U.S. Department of Justice

Civil Rights Division

Office of the Assistant Attorney General *Washington, D.C. 20035*

March 27, 1995

The Honorable Fob James
Governor
State of Alabama
Alabama State Capitol
600 Dexter Avenue
Montgomery, AL 36130

Re: Notice of Findings from Investigation of Julia Tutwiler Prison for Women

Dear Governor James:

On March 29, 1994, we notified your office of our intent to investigate the Julia Tutwiler Prison for Women (Tutwiler) pursuant to the Civil Rights of Institutionalized Persons Act (CRIPA), 42 U.S.C. § 1997 et seq. Pursuant to statutory requirements, we are now writing to advise you of our findings from this investigation. To the extent permitted by their attorneys, state officials assisted us throughout much of our investigation, and we thank them for their cooperation.

Our investigation of the Julia Tutwiler Prison for Women consisted of three tours in late May/early June, July, and August 1994. The tours were conducted by a medical consultant and a forensic psychiatrist, a penologist and sanitarian, and a fire safety engineer. During the course of the investigation, we interviewed staff and inmates, examined documents on-site, and inspected the physical facilities.

Our investigation of Tutwiler revealed a number of unconstitutional conditions. Our facts and conclusions are summarized below.

I. MENTAL HEALTH CARE

Tutwiler's mental health services are constitutionally deficient, and inmate mental health needs are not met.

A. Tutwiler does not provide needed mental health care.

Our mental health consultant interviewed eleven staff members and thirty-six inmates, and he also reviewed medical

charts and other documents. Our mental health consultant identified a significant number of patients who require considerably greater mental health services than are currently available at Tutwiler. Mental health care for these inmates fails to meet even minimal professional standards.

Generally, our consultant found that mental health care at Tutwiler is almost nonexistent. The program in place lacks most of the basic requirements of a mental health care system. For example, patient records lack adequate initial evaluations, medical histories, treatment plans, progress notes, and basic test results. There is also insufficient mental health staffing, inadequate documentation regarding the use of restraints, long delays before psychiatric hospitalization, and inadequate on-site, mental health facilities. These deficiencies have or will result in many of the inmates' mental conditions either significantly deteriorating or not improving.

Further, our consultant found that policies and procedures relating to medication protocols, treatment plans, quality assurance, and other required elements of a mental health care system, are either totally absent or excessively vague. There are long delays before mentally ill inmates receive even minimal professional attention. A typical, mentally ill inmate has to wait from one to four weeks before receiving a professional consultation. Even after receiving a consultation, the mentally ill inmate receives insufficient care.

Instead, severely, mentally ill inmates in need of hospitalization remain at Tutwiler for months without adequate treatment or monitoring. Patients who are not as ill may still require housing in an intermediate care unit, but no such facility is available. Tutwiler's mental health cells, in the "Green Room," are not adequate substitutes for a psychiatric medical facility. Rather, these cells function mainly as an observation unit.

In terms of staffing, the psychiatrist's position was vacant during our tour, and the Director of Nursing did not know whether any of her nursing staff have mental health experience.

The quality control auditing process for mental health services consists largely of the psychiatrist reviewing his or her own work, and not surprisingly, care is often inadequate. It is quite clear from the extent of the deficiencies that the existing quality control process for mental health care does not work.

B. The use and management of psychiatric drugs is dangerously deficient.

We found very serious problems with the use of psychiatric drugs at Tutwiler. During our first visit, our mental health consultant reviewed numerous medical records, and discovered that the psychiatrist often prescribes lithium without adequate laboratory testing or monitoring of patient lithium levels. Improper use of lithium can cause extremely serious complications, including death. Thus, we briefed the medical staff about the problem at the end of the tour, so that they could immediately address the imminently life-threatening situation. The staff informed us that they would remedy the problem as soon as possible. Such a gross deficiency is only one aspect of a larger problem, including poor management and improper use of psychiatric drugs.

Our consultant found that medication policies and procedures are often grossly deficient or entirely absent. At Tutwiler, inmates are treated without any apparent consideration of their past medical histories. Multiple medications are often prescribed without adequate explanation or justification. Such polypharmacy generally indicates poor clinical practice. No formal mechanism exists to promptly notify the psychiatrist when an inmate is not taking her medication. Finally, there is no regular effort to detect, treat, or monitor tardive dyskinesia and other serious medication-induced side-effects.

