DEPARTMENT OF JUSTICE

ELLEN F. ROSENBLUM
Attorney General

FREDERICK M. BOSS
Deputy Attorney General

OREGON STATE TREASURY

TOBIAS READ
State Treasurer

MICHAEL KAPLAN
Deputy State Treasurer

January 13, 2020

Mark A. Emkes, Chairman of the Board
CoreCivic, Inc.
10 Burton Hills Blvd.
Nashville, TN 37215

Re: **Stockholder Demand**

Dear Mr. Emkes:

We are (i) the Oregon Attorney General, the chief legal officer of the State of Oregon, and (ii) the Oregon State Treasurer, a member or chair of multiple different Oregon state investment boards that oversee the investment of significant funds in public and private markets (together, "Oregon"). These boards are responsible for protecting and prudently overseeing more than $100 billion in Oregon public assets, including retirement funds held in trust for hundreds of thousands of Oregon teachers, police, fire firefighters, nurses, social workers and other public employees. Oregon's public funds are invested in CoreCivic, Inc. ("CoreCivic" or the "Company").[1]

Our primary reason for writing today is to discuss numerous reports concerning conditions at immigrant detention centers and private prisons operated by CoreCivic and to emphasize your responsibilities to provide safe, humane, and legally compliant care. As fiduciaries of Oregon's public funds and a concerned citizen, these reports are deeply disturbing and reflect that your Board's breaches of its fiduciary duties expose CoreCivic to significant risk. This situation requires your immediate attention. We demand that the Company's Board of Directors (the "Board")

[1] The State of Oregon, by and through The Oregon Investment Council on behalf of the Oregon Public Employees Retirement Fund, is the beneficial shareholder of 47,537.035 shares of CoreCivic as of January 10, 2020. Additionally, as used herein, CoreCivic includes all CoreCivic employees and directors, as well as all affiliates, joint ventures, and subsidiaries.

investigate and take action to protect the Company and remedy the breaches of fiduciary duties as described herein.

As you are aware, by reason of their positions at CoreCivic and because of their ability to control the business and corporate affairs of CoreCivic, the officer and directors of the Company named below (collectively, the "Responsible Parties") owe CoreCivic and its shareholders the fiduciary obligations of loyalty, good faith, and due care. Oregon believes that the following Responsible Parties violated these core fiduciary duty principles, exposing CoreCivic to loss of business, reputational harm, and damages: Director Damon T. Hininger (who is also CoreCivic's President and Chief Executive Officer), Board Chairman Mark A. Emkes, Director Donna M. Alvarado, Director Robert J. Dennis, Director Stacia Hylton, Director Harley G. Lappin, Director Anne L. Mariucci, Director Thurgood Marshall, Jr., Director Devin Murphy, Director Charles L. Overby, and Director John R. Prann, Jr. The Responsible Parties breached their fiduciary duties by failing to ensure that CoreCivic provides safe, humane detention centers and prisons that satisfy its contractual obligations with the federal government and its broader legal obligations. As detailed below, Oregon is particularly concerned about the health and safety conditions at CoreCivic's immigrant detention centers and private prisons across the country, the high rate of deaths of individuals detained in CoreCivic facilities, and CoreCivic's use of detainees as a low-paid and captive labor force.

The Department of Homeland Security Office of Inspector General Board Found that CoreCivic Violated Health and Safety Standards

On December 11, 2017, the Department of Homeland Security Office of Inspector General ("DHS OIG") issued a report titled "Concerns about ICE Detainee Treatment and Care at Detention Center Facilities" ("OIG Report"). The OIG Report highlighted concerns at six immigrant detention facilities, including CoreCivic facility Stewart Detention Center. The report identified "significant issues" at Stewart Detention Center that "undermine the protection of detainees' rights, their humane treatment, and the provision of a safe and healthy environment" and which constitute violations of ICE's 2011 Performance-Based National Detention Standards ("PBNDS"). Detention center owners and operators like CoreCivic are contractually obligated to adhere to the PBNDS. These standards require, among other obligations, "high facility standards of cleanliness and sanitation" (Standard 1.2); that "detainees have access to appropriate and necessary medical, dental, and mental health care, including emergency services" (Standard 4.3); that "each detainee is able to maintain acceptable personal hygiene practices through the provision of adequate bathing facilities and the issuance and exchange of clean clothing, bedding, linens, towels and personal hygiene items" (Standard 4.5); and that "each detainee has access to recreational and exercise programs and activities, within the constraints of safety, security and good order" (Standard 5.4).

