S.] reports he wants “to go to education.” I told him he will be able to do that after a bit of settling in to [sic] his new environment. [C.S.] has been in a segregated situation for three years and staff agrees he needs a gradual progression to new things. [C.S.] is currently on 15” checks in the unit just while he gets acclimated to living in gen. pop. [C.S.] will also be seen daily by MH through this initiation. (Emphasis added).

This was indeed a big step and it had taken less than a year to achieve.

**IX. Did the Doc violate the VFHPAA by housing C.S. in an environment that was not appropriate for his needs?**

In order to establish a case of discrimination on the basis of disability, C.S. must prove that he is a person with a disability (or disabilities). C.S. must thus show the following:

- (a) a physical or mental impairment which limits one or more major life activities;
- (b) a history or record of such an impairment; or
- (c) being regarded as having such an impairment.

If he establishes that he is a person with a disability, he must next prove that:

- a) That the DOC denied him the “goods, services, facilities, privileges, advantages, and accommodations *in the most integrated setting*” *appropriate for his individual needs*. 9 V.S.A. §4502(c)(2); (Emphasis added), or
- b) That the DOC failed to provide him with an opportunity to participate in the benefit of services, facilities, goods, privileges, advantages, benefits, or accommodations. 9 V.S.A. § 4502(c)(1).
- c) Finally, C.S. would have to prove that the discrimination alleged in (a) and/or (b) above was by reason of his disability.

A respondent can attack the prima facie case by proving that:

- (a) C.S. is not disabled under the meaning of the statute, or that
- (b) C.S. was placed in the most integrated environment appropriate for his needs, or that
- (c) the DOC at SSCF provided him with the opportunity to participate in and receive services, benefits, privileges, advantages etc.

Finally, the respondent can attempt to prove that accommodating C.S. would cause a “fundamental alteration” or an “undue hardship.”

A. Use of the ADA in Challenging Segregation of Mentally Ill Inmates

In a May 2016 article published in the *American Constitution Society for Law and Policy*, author Professor Margot Schlanger suggested that pursuant to the ADA, correctional facilities could make reasonable accommodations and avoid illegal discrimination on the basis of disability by “cover[ing] *the route into solitary, the*

*conditions in solitary*, and the *route out of solitary*.”<sup>53</sup> (Emphasis in the original). Two examples offered by Schlanger that address the route *into solitary* applicable to C.S. are: 1) challenging the use of segregation as “a routine management technique to cope with the difficulties presented by prisoners with disabilities;” and 2) stop treating behaviors that manifest as “serious mental illness or intellectual disability as a disciplinary rather than mental health or habilitation matter.”<sup>54</sup>

To address the *conditions of solitary*, Schlanger suggests that prisons could follow the directive of the Department of Justice (DOJ), which highlights the “obligation to provide the prisoners with the opportunity to participate in and benefit from mental health services and activities, and other services, programs, and activities to which prisoners without disabilities have access.”<sup>55</sup> Professor Schlanger makes the point that “Even if a prison has a safety interest in substantial physical isolation, that should not mean that prisoners with disabilities are denied phone calls, books, education, rehabilitative programming, exercise, and the like.” SSCF failed to sufficiently provide these accommodations in any meaningful way – mostly, they were used to deprive him of access due to punishment. Professor Schlanger also suggests that:

Prisons should also accommodate disabled prisoners’ particular, disability-related vulnerability to the conditions of isolated confinement by softening those conditions. Prisoners with mental illness and intellectual disabilities are less resilient to the absence of social interaction and the enforced idleness of solitary confinement. Consequently, these features should be modified for them; they could, for example, receive controlled

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<sup>53</sup> Margo Schlanger, *How the ADA Regulates and Restricts Solitary Confinement for People with Mental Disabilities*, Issue Brief, May 2016, American Constitution for Law and Policy, p.8. While Professor Schlanger does not explicitly define the term “solitary,” her citations include references to “Administrative Segregation” and “Restrictive Housing” and she uses the term “segregation cells.” She notes: “Prisons often house prisoners with disabilities in various kinds of special housing that are, if not quite solitary confinement, at least close to it; they impose far more locked-down time than ordinary housing, restrict access to property, limit various privileges, etc. This kind of dedicated housing for people with disabilities (as well as infirmary assignments that do not actually provide medical care or treatment) violate the plain dictates of the ADA’s regulations if the housing area is not ‘the most integrated setting appropriate’ to the prisoners’ needs.” P. 11. Additionally, her ADA analysis is certainly applicable to C.S.’s circumstances. It would truly be ironic for the DOC to take issue with any imprecision with the term considering their loose usage of the terminology associated with forms of segregation.

