



**U.S. Department of Justice**

**Civil Rights Division**

*Assistant Attorney General  
950 Pennsylvania Avenue, NW - RFK  
Washington, DC 20530*

January 15, 2009

Mr. Stephen Nodine  
President  
Mobile County Commission  
205 Government Street  
Mobile, AL 36644

Sam Cochran  
Sheriff  
Mobile County  
510 South Royal Street  
Mobile, AL 36601

Re: Mobile County Metro Jail

Dear Mr. Nodine and Sheriff Cochran:

We write to report the findings of the investigation of the Civil Rights Division into conditions at the Mobile County Metro Jail ("MCMJ"). On March 12, 2003, we notified officials of Mobile County ("County") and the Mobile County Sheriff's Office ("Sheriff") of our intent to conduct an investigation of MCMJ pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. § 1997. As we noted, CRIPA gives the Department of Justice authority to seek a remedy for a pattern or practice of conduct that violates the constitutional rights of inmates in adult detention and correctional facilities.

On May 27-30, 2003, and July 6-7, 2003, and again on September 22-25, 2003, we conducted on-site inspection tours with expert consultants in the fields of corrections, custodial medical and mental health care, and safety and sanitation. We interviewed administrative and security staff, medical and mental health care providers, and inmates. We reviewed an extensive number of documents, including policies and procedures, incident reports, grievances, medical records, and use of force records.

In keeping with our pledge of transparency and to provide technical assistance where appropriate, our expert consultants conveyed their preliminary impressions and concerns to the County and the Sheriff.

As you are aware, at the conclusion of our tours, the County and the Sheriff approached us to begin negotiating a means to correct the deficiencies present at MCMJ as identified by our expert consultants. Although we would not normally engage in negotiations prior to the issuance of our statutorily-required written findings, we found the desire of the County and the Sheriff to correct the deficiencies at MCMJ sincere enough to warrant our accommodation, and we immediately began negotiations while continuing our investigation and preparing our written findings. During these negotiations, we contacted the County and the Sheriff in 2006 to request cooperation in conducting a fourth tour of MCMJ to update and inform our factual findings. In continuing our pledge of transparency and to provide technical assistance, we also provided, at that time, copies of the written reports prepared by our consultants that identified deficiencies at MCMJ and recommendations on how to correct the identified deficiencies.

It was while negotiating mutually agreeable terms and conditions of our tour that the County and the Sheriff took the extraordinary and unexpected step of ceasing all communications with the Department of Justice regarding this investigation. Accordingly, and as we advised you after each of our attempts to reinstate communications throughout 2007, we were forced to continue our investigation absent your cooperation. Specifically, since that time, we have examined state and federal survey information, media reports, and other publicly available data, as well as conducted interviews of former inmates, family and friends of inmates, attorneys, advocates, and other persons familiar with present conditions at MCMJ. In addition, as warned, we considered the failure of the County and the Sheriff to cooperate with our investigation as an adverse factor when preparing our written findings.

Consistent with the statutory requirements of CRIPA, we now write to advise you of the findings of our investigation, the facts supporting them, and the minimum remedial steps that are necessary to address the deficiencies we have identified. 42 U.S.C. § 1997b. We conclude that certain conditions at MCMJ violate the constitutional rights of the inmates confined there. As detailed below, we find that MCMJ engages in a pattern or practice of subjecting inmates to egregious or flagrant conditions, specifically in regard to: (1) the medical care of

inmates; (2) the mental health care of inmates; (3) the use of restraints; (4) the right of inmates to be protected from physical harm from other inmates; and (5) the right of inmates to be confined in sanitary and safe conditions.

## I. BACKGROUND

The MCMJ is operated by the Sheriff of Mobile County. The Sheriff has appointed a Warden to be responsible for the day-to-day operations of MCMJ. The Sheriff employs approximately 230 corrections officers and a civilian support staff at MCMJ, as well as a medical staff which includes several nurses, a physician, and a part-time psychiatrist.

The MCMJ houses a mix of pretrial detainees and convicted prisoners ("inmates") and houses both male and female inmates. The MCMJ is comprised of two facilities - the main facility, known simply as "the Jail," and a minimum security annex, referred to as "the Barracks." The main facility ("Jail") at MCMJ was built in sections, with the first portion completed in the mid-1980s and the final sections completed in 1991. The Jail has a design capacity of 816 inmates. The Jail is constructed as a remote supervision facility, in which staff work in control areas observing inmates housed in ten semi-circular "pods." Eight pods house male inmates, and two pods house female inmates. The eight pods housing male inmates are subdivided into six eight-cell "wedges," designed to house 16 inmates in each wedge. The two pods housing female inmates are subdivided into two twelve-cell wedges. For male inmates, two wedges are designated for administrative segregation; two wedges are designated for protective custody; one wedge is designated for medical housing; and one wedge is designated for potentially suicidal inmates. The Jail also has a medical clinic and a booking area with holding cells for recent arrestees.

The MCMJ's minimum security annex ("the Barracks"), is located across the street from the Jail. The Barracks opened in September 2002, with a design capacity of 325 inmates. The Barracks contains eight dormitory-style housing units that resemble military barracks.

The population of the Jail steadily remained at approximately 1,000 inmates during 2007, while the Barracks averaged close to 300 inmates. Prior to 2007, the population in the Barracks had been significantly below design capacity. For example, at the time of our first tour in May 2003, there were only 113 inmates in the Barracks. By contrast, the Jail has frequently exceeded design capacity. For example, in the six

months prior to our first tour in May 2003, the average daily population for each month was over 1300 inmates for the Jail and Barracks combined.