II. MEDICAL CARE

Our medical expert found significant deficiencies in the following areas: access to medical care; medication policies and practices; communicable disease management; facilities for the physically disabled; dental care facilities; chronic care programs; and health care unit conditions. Each of the deficiencies identified in our expert's report violates professional standards, and together or in part, constitute the denial of adequate medical care.

A. There is inadequate access to health services.

Tutwiler has numerous policies and procedures which unreasonably restrict access to medical care. An inmate must see the prison doctor before she can receive even the most basic medical services such as over-the-counter medication (OTC's). To get an appointment with the doctor, inmates must first sign up for sick call during mealtime. Sick call takes place in the middle of the night, and is primarily a screening process conducted by unsupervised and unqualified L.P.N.'s. These L.P.N.'s, who have no training in triage and do not follow written protocols, decide on their own whether an inmate may see the doctor the next day. This process means that an inmate may

have to wait days before she can get any medication of any kind - even a simple aspirin. The consequences are much more serious for inmates with severe medical conditions.

Inadequate physician staffing exacerbates the problem. The physicians who work at Tutwiler are overburdened and do not have the resources to do their jobs properly. Medical records show that the Tutwiler physicians cannot or will not adequately examine patients, take medical histories, make diagnoses, ensure continuous care, or devise adequate management plans for patients. A prescription order is often the only medical management plan for a patient. The clinical director must approve all outside referrals of a non-emergency nature; yet the director is only on site about once per month. Thus, even getting an x-ray for a patient is very difficult. There is no on-site x-ray machine, and any inmate who needs an x-ray must be sent to one of the men's prisons. This complicated procedure causes unnecessary delays. Even after an inmate receives outside tests or treatment, there is poor continuity of care. Medical records indicate that the Tutwiler medical staff often fail to review laboratory tests or ignore recommendations by the outside physician consultants.

B. Medication policies, practices and procedures are inadequate.

Our physician found numerous problems with the prison's medication policies and procedures. Many of these policies cause serious delays before inmates can obtain needed medication. For instance, there is no "medication on person" program at the facility, and anyone who needs medication must go through a complex process which causes substantial delays in treatment. Under this procedure, most inmates requiring medication must first go through the late night sick call screening discussed above, wait for a physician to see them and approve their medication the next day, and then go to the separately scheduled pill lines for every dose of medication. Inmates in the reception unit cannot receive any medications at all until a physician has performed an initial physical exam. Yet, medical records indicate that there is a routine wait of at least three weeks before the physician performs such an exam. Therefore, during that period, the inmates in reception are generally denied medication.

The dispensing of drugs is also plagued by a number of improper practices. Medical records show that physicians order medications without explanation. Our consultant also found blank medication order sheets which were pre-signed by the physician, a procedure which blatantly violates professional licensing standards.

C. The facility's communicable disease program is deficient.

Julia Tutwiler's existing tuberculosis control program violates accepted standards. For example, one inmate receiving INH medication for TB exposure did not have chest x-ray reports, a liver function test, or other important documentation in her medical records. Another inmate who had a positive PPD test was placed in isolation without ever being given a chest x-ray or having her medical history taken. Yet another inmate was given a PPD test, but the test was never read, the inmate's coughing was unaddressed for four months, and the inmate never received a chest x-ray. These do not appear to be isolated examples.

D. Dental care is inadequate.

Our medical expert found that the dental unit does not have adequate dental staffing for this sized population. For instance, the facility does not have a licensed dental hygienist, and must rely on an inmate to provide some dental services. Using an inmate to provide direct dental care violates all accepted professional norms and does not resolve the inadequate staffing problem. While records regarding dental services are incomplete, it appears that over 50% of the inmates do not receive dental screenings. The dental office itself is dilapidated with damaged furniture and exposed wiring.

E. The chronic disease clinics do not provide adequate care.

Although the clinical medical director has ordered all state facilities to implement a chronic disease program, Tutwiler has not fully implemented these clinics. No quality assurance review exists to see if the facility is in compliance with the clinical director's instructions. L.P.N.'s are charged with conducting these clinics even though they are not trained to do so. Records indicate that inmates are arbitrarily removed from the chronic care program. Generally, the medical care delivery system is too disorganized and there are too few staff to implement the chronic care clinics.