<sup>54</sup> *Id.* (citations omitted).

<sup>55</sup> *Id.* at 9 (citing Letter from Thomas E. Perez, Assistant Attorney Gen., Civil Rights Div., U.S. Dep’t of Justice, to The Honorable Tom Corbett, Governor of Pa., Re: Investigation of the State Correctional Institution at Cresson and Notice of Expanded Investigation, 33-34 (May 31, 2013), available at [http://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson\\_findings\\_5-31-13.pdf](http://www.justice.gov/sites/default/files/crt/legacy/2013/06/03/cresson_findings_5-31-13.pdf) [hereinafter Cresson Letter]).

programming, increased recreation hours, expanded access to educational materials and similar accommodations.<sup>56</sup>

Finally, to address the *route out of solitary*, Schlanger notes that the ADA “requires modifications to the route out of solitary—that is, to eligibility and step-down type requirements for prisoners in solitary confinement or other high-security housing that are ill-suited or even impossible for prisoners with disabilities. Indeed, the same theory could reach denials of opportunities for a route out of prison altogether, if parole is denied on the basis of a solitary stint, or on lack of completion of rehabilitative programming that is unavailable to those in solitary.”<sup>57</sup> In C.S.’s case, the “step-down” to Bravo was insufficiently contrasted with the circumstances of where he had come from (Alpha and Fox) and his behavior plan continued to be mainly prohibitive and isolative in construct – not integrative. If C.S. “maxes-out” his sentence, the DOC would have no power to control his actions through the parole structure, however the accumulation of DRs can certainly slow down the possibility of parole or furlough. This report now turns to an analysis of the individual elements of the *prima facie* case.

#### B. Is C.S. a person with a disability within the meaning of the statute?

There is no doubt in this investigation’s opinion, that C.S. is a person with several disabilities that substantially limit one or more major life activities. This investigation reached that conclusion after reviewing all available records in light of the American with Disabilities Act Amendments Act of 2008 (“ADAAA”), which went into effect on January 1, 2009.<sup>58</sup>

C.S. was sexually abused and experienced severe violence and extensive neglect from his father and mother. He passed through psychiatric facilities, “therapeutic foster homes,” and schools for children with behavioral problems. From childhood on, all assessments recognized C.S. as having “developmental disabilities,” which is defined as: “...a severe, chronic condition that manifests in the developmental period (birth through age 18), [that] requires an array of mild to intensive supports, and is expected to last for a lifetime. Developmental disabilities may be cognitive, physical, or a combination of both.”<sup>59</sup>

In addition, from at least age 8 on, (when C.S. was committed to DCF custody), to the period just prior to incarceration at SSCF - C.S. has been given

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<sup>56</sup> Schlanger at 9-10.

<sup>57</sup> *Id.* at 10 (citations omitted).

<sup>58</sup> 42 U.S.C. § 12101 et seq.

<sup>59</sup> See *supra* note 11 at 1185.

serious psychiatric diagnoses, including Bi-Polar Disorder and Post-Traumatic Stress Disorder. He has many of the classical symptoms of Attention Deficit Disorder, which is classified as a brain disorder. He had significant impediments to learning between his IQ score and General Intellectual Ability score although it is clear his handwriting and expressive ability has improved over time.