The DHS OIG found numerous violations of these standards at Stewart Detention Center, including but not limited to the following:

- Medical care "may have been delayed and was not properly documented."

- Individuals with high-risk criminal convictions were improperly classified, resulting in them being housed with low-risk detainees.
- CoreCivic lacked a consistent and adequately documented grievance resolution process. "Many serious complaints" had "only cursory and uninformative explanations of the resolution." Notably, it was unclear whether a "particularly troubling allegation of misconduct by facility staff" was investigated. Additionally, methods of reporting violations externally were severely limited. Telephones in the housing area did not work and, alarmingly, the facility restricted the phone number for the OIG Hotline.
- CoreCivic violated standards governing the "administration, justification, and documentation of segregation and lock-down of detainees." Detainees were locked down in their cells for minor violations. CoreCivic failed to properly justify the use of segregation or lockdown and sent people to segregation for extended periods without conducting periodic review to consider whether ongoing segregation was justified. CoreCivic did not consistently document daily medical visits and meals for detainees in segregation – a particularly concerning lapse given the deaths of individuals in solitary confinement at Stewart.
- The DHS OIG found a "lack of cleanliness and limited hygienic supplies." Specifically, the report noted "detainee bathrooms that were in poor condition, including mold and peeling paint on walls, floors, and showers"; bathrooms with no hot water and showers without cold water; and water leaks in housing areas. Additionally, detainees reported that basic hygienic supplies like toilet paper, shampoo, soap, lotion, and toothpaste were not promptly replenished and they were forced to purchase those items at the commissary.
- There were problems with food handling and safety that "could endanger the health of detainees," including spoiled and moldy food in refrigerators and expired food (including meat).
- Staffing levels were inadequate.
- Religious observance was not consistently respected, with staff sometimes interrupting or delaying Muslim prayer times.

These clear and continuing violations of the PBNDS and basic standards of decency raise serious concern about CoreCivic's operations and demonstrate the Board's failure to adequately oversee the Company's operations.[2]

[2] Importantly, these issues are not limited to Stewart Detention Center. The concerns raised in the OIG Report are consistent with issues identified by journalists and human rights watchdogs at other CoreCivic facilities. For example, a 2019 CNN report noted that a Tennessee judge released inmates from CoreCivic's Silverdale Detention Center because he determined that the medical care provided to those inmates was "inexcusable," including an inmate who said his cancer was not being treated and that he was receiving only Tylenol for an injury that left a bone protruding from his shoulder. *See* Blake Ellis and Melanie Hicken, *Behind bars*, CNN (June 2019). And a 2018 report described "harsh and inhumane" conditions at CoreCivic's Elizabeth Contract Detention Facility, including worms or maggots in the shower area, insufficient or damaged clothing and hygiene products (including insufficient access to menstrual sanitary products),

Numerous Deaths Demonstrate Widespread Health and Safety Issues at CoreCivic Immigrant Detention Centers and Private Prisons

Numerous deaths of individuals housed in CoreCivic facilities – including at the Stewart Detention Center that was the focus of the OIG Report – create serious concern that the Board has failed to correct the problems identified in the OIG Report and to ensure compliance with its legal obligations to provide a safe environment with appropriate medical and mental health care.