F. The medical clinic is inadequate for carrying out needed health services.

All nurse triage and physician encounters are performed in one room of the medical unit. This room does not have enough space for the medical staff to conduct examinations, and there is no way to ensure patient privacy under these circumstances.

G. Inmate deaths.

During our physician's tour, a problem arose which prevented a review of inmate death records. State and Justice Department representatives eventually decided to deal with this complication by allowing another Justice Department consultant to review the death records during our subsequent tour of the Easterling Correctional Facility. Our medical consultant for Tutwiler then debriefed this reviewer, and concluded that medical care at the facility is so inadequate as to jeopardize the health and safety of inmates. For example, one decedent had a history of heart disease; yet, staff ignored her symptoms of unstable angina two days before she died. The patient never received a chest x-ray, EKG, or cardiology consultation. The physician ordered medications for the patient, but did so without ever making a diagnosis or providing a justification for the medications. Another inmate complained about respiratory problems for three days shortly before she died, but was apparently never examined by a physician. She was never provided with a plan of management for her asthma and respiratory distress.

III. CORRECTIONS

Our corrections expert was favorably impressed with several areas of prison operations including the classification system, staff correctional training, the quality of the law library, educational and vocational programs, and the general lack of idleness among inmates. He finds the facility's administrators and staff are doing some things very well, and many things adequately. However, there remain several major deficiencies which must be addressed.

A. Tutwiler subjects inmates to unconstitutional disciplinary practices.

Tutwiler utilizes a perpendicular steel pole, called the "rail," as a punishment device for inmates who are tardy or refuse to work. Inmates are handcuffed to fixed rings on the "rail," which is adjacent to the outdoor inmate work area, and must remain in a standing position at the "rail" for up to a day. Inmates may be placed on the "rail" for refusing to work or for being tardy. Use of the "rail" is extremely troubling for several reasons. First, it is an improper restraint. The accepted correctional practice is never to use restraints as punishment. Rather, restraints should only be used on inmates who are escape risks or pose a risk of harm to themselves or others. This is not the case at Tutwiler. Second, the "rail" is similar to corporal punishment. The punished inmates must remain standing in a cramped position, for up to a day, with no protection from the elements other than their light jackets. Subjecting someone to such conditions is indefensible given the array of conventional disciplinary options available to staff.

Third, the "rail" is used in a manner which violates even the minimal safeguards devised by state officials. For example, inmates are officially allowed water, food, and bathroom breaks. Yet, during our tour, we received complaints from inmates that they were denied water while on the "rail." Additionally, our expert observed that the bathroom used by "rail" inmates is located in a basement boiler room. During our tour, this bathroom was flooded by rainwater. Fourth, there are few limits on who can be placed on the "rail." Inmates receive a disciplinary hearing only after they have spent a day on the "rail," and the hearing merely determines whether the inmate should be further punished through the regular disciplinary process. To make matters worse, no medical clearances are required, so inmates who may have medical excuses for their inability to work may be punished unfairly. For instance, our consultant found one inmate who was punished for not waking up for work on time. The officers did not realize that the inmate was on medication which made her constantly drowsy. Fifth, in violation of the state's own policies, regular officers sometimes impose punishment without supervisor approval.

As for the regular disciplinary process, the existing segregation practices generally comport with accepted standards. The only exception is that inmates in disciplinary segregation are given only two meals, without desserts or condiments, per day. While denying inmates desserts and condiments is acceptable, denying them basic nourishment is not. The problem is of special concern, because facility documents do not adequately demonstrate that meal plans have been reviewed for adequate nutritional content.

B. Supervision problems.

Our penologist received allegations of staff supervision problems. In particular, he received credible reports of sexual relations between inmates and staff. While these allegations involve only a small minority of the staff, such conduct is reprehensible and intolerable. The offending staff members reportedly reward inmates with food, cosmetics, and money for their participation. There is no indication that administrators knowingly condone such conduct, and there are no allegations of physically forced rape. The sexual relationships are not appropriate or truly "voluntary" given the institutional setting.

C. Physical security is inadequate.

The prison contains physical plant deficiencies which increase the risk of suicide and escape.

Three physical plant deficiencies increase the risk from suicide. First, the existing window screening has large apertures through which a suicidal inmate can easily tie a noose.