He has had significant difficulty regulating his emotions and conforming his behavior in appropriate ways from the earliest years of life, both in and out of confined settings. It was well documented, at least initially, that he had trouble reading at the DOC, and that he was a slow reader who had difficulty with comprehension. He lacked fundamental social skills.<sup>60</sup> He initially lacked personal hygiene and was constantly cited for the filthiness of his cell and for hoarding – a habit he inherited from his family.<sup>61</sup> His naiveté about how to interact appropriately with other inmates nearly resulted in his death as well as complaints from other inmates about the content of his conversations with them.<sup>62</sup> In addition, his short attention span, reactivity and impulsiveness, his inability to process information and his tendency to get overwhelmed quickly made him unable to conform to life in prison successfully.<sup>63</sup> He languished in a cycle of DRs and lived in a segregated status for years.<sup>64</sup>

The ADAAA defines major life activities on an individual level and the amendments expanded the definitions to include caring for one's self, learning, reading, concentrating, thinking and communicating – all areas in which C.S. had extreme and well documented difficulties. The amendments also make it clear that the

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<sup>60</sup> *Id.*

<sup>61</sup> *Id.* at 1186, (citations omitted): "Many developmentally disabled prisoners have poor self-care skills. They may need reminders to bathe, brush their teeth, and wash their clothes, and they can have soiled or unkempt clothing, poor eating habits, and dirty or disorganized cells." (Citations omitted).

<sup>62</sup> *Id.* at 1186 (citations omitted). This refers to his being lured into another inmate's cell and nearly killed on April 27, 2012. "Many prisoners with developmental disabilities have poor socialization skills. These prisoners have a 'mental youngness', and are naive with respect to prison culture and routines. This 'mental youngness' is especially problematic in prison settings because prisoners exhibiting this characteristic are vulnerable to abuse and manipulation by other prisoners."

<sup>63</sup> *Id.* at 1186, (citations omitted). The *Clark* court cited the *Cowardin Report* on this issue. Prisoners with developmental disabilities, it noted, "are susceptible to becoming involved in a cycle of disciplinary infractions involving other prisoners and staff members as a result of their lack of judgment and inability to understand consequences... (failure to 'understand the fine points or nuance of complex social situations ... increases the risk that they will misunderstand changing rules and regulations, make poor decisions based on confusion or misunderstanding, and get into trouble')."

<sup>64</sup> *Id.* (citations omitted). "They are susceptible to becoming involved in a cycle of disciplinary infractions involving other prisoners and staff members as a result of their lack of judgment and inability to understand consequences." Additionally, failure to "understand the fine points or nuance of complex social situations ... increases the risk that they will misunderstand changing rules and regulations, make poor decisions based on confusion or misunderstanding, and get into trouble").

greater focus should be on whether the covered entity – here SSCF and its staff – complied with the substantive statutory obligations and this investigation finds that they did not. Thus, the first element is met – C.S. is a person with a disability pursuant to the statute.

C. Did the DOC at SSCF violate the integration mandate?

The prohibition of a violation of the integration mandate is codified at 9 V.S.A. §4502(c)(2). The ADA regulations specifically pertaining to inmates add detail to the general mandate. The regulations provide, in part:

- (b)(2) Public entities shall ensure that inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals. Unless it is appropriate to make an exception, a public entity–
- (i) Shall not place inmates or detainees with disabilities in inappropriate security classifications because no accessible cells or beds are available;
  - (ii) Shall not place inmates or detainees with disabilities in designated medical areas unless they are actually receiving medical care or treatment; [and]
  - (iii) Shall not place inmates or detainees with disabilities in facilities that do not offer the same programs as the facilities where they would otherwise be housed.<sup>65</sup>

However, Schlanger notes that correctional facilities often violate these prohibitions with respect to mentally ill inmates:

More commonly, though, confinement of prisoners with disabilities to restrictive housing is not because of a shortage of accessible cells elsewhere, but rather because *prisons choose to manage difficult, disability-related behavior with solitary confinement rather than less harsh housing assignments and services.... In prison or jail, when solitary confinement is triggered by a prisoner's disability (and resulting conduct), that means that prison services are provided in a setting that lessens the prisoner's contact with other, non-disabled prisoners.* This is “segregated” not only in the way the term is used in prison, but also in the way the term is used in the *Olmstead* opinion to describe civil institutionalization, which the Court held can be a form of unlawful discrimination.<sup>66</sup> (Emphasis added).