Four people died within the last two years at the Stewart Detention Center. In August 2019, Pedro Arriago-Santoya died of cardiopulmonary arrest after being taken from Stewart to the hospital. In July 2018, Efraín Romero de la Rosa – who suffered from mental illness – died of suicide after twenty-one days in solitary confinement at Stewart Detention Center. Additionally, Yulio Castro-Garrido had no health problems when he entered Stewart Detention Center but died in January 2018 after contracting pneumonia, a lung infection, and viral influenza there. In May 2017, Jeancarlo Jimenez-Joseph died of suicide at Stewart Detention Center after nineteen days in solitary confinement at Stewart. ICE's review of Jimenez-Joseph's death identified 11 "deficiencies" and 22 "areas of concern" in CoreCivic's compliance with the PBNDS, including insufficient access to psychiatric care.

Beyond Stewart, a recent report found that the rate of homicides in CoreCivic-operated private prisons in Tennessee was higher than in the state's public facilities, noting three homicides in CoreCivic prisons in 2019 alone (Tyrone Elliott Montgomery, Dameion Nolan, and Ernest Edward Hill).

Additionally, Oregon is profoundly concerned about the death of a young child who became sick while in a CoreCivic facility. In May 2018, 1-year old migrant Mariee Juárez died just weeks after she was released from CoreCivic's detention center in Dilley, Texas, one of the largest family detention centers in the United States. Her mother, Yazmin Juárez Coyoy, reported that while at Dilley, Mariee suffered from respiratory illness, a 104.2-degree fever, coughing, and vomiting; one day after she left the facility she entered the emergency room, and a few weeks later she died of a hemorrhage. Marie's death drew tremendous public attention to CoreCivic's practices and resulted in litigation against the Company. Ms. Coyoy testified to the United States House of Representatives and has sued CoreCivic for $60 million. The court has sustained Ms. Coyoy's allegations that CoreCivic breached its duty to provide safe, sanitary living conditions and that this breach was a proximate cause of Mariee's death. *See Yazmin Juarez Coyoy, as surviving parent of Mariee Camyl Newberry Juarez v. CoreCivic, Inc.* 19-cv-916, Dkt. 19 (W.D. Tex. Oct. 9, 2019). Major news outlets have published articles about Mariee's death and the unacceptable conditions leading to it. *See, e.g.*, *Mother blames toddler's death on poor medical care in U.S. immigration*

---

drinking water with an obvious white coloration similar to bleach, and no real outdoor recreation. *See Ailing Justice: New Jersey*, Human Rights First (Feb. 2018).

jail, Washington Post, Aug. 28, 2018; *Mother Whose Child Died After ICE Detention Sues for $60 Million*, The New York Times, Nov. 28, 2018.

These recent deaths mark a continuation of a long-standing pattern that CoreCivic and its Board have not adequately attended to serious safety and compliance guidelines, despite clear violations and red flags. For example, the Eloy Detention Center in Arizona has been described as the "deadliest immigration detention center in the nation." Daniel González, *Another death at Eloy migrant-detention center*, The Republic (Nov. 28, 2016). At that facility alone fourteen people died between 2003 and 2015, five from suicide. Beyond Eloy, there are numerous other deaths documented by human rights reports and mainstream news outlets. For example, Igor Zyazin died under CoreCivic's care in May 2016. Mr. Zyazin suffered from a pre-existing heart condition and asked to be seen by medical staff because he had chest pains and felt dizzy; rather than obtaining emergency medical treatment, he was transferred from one CoreCivic facility to another facility hours away, where he died. Marjorie Annmarie Bell died in February 2014 of a heart attack. She had a history of heart disease and at least three stents in her heart. While detained at San Diego County Detention Facility, CoreCivic failed to provide her the necessary close observation and monitoring by a heart expert or promptly call 911 on the day of her death when she said that she had chest pains. Carlos Aguirre-Venegas, detained at Eden Detention Center, died of liver failure after medical staff administered an antibiotic known to cause liver failure and failed to provide the necessary close monitoring. Aguirre-Venegas reported to his family that he knew the pills were making him sick but he feared that if he stopped taking the doses he would be disciplined by being sent to segregation or being denied phone and visitation rights – his only access to his family and the outside world. *See Code Red: The Fatal Consequences of Dangerously Substandard Medical Care in Immigration Detention*, Human Rts. Watch (June 20, 2018); *Systemic Indifference: Dangerous & Substandard Medical Care in US Immigration Detention*, Human Rts. Watch (May 18, 2017); Seth Freed Wessler, *The 25 Men Whose Lives Ended Under Questionable Circumstances*, Nation (Jan. 28, 2016).