Second, many ventilation openings have uncovered steel slats which can also be used to facilitate suicide by hanging. Third, many housing units contain protruding shower heads and faucets which pose the same problem.

In regards to security deficiencies which increase the probability of escape, we have elected not to discuss some of the details in this public document. Rather, we will phone the state representatives to appraise them of our more detailed findings. Without exaggerating the problem, we believe a more discrete approach is warranted and legally adequate. Suffice it to say that there appears to be a significant security weakness at the facility which increases the risks associated with escape attempts.

D. Adequate food.

Because the dining hall is also used for visitation on weekends, inmates receive only two meals a day on Saturday and Sunday to accommodate visitation needs. The two meals are served at approximately 7:00 a.m. and 3:00 p.m. This excessive time between meals and the possible failure to provide basic nutrition on the weekends violates generally accepted standards.

IV. ENVIRONMENTAL HEALTH AND SAFETY

A. Physical plant.

The prison needs physical repair and improvement. For instance, many electrical outlets are loose, improperly grounded, and lack ground fault interrupters. The plumbing system lacks vacuum pumps, so sewage can backflow into the water supply. It also lacks circulating pumps, so that in some bathrooms, water temperatures are too cold from a sanitation standpoint, while in others, they are scalding hot. There are no window screens, so insects can be found on food trays, mixers, and within storage containers. In one unit, a hinge is broken, and an entire window is in danger of collapsing onto someone. The ceiling leaks in a number of places, and there is a serious standing water problem in the boiler room.

B. Food Service and Kitchen conditions.

The food service program is unsanitary.

Kitchen utensils, equipment, and pans are improperly washed. For example, our sanitarian observed dirt and food particles in kettles and pans which had just been washed. He also noticed that the sanitizing element for one of the dishwashing sinks is a thermal device which heats the water to an extremely hot 180 degrees Fahrenheit. This device was not functioning properly during our tour. Our sanitarian also noticed that the workers

did not have any detergent to wash the pans. When the problem was called to the kitchen supervisor's attention, the supervisor retrieved a container of orange detergent. The container itself was mislabeled as "orange drink mix."

The kitchen's physical plant is completely unsatisfactory. The tile floor is badly cracked. Thus, it is impossible for workers to clean the kitchen, since dirty water seeps beneath the tiles where it cannot be drained. Drainage is also hampered by the fact that all but one of the floor drains has been sealed with concrete. The kitchen reeks from the smell of the stagnant, black liquid which has formed under the floor. Ceiling tiles are missing over the hood, and dirt has accumulated on overhead pipes.

Other food service problems exist as well. Insects are everywhere. Served food is often not hot enough to prevent foodborne illnesses. Perishables are kept in refrigerators that are warmer than they should be. Bulk food containers are unlined. The dietary plan does not appear to be adequately updated to ensure nutritional adequacy, and the provisions for medically necessary diets are vague and muddled. Food service training appears inadequate, since the food service managers appear either ignorant of, or unwilling to perform, their food sanitation duties.

C. Training, Inspections, and Procedures.

Other environmental health and safety problems involve procedures and training. For example, there is no "Housekeeping Policy and Procedure," or at least, personnel do not seem to be aware of it. Thus, there is no system to ensure adequate provision of waste disposal containers, sanitary supplies, and cleaning equipment. There is no process for testing water fountains for lead. Staff do not appear to be familiar with procedures regarding cleanup of blood and bodily fluids. The medical autoclave has not been inspected recently, and so medical instruments may not be properly sterilized.

D. Overcrowding.

Overcrowding has exacerbated some of the sanitation problems. For two dorms, there are insufficient lavatories and showers. In dorms 1 and 4, the ratios of inmates to lavatories and showers are 1:22 and 1:16 respectively. This compares with recommended ratios of 1:12 and 1:8 respectively. Our sanitarian identified a number of dorms which are overcrowded given objective square footage standards.

E. Personal hygiene.

The facility administration makes some effort to ensure adequate inmate, personal hygiene.

The prison canteen has a good selection of personal care items. One missing essential item is wide-tooth combs for African-American women. Also, women do not always receive hygiene items on a timely basis. One common complaint was that inmates do not receive an adequate supply of toilet paper. Correctional personnel confirmed that the women only receive four rolls per person per month.

The prison administration does a good job ensuring that inmates have clean linens and clothing. There is a twice a week laundry exchange and the facility's home-style automatic washers are of great help in ensuring personal cleanliness and hygiene.