SSCF indisputably violated the integration mandate, and made admissions against its own interest supporting this finding in both interviews and records.

<sup>65</sup> 28 C.F.R. § 35.152.

<sup>66</sup> Schlanger at 12 (citations omitted).

Potanas, Marsh, CCS Employee #1, CCS Employee #2 and Larson all admitted that SSCF had failed to provide or figure out how to provide, what C.S. needed. Potanas, CCS Employee #1 and CCS Employee #2 admitted C.S. might do well with a new staff and in a new facility. Not only was the SSCF staff untrained in the writing of behavior plans, but they seemed to not recognize (or care about) the extent of C.S.'s developmental disabilities and psychiatric issues. Their failures become starker when compared to Newport's success. SSCF seemed to myopically cling to the mostly punitive strategy of ignoring C.S.'s actions, then punishing him for acting out as a result of sheer deprecation, boredom and isolation, by stripping him of any miniscule privileges he had or might have been able to have. The mental health unit appears to have almost always signed off on the penalty the facility meted out for DR's. There are several documents where CCS Employee #1 and CCS Employee #2 suggest segregation or "any appropriate sanction."<sup>67</sup> There were no creative inputs, no suggestions, and no cautions, even in the face of continued and regular self-harm. Central Office – that is the DOC upper administration signed off on his continued segregation, with then Deputy Commissioner, now Commissioner Lisa Menard, penning what must be her signature or that of her designee's since she was the assistant commissioner at the time. These forms provided no substantive information.

Superintendent Potanas asked for C.S. to be moved because he said he believed that C.S. needed a fresh start. Implicit in this view is that there was nothing left for that facility to do in a constructive way, countering, at least officially, the view of SOS Rutherford and CCS Employee #1 who believed he should have been placed in disciplinary segregation. SSCF most certainly violated the integration mandate for the 2.4 years he was there in spite of all the indicators which should have resulted in assessments and reasonable accommodations. Since thus investigation finds that SSCF violated the integration mandate, this investigation will not provide an analysis of 9 V.S.A. §4502(c)(2). As Schlanger noted:

A prison seeking to fend off a challenge to placement of prisoners with disabilities in solitary confinement or high-security mental health housing might argue that the housing assignment is needed in order to provide adequate services (e.g., safety) to those prisoners, and therefore authorized by the regulations. But if that were the case, *one would expect conditions of*

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<sup>67</sup> SFI Mental Health Reviews for Disciplinary Reports show what looks like an agreed abdication of any semblance of mental health interventions. Once C.S. was designated as SFI, mental health had to review possible sanctions. On 5/22/13, 6/12/13, 6/23/13, 6/24/13, 6/25/13, CCS Employee #1 recommended 14 days of segregation for the sanction. On 7/4/13 he recommended any appropriate sanction. On 6/24/13 he recommended limiting phone access, on 6/27/13 he recommended limiting TV access. On 8/20/13 and 8/25/13, CCS Employee #2 wrote "no mental health-specific recommendation" "sanction at DOC discretion."

*confinement to be as therapeutic as possible. This defense, then, encourages prisons and jails to demonstrate a softer, more individuated, less punitive form of isolation in order to prevail. In the absence of that kind of evidence—which could rarely be produced—this defense is simply implausible.*<sup>68</sup>(Emphasis added).

D. Can the DOC show that it was an undue burden to accommodate C.S.?

A modification of “policies, practices and procedures” is not required if the modification(s) would “fundamentally alter the nature of the service, program, or activity.”<sup>69</sup> The separate ADA requirement of program accessibility has a similarly restrictive caveat - public entities need not take actions if they “can demonstrate [the action] would result in a fundamental alteration in the nature of a service, program, or activity or in undue financial and administrative burdens.”<sup>70</sup> The inquiry is done on a case by case basis, considering the factors that come into play in the provision of the service or access to service, including of course, costs and staffing.<sup>71</sup>

The ADA regulations allow the correctional facility two defenses. The first states that:

A public entity may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on *actual risks, not on mere speculation, stereotypes, or generalizations about individuals with disabilities.*<sup>72</sup> (Emphasis added).