The number and frequency of deaths in CoreCivic facilities reveals the inadequacy of the medical and mental health care provided at these facilities, and the lack of Board oversight to ensure the Company provides a safe and healthy environment for individuals in its care.

CoreCivic's Labor Practices May Constitute Human Trafficking

Further, Oregon is alarmed about credible allegations in a class-action lawsuit against CoreCivic regarding its "voluntary work program." The program allegedly involves individuals detained at Stewart Detention Center performing labor for the institution, including preparing meals, washing laundry, and scrubbing bathrooms, in exchange for $1-4 a day, which the individuals can use to purchase items from the commissary. In what plaintiffs deem a "deprivation scheme," they are forced to take these jobs to have funds to purchase basic needs items that CoreCivic refuses to provide like soap, toilet paper, and toothpaste. Further, the complaint alleges that CoreCivic retaliates against individuals who refuse to work by threatening to transfer them to less desirable housing units, transferring them to solitary confinement, initiating criminal proceedings against them, or revoking their commissary access. The court upheld allegations that

CoreCivic's conduct violates the Trafficking Victims Protection Act and constitutes unjust enrichment under Georgia law. *See Barrientos et al. v. CoreCivic, Inc.* 18-cv-00070, Dkt. 38 (M.D. Ga) (on interlocutory appeal on denial of CoreCivic's motion to dismiss).

Further corroborating the allegations in the lawsuit, a news outlet reported that CoreCivic officials put a detained individual into solitary confinement for ten days after a pay dispute over $8. *See* Ryan Deveraux, *Immigrant Detainee Accuses ICE Contractor CoreCivic of Locking Him in Solitary Over $8,* The Intercept (Apr. 19, 2018).

CoreCivic's abuse of detainees and failure to provide basic necessities is a violation of its legal and contractual obligations. That it does so to create a captive, cheap labor force which it then controls through threats, intimidation, and the use of solitary confinement is abhorrent. The Board's failure to end and correct this practice is a serious breach of its fiduciary duties.

The Board's Failure to Fulfill its Oversight Obligations

There can be no doubt that each member of the Board is aware of these issues. They are widely reported in the news media and are the subject of litigation against the Company and have been for some time. Further, certain Board members serve on committees charged with oversight and review of the issues identified in this letter. Specifically, Directors Alvarado, Mariucci, Marshall (Chair), and Overby are members of the Risk Committee, which pursuant to its Charter is charged with reviewing and discussing with management "the Company's significant enterprise risks" and providing "oversight with respect to the steps management is taking to assess and manage such risks, the adequacy of the Company's resources to fulfill its risk management responsibilities and the Company's risk management culture." Additionally, the Committee reviews with management "the Company's policies and practices relating to the care and treatment of the inmate, detainee, and resident populations"; "the Company's compliance and auditing systems regarding operational performance and government contract compliance"; and "material pending legal proceedings and investigations involving the Company and other contingent liabilities." The Risk Committee also reviews issues of public policy and other trends that relate to the Company's "business operations, public reputation and performance."

Additionally, Directors Prann (Chair), Alvarado, Mariucci, and Murphy are members of the Audit Committee, which pursuant to its Charter is responsible for "consider[ing] the Company's major financial risk exposures, including but not limited to, review of material legal proceedings involving the Company" and "the Company's policies and procedures regarding compliance with laws and regulations." The Audit Committee works closely with the Risk Committee, including the Committee Chair and members attending Risk Committee meetings, receiving reports, and annually inviting the Risk Committee Chair to report on its activities at an Audit Committee.