The facility has a problem with torn mattresses in various dormitories. Damaged mattresses create sanitation and fire safety problems.

V. FIRE SAFETY

An environmental health and safety expert and a fire safety engineer reviewed fire safety conditions at Tutwiler. Both of these experts concluded that the facility is presently unsafe because of an extensive array of fire safety deficiencies.

Our environmental health and safety expert toured a few weeks before the engineer. He interviewed staff, inspected the facility for non-architectural fire safety factors, conducted a fire drill, and identified several significant deficiencies. Based upon his tour, our environmental health and safety expert concluded that current fire safety procedures, training, inspections, and drills are inadequate. While touring the facility, he was able to observe a power outage and conduct a fire drill. During the power outage, the entire phone system, including emergency backups, failed. During the fire drill, response times were slow, and at least seventy-inmates were unable to evacuate before the all-clear was sounded by someone on the prison staff. As part of the cumbersome fire drill procedure, inmates deposited fire extinguishers in the middle of the hallway, obstructing egress. There is no fire team to report to a fire scene and actually use the extinguishers. The entire fire inspection and training process is chaotic, with duties spread between everyone from the Business Manager to the facility's Fire Marshal. No one person or committee coordinates their efforts. There are no records regarding weekly fire inspection reports, smoke detector tests, fire hose "flow tests," or emergency generator fuel and oil checks. Some type of fire alarm testing takes place, but the reports are not actually

reviewed. The training program does not cover the use of fire extinguishers and appears inadequate. One kitchen manager did not even know where the "remote pull" was for activating the kitchen's fire suppression system. Facility staff consider fire drills to be adequate fire safety training, even though drills are really evaluation tools to determine what has been learned, not training per se. Additionally, the drills are not conducted on all shifts, and the fire drill reports lack such basic information as head counts and evacuation notes. For all practical purposes, the fire drill reports are useless.

Our fire engineering consultant reviewed the prison's architectural features and interviewed a number of state personnel. He found that Tutwiler does not fully meet nationally recognized standards, such as the Life Safety Code, which require minimum levels of fire safety for correctional institutions. While some aspects of the prison architecture offer inherent fire safety, those strengths are undermined by a number of significant deficiencies. The total absence of smoke detectors in most of the housing areas is the gravest problem. The failure to provide an egress door which can be unlocked from the outside of Dorm 9 and the failure to properly mark and organize emergency keys are also serious deficiencies. Our fire engineer notes in his report that using foam, "egg crate," sleeping pads is risky, because such pads will burn readily. For a number of reasons, he does not however recommend their total removal. Rather, he believes that they may be acceptable if they are carefully controlled and used only when necessary. Other miscellaneous problems include the failure to test the emergency generator under load, conduct fire drills on each shift, and train staff in the use of fire extinguishers.

There are a number of miscellaneous problems with emergency and safety procedures generally. For example, there are no emergency procedures or training for other types of disasters, such as tornadoes. Corrosive substances may be used in areas without eye wash basins. There is no inventory of toxic, flammable, reactive, and radioactive materials, and there is no training regarding chemical safety. There are no Material Safety Data Sheets for hazardous chemicals at work sites. Burning and welding takes place without a "hot works permit" system in place to minimize the risk of smoldering fires. One of our safety experts found an unsecured oxygen cylinder in the medical unit, and also found acetylene and oxygen gas cylinders stored dangerously close together in the vocational school.

VI. AMERICANS WITH DISABILITIES ACT

Some of our experts noticed rather obvious problems involving the rights of disabled inmates. For example, our corrections expert noticed obstructions in bathrooms which impede handicapped access. It appears that the state has already

started addressing some of these problems. Their continued efforts are recommended; for such deficiencies can, and should, be remedied.

Since we are primarily concerned with constitutional violations, we have not however formally evaluated Tutwiler's policies and procedures under new regulations issued pursuant to the Americans with Disabilities Act. Therefore, we have not made any significant findings or recommendations regarding potential state ADA violations. In particular, the new ADA regulations prohibit state programs from unfairly discriminating against inmates with disabilities, such as physical handicaps or communicable diseases, and require that facilities maintain those conditions, such as handicapped ramps and other fixtures, which are needed to ensure handicapped access to programs and services. Our silence on ADA matters should not be interpreted as approval for any policies, procedures, conditions, or practices which may violate the ADA and its implementing regulations.