The second regulatory defense similarly provides:

(a) This part does not require a public entity to permit an individual to participate in or benefit from the services, programs, or activities of that public entity when that individual poses a direct threat to the health or safety of others.

(b) In determining whether an individual poses a direct threat to the health or safety of others, *a public entity must make an individualized*

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<sup>68</sup> Schlanger at 16 (citations omitted).

<sup>69</sup> 28 C.F.R. § 35.130(b)(1)(7).

<sup>70</sup> 28 C.F.R. § 35.150(a)(3).

<sup>71</sup> *Olmstead v. L.C.*, 527 U.S. 581, 597-606, (1999) n. 16. An analysis of “undue hardship” requires a ‘case-by-case analysis weighing factors that include: (1) [t]he overall size of the recipient’s program with respect to number of employees, number and type of facilities, and size of budget; (2) [t]he type of the recipient’s operation, including the composition and structure of the recipient’s workforce; and (3) [t]he nature and cost of the accommodation needed.’” (citations omitted).

<sup>72</sup> 28 C.F.R. § 35.130(h).

*assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.*<sup>73</sup>(Emphasis added).

The DOC failed to do the necessary, individualized assessments and evaluate all the factors cited in the rule. Instead, they put the proverbial cart before the house and let C.S.'s disabilities go unrecognized and untreated. As a result, his behaviors and mental health issues became the characteristics which defined him. Had he been assessed, reasonable accommodation(s) that might have been put in place that ameliorated risk - if in fact, there were any risks at all. The lack of treatment created risk for C.S. and everyone else who came into close contact with him, yet the full responsibility of the ongoing dysfunction was placed upon him alone. The facility continually rationalized their decisions by saying he should stay in segregation because he continued "to be a threat to the secure and orderly running of the facility." This phrase in no way equates with an individualized assessment required by the rule.

Even without these assessments, Newport's success with C.S.'s upon his return to that facility in August of 2013 demonstrates that there were no necessary fundamental alterations or undue burdens related to moving C.S. even in his deteriorated state; indeed, a change in venue had been considered by Dr. Larson and Superintendent Potanas in January of 2013 as noted in one of her memoranda. Once the decision was made to move him, the Superintendent, CCS Employee #2 and CCS Employee #1 acknowledged that a new place and new people might be positive changes. In addition, as Dr. Larson noted and as the DOC's own facts and figures have shown, SSCF should have been the place most likely to effect positive outcomes. In sum, the DOC has failed to articulate any defenses that demonstrate a fundamental alternation and/or an undue burden defense.

E. Was the discrimination that C.S. faced "because of" his disability?

Schlanger writes that segregation is essentially the "go-to" status for inmates with mental illness and intellectual disabilities. This decision *is* therefore based upon their disability – it is a decision that does not include any attempt at assessment or accommodation – it simply "dumps" them into a state of isolation with few resources

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<sup>73</sup> 28 C.F.R. § 35.139. See also 9 V.S.A. §4502(h).

or quality services.<sup>74</sup> There seems to be an implicit assumption that their mental illness will somehow protect the facility and staff from outsiders seeking to question inmate complaints about their care. That is, a facility can try to convince friends and family that everything is fine, that their mental illness is making them imagine things or complain about things that are not actually happening. As to the inmates themselves, the facility can provide very little care and not be held accountable. The facility can say it gave the inmate his or her pills, but he or she didn't take them. It becomes difficult for an outsider to pick this event apart. Is it the "right" medication? Is it the "right time" to give the medication? Has the inmate objected to it for some legitimate reason that is dismissed by staff because the inmate has mental health issues?

Similarly, the facility can say it offered therapy, or recreation, but the inmate did not want to participate. Is it because "therapy" was offered in a non-private setting? That it only occurred in 15-minute blocks? That it occurred through the slot in cell where neither party could see each other? The inmate's mental illness and behaviors enhanced by prolonged segregation become a protective smokescreen for the facility – a means by which it can defend itself from outside inquiries into its internal accountability. Often, a facility will "paper-up" – that is, generate lots of documentation to make it look like there is attention being paid to the inmate, even though the documentation is mostly insubstantial – it tells the investigation more about what is missing more than it reveals what is actually being done. These actions rest upon a view of mentally ill and intellectually disabled inmates as individuals who can be "dumped on" – thus, their disabilities do become the reason for the discrimination. They afford a facility a convenient and expedient way of cutting costs and managing people by providing only the most marginal of resources.