Thus, in addition to their participation on the Board, these committee directors have specific responsibilities to ensure that CoreCivic complies with applicable compliance standards.

Risks and Potential Damages to CoreCivic

Due to the failure of the Responsible Parties to properly oversee the Company's compliance with contractual and regulatory guidelines, and failure to heed various red flags and warnings concerning CoreCivic's operations, the Company is now facing: (1) the risk of losing contracts with Immigration and Customs Enforcement and the Bureau of Prisons (2) damages from multiple litigations (both individual and class actions) and enhanced scrutiny; and (3) loss of necessary financing from major banks.

Risk to ICE Contracts

CoreCivic's contracts with Immigration and Customs Enforcement ("ICE") are critical to its financial success. As noted in the 10-K for FY 2018, the Company "currently derive[s], and expect[s] to continue to derive, a significant portion of our revenues from a limited number of governmental agencies" including ICE. Form 10-K for FY 2018 at 11. Contracts with ICE accounted for 25% of CoreCivic's total revenue for years ending December 31, 2018 and 2017, respectively. Form 10-K for FY 2018 at 36. As noted in the 10-K, "the loss or substantial reduction in value of one or more of such contracts [with a federal government agency like ICE] could have a material adverse impact on our financial condition, results of operations, and cash flows." Form 10-K for FY 2018 at 36.

As discussed above, the Board has failed to ensure CoreCivic's adherence to these standards. The DHS OIG's focus on these issues means ICE is clearly on notice of the problems and creates a risk that the government will choose to not renew CoreCivic's valuable contracts.

Exposure to Litigation and Investigations & Enhanced Scrutiny

The Board's breaches of duty have subjected the Company to litigation, investigations, and scrutiny from regulators from which the Company must now defend itself. In addition to the OIG Report and the litigation matters described above (gross negligence in detention center conditions and human trafficking), CoreCivic currently faces securities litigation that "would have a material effect on our financial position, results of operations or cash flows." The litigation, which has withstood motion to dismiss and in which a class was certified, involves allegations of systemic understaffing, inadequate physical and mental health care, and unclean and unsanitary environments in CoreCivic facilities under contract with the federal Bureau of Prisons. *Grae v. Corrections Corporation of America, et al.*, No. 3:16-cv-02267, Dkt. 57 (M.D. Tenn. March 13, 2017).

Loss of Access to Major Banks

In the past year, three of the lead lenders in CoreCivic's $1.1 billion secured credit facility have announced that they will stop lending or providing financing to private prison companies, including CoreCivic. In January 2019, Wells Fargo announced it was reducing its relationship with private prisons, including CoreCivic, as part of its "environmental and social risk management,"

noting that its "credit exposure to private prison companies has significantly decreased and is expected to continue to decline." Then in March 2019, JPMorgan Chase & Co. ("JPMorgan") announced that it would "no longer bank the private prison industry," based on its evaluation of the costs and benefits of serving different industries. Previously, JP Morgan underwrote bonds or syndicated loans for CoreCivic. Finally, in July 2019, SunTrust Banks Inc. stated that it would not provide future financing to private prison and immigrant detention companies, a decision which was "made after extensive consideration of the views of our stakeholders." Predictably, this loss of financing negatively impacted CoreCivic's credit rating. In June 2019, Fitch Ratings downgraded CoreCivic from BB+ to BB and the ratings outlook from stable to negative, in part due to the Company's limited access to capital. The downgrade in ratings will result in higher borrowing and other costs to CoreCivic.