RECOMMENDATIONS:

We have enclosed our expert reports. Those reports contain numerous recommendations on how to improve facility operations. Because the reports are highly detailed, we have only listed the major recommendations below. State authorities must make the following improvements to assure inmates of minimally adequate conditions of confinement.

I. Mental health care.

A. Establish and implement policies and procedures which will ensure adequate medication protocols, treatment plans, quality assurance, program notes, and any other areas outlined by national organizations such as the National Commission on Correctional Health Care. The scope of deficiencies suggests that the state needs to thoroughly review and revamp its existing mental health care system to ensure adequate care. The state can select from a variety of models, and should employ outside consultants to assist in implementing a mental health program.

B. Provide inmates with severe mental illnesses timely access to services available at acute psychiatric care facilities. Inmates who do not need psychiatric hospitalization, but are unable to function adequately within general population housing units because of their mental illnesses, must have timely access to services available at an intermediate care unit.

C. Immediately review all medication policies, procedures, and practices and bring them up to professional standards. Adequate documentation and justification must exist for any polypharmacy. Lithium and other potentially dangerous drugs

should not be prescribed without adequate laboratory testing and monitoring of drug levels and drug effects.

D. All mentally ill inmates should be carefully screened, identified, diagnosed, evaluated, treated, and monitored by qualified professional staff. Medical records should include initial evaluations, progress notes, treatment plans, test results, and other essential records. The mental health staff must provide follow-up and long term mental health care as well as crisis intervention.

E. Renovate the mental health unit to make it suicide-safe and conducive to treatment of the mentally ill.

F. Hire sufficient mental health staff to provide adequate treatment of mentally ill inmates. To start, the psychiatrist's position must be filled and mental health unit nurses must have adequate mental health training.

G. Screen inmates for mental health needs at the initial reception process. Corrections staff should be trained in identifying inmates who may be mentally ill. The mental health staff should evaluate and treat any inmates who need mental health care in a timely manner.

H. Separately log all use of restraints.

II. Medical care.

A. Dental care.

Ensure that the actual dental program complies with dental policies. Implement a system of logs to identify and track inmate dental needs. Do not use inmates to provide dental care. Increase dental staffing to meet the population's dental needs. Renovate the dental office and ensure that equipment is well-maintained and up to date.

B. Sick call.

Medical triage should be conducted by qualified and adequately supervised staff. Have the Tutwiler physician write protocols for the medical triage operation. Conduct sick call during either the first or second shifts.

C. Pharmacy.

Permit nurses to give over-the-counter medications (OTC's) to inmates for simple complaints, and implement a procedure that would make OTC's available in the housing units. Under no condition should medication for one inmate be taken from another inmate's prescription. If medication does not arrive on time,

that fact should be specifically noted in the medication logs. Cease using pre-signed medication order sheets.

D. Laboratory tests and x-rays.

Provide on-site x-ray testing. All laboratory work must be reviewed by the physician and that review should be indicated on the laboratory reports before they are filed in the patient charts. The physician should discuss the results of laboratory tests with the inmates.

E. Reception process.

Establish a procedure so reception center inmates who need medication can get it in a timely fashion. Nurses must take a health history of the inmates in reception within three days of arrival, and the physician must perform physical exams within seven days.

F. Physician services.

Ensure that the physician examines patients, takes appropriate histories, makes diagnoses and assessments, devises management plans for inmate medical problems. Ensure that medical records contain all necessary documentation.

G. Chronic disease clinics.

Fully implement the chronic disease program and chronic care forms which were recommended by the clinical medical director.

H. Medical grievances.

Improve the existing quality control process to ensure more frequent and comprehensive review of medical care at Tutwiler.

I. Medical clinic and infirmary.

Provide the medical staff with sufficient, and adequately equipped, clinical space to examine patients in a private setting.

J. Communicable diseases.

Provide chest x-rays and any other needed tests in a timely fashion for inmates who may have communicable diseases. Ensure that tests for communicable diseases are read and that there is adequate continuity of care for all inmates with medical problems.

K. Facilities.

Continue upgrading physical facilities so that they are handicapped accessible.

III. Corrections

A. Provide inmates with a third meal on Saturdays and Sundays. Inmates should not go without food for more than fourteen hours. Meals should be nutritionally adequate for all inmates.