SSCF's decisions were based on their ignorance of C.S. The perceptions of the SSCF staff seemed disjointed. His CSS saw one person, his SSCF mental health provider another, his recreational therapist yet another and COs yet another. His SSCF caseworker, Christina Granger, said it was clear he needed extra attention. CCS Employee # 1, his mental health worker thought he was "a pretty smart kid." No one at SSCF seemed to be extensively familiar with his mental health history or cognitive testing. The SSCF behavior plans and mental health services were delivered in fragmented pieces which never fit together well. While staff sometimes acknowledged his difficulty with paying attention, they might couch it by saying, as CSS Granger did – "Well he paid attention for me." However, a person with complex needs and issues is more than just one person's experience with that staff member,

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<sup>74</sup> Schlanger at 12.

particularly when there are treatment issues and a critical need for information sharing. The fact that “team” meetings were held matters little; the attendees, in any case, were, by many of their own admissions, ill-equipped to deal with C.S. and not trained to deliver what he needed. No suggestions for accommodations or for testing or assessment came out of these meetings.

The second Newport experience, while imperfect, wove the tattered pieces of C.S. back together. The staff wrote good, short term, concrete plans; they wanted him to succeed and they told him so – over and over. They remained flexible and thought outside of the box, something that staff at SSCF utterly failed to do. SSCF staff focused on his behaviors only as choice and mainly treated him as a “naughty boy.” CCS Employee #3, Dr. Larson and CCS Employee #2 chose to withdraw individualized attention and essentially wash their hands of any intensive treatment possibilities, a policy they passed on to staff and instructed them to follow. The error of this approach is underscored by Dr. Connelly and Dr. Kennedy’s assessments of his need for treatment and the array of issues that would need intensive psychological and pharmacological interventions. In sum, the treatment of C.S. by the SSCF staff almost classically violates the integration mandate. Thus, the DOC violated the integration mandate and the VFHPAA.

## **X. CONCLUSION**

It will be undeniably difficult for C.S. to navigate the outside world upon his release given the general recidivism rates in the U.S. and lack of support services for inmates re-entering the community, particularly those who have the stigma associated with being a sex offender. In addition, C.S. has inconsistent family support, no solid job skills or education and it is not clear that he will behave appropriately in a community setting without guidance and consistent support. The consistent view is that he will need extensive support services upon release. Ideally he would enter a residential setting with 24/7 staffing and vocational training. The goal would be for him to get a job and pay towards his expenses with the possibility of gradually stepping down the level of supervision if he does well. He would need access to individual and group therapy as well as psychiatric medication. However, if he leaves prison after “maxing out” his sentence, there will be no clear avenue for him to do this as community services for released SFI inmates were terminated in 2013.<sup>75</sup>

In some respects, C.S. has been able to “grow up” - for lack of a better term. He likes having a job. His will to live is obviously strong. He still has the capacity to

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<sup>75</sup> “Services cut for inmates with ‘serious functional impairments,’” <http://vtdigger.org/2013/05/23/services-cut-for-inmates-with-serious-functional-impairments/>

trust. He has shown he can be innovative and persistent. He has taken responsibility for the abuse of his brothers and has demonstrated empathy and sorrow for the pain he has caused them and his mother. He has continued to use his journal and seems to have developed at least some insight into the things that set him off and how to blow off steam more appropriately. His writing and reading comprehension have improved. He seems to know when he needs “time out” – but will need to figure out how to get that in the community in appropriate ways.