Rather than acknowledging the deep public concern about immigration detention center standards and refocusing its efforts to ensure a future for CoreCivic by implementing policies and practices to maintain facilities that are safe, humane, and dignified, the Company issued the tone-deaf response that the banks were "caving to political pressure" and "have kowtowed to a small group of activists rather than engaging in constructive dialogue." *See* Lananh Nguyen, SunTrust is Latest Bank to Halt Financing of Private Prisons, *Bloomberg* (July 8, 2019). To the contrary, we do not believe these concerns are reflective of just a small group of activists but are shared by concerned CoreCivic stockholders like Oregon. The Board's failure to ensure CoreCivic's compliance with its legal obligations and its provision of a safe and humane environment fuels the public opposition to the private prison industry that led to these decisions.

Demand that the Board Take Remedial Action

We hereby request that the Board take immediate action against the Responsible Parties to remedy the breaches of fiduciary duty described herein and adopt remedial measures to avoid further harming the Company and its stockholders, including but not limited to the following:

1. **Ensure Compliance with Contractual and Legal Obligations:** The Board shall take immediate action to ensure the Company's complete compliance with all contractual and applicable legal obligations at its detention centers and private prisons, including compliance with the ICE PNBDS where contractually obligated and compliance with all wage and hour laws for its detainees. That compliance shall be verified by an outside compliance firm and reported to the shareholders, along with a report of (i) all instances of non-compliance at each facility and (ii) all steps the Company has taken to remedy non-compliance.

2. **Create Suicide Prevention Plan:** The Board shall ensure that each facility has a suicide prevention plan. The Company shall conduct an annual audit evaluating compliance with the suicide prevention plans, the results of which shall be provided to the Board.

3. **End Inhumane Solitary Confinement Practices:** The Board shall retain a third-party consulting expert to conduct an immediate review of solitary confinement practices at CoreCivic facilities, including duration of confinement, use of confinement for mentally

ill individuals, and punitive confinement. The Board shall end the Company's use of solitary confinement practices that are inhumane or in violation of applicable contractual or legal requirements.

4. **Risk Committee Refreshment:** Before each of the next three annual elections, the Board shall replace one of the current members of the Risk Committee to allow for refreshment, and limit participation on the committee to a four-year term to assure Committee refreshment.

5. **Improve Transparency:** To allow shareholders to evaluate whether the Risk Committee has fulfilled its charge as set forth in its charter, the Company's Annual Report to Shareholders shall include a report from the Risk Committee describing the specific matters it reviewed and considered pursuant to its Charter during the prior fiscal year.

6. **Review of Deaths:** The Risk Committee shall conduct a quarterly review of any deaths that occurred in CoreCivic facilities, including reviewing available company, governmental, or public analysis of the circumstances of the death and any remedial measures taken by the Company in response to the death. The Risk Committee shall present an annual report to the full Board regarding all deaths in the prior year and any remedial measures taken by the Company in response to the deaths.

7. **Increased Interaction with the Business and the People Served:** CoreCivic's charge is to care for the people in its custody. To ensure that the Risk Committee members have greater insight into their experiences at CoreCivic facilities, the Risk Committee or one of its designated members shall conduct at least one unannounced visit to a CoreCivic facility each year that includes observation of living quarters, medical facilities, solitary confinement and other disciplinary or segregation spaces, cooking and dining facilities, and the outdoor recreation space.

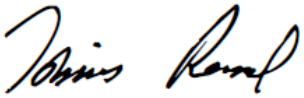
8. **Budget Examination:** Each year, the Risk Committee shall evaluate CoreCivic's annual spending on physical healthcare, mental healthcare, wages, and staff training on physical and mental healthcare and advise the full Board on whether to recommend any adjustments to those budgets.

9. **Enhanced Board Expertise**: The next open seat on the Board of Directors shall be filled by a director with training and experience providing medical, psychological and related services to large populations in a hospital or institutional setting.

This Stockholder Demand also serves to put all affected entities and individuals identified herein on notice of their document preservation and collection responsibilities.

Thank you for your consideration of these matters. We look forward to hearing from you shortly to discuss Oregon's demands.

Sincerely,



Tobias Read
Oregon State Treasurer

Ellen F. Rosenblum
Oregon Attorney General

cc Julie Goldsmith Reiser
Richard Speirs
Molly Bowen