B. Replace the bunks in the mental health cells with suicide-resistant bunks which are not perforated.

C. Replace the existing window screens in the mental health cells with suicide-resistant, small aperture, screens.

D. Protect ventilation openings with fine screens or grills to prevent inmates from gaining access to the ventilation slats.

E. Ensure that at least some of the posts in the main prison complex are staffed by female officers at all times. Shift supervisors should make frequent rounds throughout the institution. Refer all allegations of staff misconduct to a neutral outside entity for investigation. Train staff to bring legitimate suspicions about possible staff misconduct to the prison administration.

F. Cease using the "rail", improper restraints, or corporal punishment. Inmates who refuse to work or otherwise misbehave should be punished only through normal disciplinary policies and procedure.

G. Renovate the facility's fixtures to make the facility as protrusion-free as possible, especially in the inmate housing areas and showers.

H. Remedy security deficiencies which seriously increase the probability of escape. Escape attempts create a risk of injury to inmates or other bystanders.

IV. Sanitation

A. Repair and maintain physical facilities and equipment, such as the roof, plumbing fixtures, electrical systems, the medical and housing units, medical equipment, kitchen equipment, washers, and other utilities. Qualified personnel with training in environmental health and safety should conduct periodic inspections of the physical plant, and qualified professional plumbers, electricians, and skilled tradesmen, should make all repairs.

B. Replace the existing kitchen with a sanitary facility or otherwise renovate it so that it complies with professional health standards. Train all kitchen staff and workers on safe food handling and food sanitation practices. Properly store, handle, and prepare all food.

C. Devise and implement a housekeeping plan. Train staff in environmental health and safety policies and procedures. Such training should cover the cleanup of blood and bodily fluids.

D. Ensure an adequate number of lavatories and showers for the inmates. Provide inmates with an adequate supply of toilet paper.

E. Cover all windows with institutional screens, and conduct periodic pest extermination.

F. Replace torn and damaged institutional mattresses with new ones.

V. Fire safety

A. Provide smoke detectors for all housing areas and areas which are not separated from inmate housing by 1-hour fire rated construction.

B. Ensure that the padlocked egress door at Dorm 9 can be unlocked and opened from either side.

C. Mark all keys required for emergency evacuation so they are readily identifiable by sight and touch. One consolidated set of emergency keys should be readily available to staff at all times.

D. Remove all "egg crate" mattresses as soon as they are no longer medically necessary. Carefully manage and monitor the distribution of such mattresses. Establish a "hot works" permit system, and ensure proper storage of oxygen, acetylene, and potentially explosive substances.

E. Conduct adequate fire safety training for all staff. Qualified personnel should conduct regular fire and emergency drills. Drills should be evaluated, and any identified deficiencies should be rectified. Fire and other safety inspections should be coordinated among responsible personnel.

F. Establish and implement a chemical safety program.

Pursuant to CRIPA, the Attorney General may initiate a lawsuit to correct deficiencies at an institution at least forty-nine days after appropriate local officials are notified of them. 42 U.S.C. § 1997b(a)(1). Therefore, we anticipate hearing from

you as soon as possible and certainly before that date with any response you may have to our findings and a description of the specific steps you will take or have already taken to implement each of the minimum remedies set forth above and in our consultant reports.

If you do not respond within the stated time period, we will consider initiating an action against your jurisdiction to remedy the unconstitutional conditions. We look forward to working with you and other state officials to resolve this matter in a reasonable and expeditious manner. Please note that during our second tour, Mr. Murray Gregg, with the State Board of Post-Secondary Education, requested a copy of this findings letter. While this is an unusual request and is not required by statute, we have agreed to send a courtesy copy to Mr. Gregg's attorney. If you or members of your staff have any questions, please feel free to contact attorneys Andrew Barrick at (202) 514-6249, Christopher Cheng at (202) 514-8892, or Shanetta Brown at (202) 514-0195.

Sincerely,

Deval L. Patrick
Assistant Attorney General
Civil Rights Division

Enclosures

cc: The Honorable Jeff Sessions
Attorney General
State of Alabama

David B. Byrne, Esquire

John R. Formby, Jr., Esquire

Ms. Shirley Lobmiller
Warden

Redding Pitt, Esquire
United States Attorney