As of April 11, 2016, when this investigation interviewed him, C.S. was at the facility at NWSCF in St. Albans, doing the sex offender education course – VTPSA. His appearance was a testament to how far he has progressed. He walked into the interview room without a guard, free of any restraints, holding his journal, a coffee cup and wearing nearly normal clothing. He shook this investigator’s hand and that of his counsel. He had been allowed to pierce his ears and had a watch attached to his belt and his rubber band on his wrist. He was guarded, but not hostile. He was frequently distracted and turned away from this investigator and his attorney to see what was going on in the hall outside as other inmates moved around. He had greater insight than this investigation might have expected. C.S. stated that his time at SSCF had been “miserable.” He described a situation where he would be serving a sanction for a DR and they would then impose another sanction – “extra weight” as he termed it – “taking more and more” “stuff” usually by stripping his cell and taking his mattress, covers and all his clothes except for his boxer shorts, even when it was winter out and cold in the unit. He said staff would take more from him just because they could even if it was just because he had an extra pair of socks or an extra book. He said his DRs just built up until he said he felt “no hope” at SSCF.

He said the reason he self-harmed was to take back some sort of “control” of his life because the staff in the facility were causing him “emotional and mental pain.” He said “it felt good – to have more control over the pain that I could give myself” than they could give to him. He described himself as being on nearly constant “shitbag status,” i.e. close custody, on Restraint I status, with a black box, each time he came out of his cell, whether to shower, go to the med-line, or to recreation. He noted that SSCF’s “close custody status” was comparatively more severe than Newport’s, for example, in terms of access to TV and amount of recreation.

While he acknowledged that he had “stupidity moments,” and that he “cut up,” he said SSCF staff did not help him at all and there seemed to be no achievable goal. He felt they had made him “crazy” – “I feel they made me do everything I had to do.” He believes that the staff treated him like an “animal.” He stated that the most time he spent with any mental health staff was the recreational therapist – not actually a

mental health social worker or psychologist. He said he met with CCS Employee #1 or one of the other mental health staff in the dayroom, in shackles and on black-box status for an average of 15 minutes per session. He stated he went to get out of his cell and that the sessions involved "chatting" more than anything – he said he did not want to talk to CCS Employee #1 or anyone else at SSCF about his problems – and of course the lack of good mental health services was part of the systemic problem at SSCF. He believed there was a battle between mental health and the DOC and he said he believed he was "stuck in between." He said his late, provisional SFI designation in January of 2013 made no difference in his quality of life at SSCF, except that things had to be run through mental health more often. He did not understand why he had not received this designation when he entered the DOC in 2010.

He stated that he believed that CCS Employee #3 had gotten him on the right medications, but then complained that "they" had played games with his access – especially Adderall, by prescribing it in the morning and at night, which caused him to lose sleep. This resulted in his "cheeking" his meds because he was told he either had to take the two doses in the morning and at night or none at all. He felt the behavior plans, (which as he recalled came into use mostly near the end of his SSCF stay), had been used against him since they took his "stuff" from him if he failed. He did not feel that any of the SSCF staff had been fair with him or worked with him. He said they used the reason "threat to the facility" to keep him in some form of segregation – as reflected by the documentation and as shown to be permissible by rule and policy.

He stated that Newport was "the best thing that's happened to me so far" and that it was different than SSCF "because they worked with me." He said the first few days he was there, the Chief of Security there offered to take him off restraint status, and said he would allow him to get rid of the safety smock and shower if he promised not to self-harm for 24 hours. He said to himself - "I'll try – I'll see if they mean it." He then stated "And sure enough, they did." He said that there were 3-4 staff who could calm him down, one of them being CSS, Shawn Smith. He said "Shawn did miraculous work with me. There was a day I'd be covering my window – he'd tell the SOS to open the door." He said the security staff cautioned Smith against going into the cell and speaking in person with C.S. He said Smith told them to let him in anyway. C.S. reported that he would hear the key, and Smith would then come in and say - "Sit the fuck on the bed – what's your problem?" C.S. would tell Smith he wasn't getting his way, and Smith would ask heretofore rarely spoken words: "What do you want?" Basically, C.S. said, Smith – and others listened to him and paid attention to him, but put up with no nonsense. He also said that CCS Employee #4

from mental health was “alright – she was helpful.” He said medical was also more involved at Newport.

He described being pepper sprayed a week before he was actually sent to GP and in his own way, told the story to illustrate that the Newport staff knew that there was “only so long” C.S. would “work with us [them]” until he would begin to think Newport was like SSCF. Thus, a week after that incident, he went to GP – although his continued struggle with compliance resulted in him rotating out of GP and then back in. In sum, Newport not only spent more time with him, but the time spent was of a higher caliber. C.S. explained “We could say they built my trust – they made - ...they really put in an effort – there were times they put in more effort than I did. It was a game to me at first. I had my setbacks, but they always made that next step to help me.”

Fellner recognized that, “Placing the mentally ill in a brutal environment that they are not equipped to navigate without the aid of robust mental health services promotes neither rehabilitation nor prison security. It smacks more of cruelty than of justice.”<sup>76</sup> Inmates are not supposed to come out of prison “worse” than when they went in, but they often do, sometimes based on their interactions with other prisoners, but also upon the way staff treat them, particularly when they have a mental illness or other co-occurring conditions that disable them within the meaning of the law. C.S. spent four years waiting for “the system” to recognize and accommodate his needs. Hopefully the positive experience that started at Newport and has him now enrolled in programming in St. Albans will provide tools for a better future.

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<sup>76</sup> See *supra* note 42 at 412.

PRELIMINARY RECOMMENDATIONS

1) This investigation makes a preliminary recommendation that the Human Rights Commission find there are **reasonable grounds** to believe that the Department of Corrections discriminated against C.S. on the basis of his disability and violated the VFHPAA "integration mandate" in 9 V.S.A. §4201(c)(2) and the general prohibition related to denial of access to services etc. codified at 9 V.S.A. §4201(c)(1).

  
Nelson M. Campbell  
Administrative Law Examiner

  
Karen Richards  
Executive Director

STATE OF VERMONT  
HUMAN RIGHTS COMMISSION

"C.S.",  
Complainant )  
)  
)  
)  
v. ) VHRC Complaint No. PA15-0007  
)  
)  
Vermont Department of Corrections,  
Respondent )

FINAL DETERMINATION

Pursuant to 9 V.S.A. 4554, the Vermont Human Rights Commission enters the following Order:

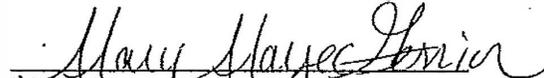
1. The following vote was taken on a motion to find that there are reasonable grounds to believe that the Vermont Department of Corrections, the Respondents, illegally discriminated against "C.S.", the Complainant, on the basis of his disability and violated the VFHPAA "integration mandate" and the general prohibition related to denial of access to services, etc. in violation of Vermont's Fair Housing and Public Accommodations Act.

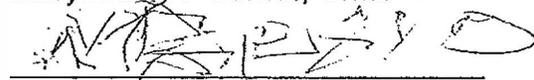
Mary Marzec-Gerrior, Chair	For <input checked="" type="checkbox"/>	Against <input type="checkbox"/>	Absent <input type="checkbox"/>	Recused <input type="checkbox"/>
Nathan Besio	For <input checked="" type="checkbox"/>	Against <input type="checkbox"/>	Absent <input type="checkbox"/>	Recused <input type="checkbox"/>
Mary Brodsky	For <input checked="" type="checkbox"/>	Against <input type="checkbox"/>	Absent <input type="checkbox"/>	Recused <input type="checkbox"/>
Donald Vickers	For <input type="checkbox"/>	Against <input type="checkbox"/>	Absent <input checked="" type="checkbox"/>	Recused <input type="checkbox"/>
Dawn Ellis	For <input checked="" type="checkbox"/>	Against <input type="checkbox"/>	Absent <input type="checkbox"/>	Recused <input type="checkbox"/>

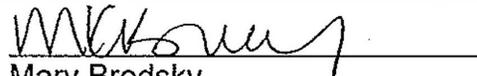
Entry:  Reasonable Grounds  Motion failed

Dated at Montpelier, Vermont, this 23<sup>rd</sup>, day of June 2016.

BY: VERMONT HUMAN RIGHTS COMMISSION

  
Mary Marzec-Gerriot, Chair

  
Nathan Besio

  
Mary Brodsky

  
Donald Vickers

  
Dawn Ellis