## II. LEGAL STANDARDS

CRIPA authorizes the Attorney General to investigate and, when necessary, initiate civil action to obtain appropriate relief from egregious jail conditions that subject inmates to a pattern or practice of deprivation of their constitutionally protected rights. 42 U.S.C. § 1997. The Eighth Amendment affords convicted prisoners protection from cruel and unusual punishment. U.S. Const. amend. VIII. This protection is incorporated into the Due Process Clause of the Fourteenth Amendment and binding upon the states. Robinson v. California, 370 U.S. 660, 667 (1962). Moreover, the Due Process Clause of the Fourteenth Amendment affords at least the same Eighth Amendment protection from cruel and unusual punishment to an inmate of a jail incarcerated prior to trial, as it would to a convicted prisoner. City of Revere v. Massachusetts Gen. Hosp., 463 U.S. 239, 244 (1983). As defined by the Supreme Court, this constitutional protection from cruel and unusual punishment requires corrections officials to provide "humane conditions" of confinement to jail inmates. Farmer v. Brennan, 511 U.S. 825, 832 (1994).

When a jurisdiction takes a person into custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. County of Sacramento v. Lewis, 523 U.S. 833, 851 (1998) (citing DeShaney v. Winnebago County Dept. of Social Servs., 489 U.S. 189, 199-200 (1989)).

The duties imposed and rights conferred by the Eighth Amendment apply to the unreasonable risk of serious harm, even if such harm has not yet occurred:

We have great difficulty agreeing that prison authorities may not be deliberately indifferent to an inmate's current health problems but may ignore a condition of confinement that is sure or very likely to cause serious illness and needless suffering the next week or month or year . . . . That the Eighth Amendment protects against future harm to inmates is not a novel proposition. The Amendment, as we have said, requires that inmates be furnished with the basic human needs, one of which is reasonable safety.

Helling v. McKinney, 509 U.S. 25, 33 (1993) (internal citations and quotations omitted).

#### **A. Medical Care**

A corrections official's "deliberate indifference" to an inmate's serious medical needs is a violation of the Eighth Amendment. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Farrow v. West, 320 F.3d 1235, 1243-46 (11th Cir. 2003); Steele v. Shah, 87 F.3d 1266, 1269 (11th Cir. 1996). Corrections officials act with deliberate indifference when an inmate needs serious medical care and the officials fail to, or refuse to, obtain or provide that care. Farrow, 320 F.3d at 1246. Said another way, a corrections official will violate the protections of the Eighth Amendment when the official "knows of and disregards an excessive risk of inmate health." Farmer, 511 U.S. at 837. The corrections official must "both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." Id. Providing only cursory care is insufficient when the need for more serious treatment is obvious. McElligott v. Foley, 182 F.3d 1248, 1255 (11th Cir. 1999).

#### **B. Mental Health Care**

The constitutional requirement imposed on corrections officials to provide adequate medical care includes a duty to provide adequate mental health care. Farmer, 511 U.S. at 832; see also Campbell v. Sikes, 169 F.3d 1353, 1362 (11th Cir. 1999) ("proper medical care" in question consisted of mental health care provided by defendant corrections psychiatrist); Steele, 87 F.3d at 1269 (same). Delay in providing hospitalization to a prisoner in need of immediate psychiatric care may constitute deliberate indifference. See e.g., Gibson v. County of Washoe, Nev., 290 F.3d 1175, 1190-91 (9th Cir. 2002).

Furthermore, corrections officials have a constitutional obligation to act when there is a strong likelihood that an inmate will engage in self-injurious behavior, including suicide. Snow ex rel. Snow v. City of Citronelle, AL, 420 F.3d 1262, 1268-69 (11th Cir. 2005). In corrections suicide cases alleging constitutional violations, "the plaintiff must show that the jail official displayed 'deliberate indifference' to the prisoner's taking of his own life." Cook ex rel. Tessier v. Sheriff of Monroe County, 402 F.3d 1092, 1115 (11th Cir. 2005) (quoting Cagle v. Sutherland, 334 F.3d 980, 986 (11th Cir. 2003)). In order to establish 'deliberate indifference' in a corrections suicide case, the plaintiff must demonstrate: "(1) subjective

knowledge of a risk of serious harm; (2) disregard for that risk; (3) by conduct that is more than mere negligence." Cook, 402 F.3d at 1115 (quoting Cagle at 986).

### **C. Use of Restraints**

The Eighth Amendment protection from cruel and unusual punishment forbids the use of excessive physical force against inmates. Hudson v. McMillian, 503 U.S. 1, 5 (1992); Skrutch v. Thornton, 280 F.3d 1295, 1301 (11th Cir. 2002). The use of mechanical restraints is a type of physical force, and the initial decision to employ such restraints is evaluated under Eighth Amendment standards. See Williams v. Burton, 943 F.2d 1572, 1575 (11th Cir. 1991) (initial decision to place inmate into four-point restraints evaluated under Eighth Amendment use-of-excessive-force standards). The use of force by a corrections officer will violate the Constitution when it is not applied "in a good-faith effort to maintain or restore discipline," but instead is administered "maliciously and sadistically to cause harm." Hudson, 503 U.S. at 6-7; Campbell, 169 F.3d 1353, 1374 (11th Cir. 1999); Harris v. Chapman, 97 F.3d 499, 505 (11th Cir. 1996); Williams, 943 F.2d at 1575. Courts may examine a variety of factors in determining whether the force used was excessive, most commonly including: (1) the need for the application of force; (2) the relationship between the need for force and the amount of force applied; (3) the threat, if any, reasonably perceived by responsible corrections officers; and, (4) any efforts made to temper the severity of a forceful response. Hudson, 503 U.S. at 7-8; Campbell, 169 F.3d at 1375; Harris, 97 F.3d at 505; Williams, 943 F.2d at 1575. Additionally, courts will also factor into the analysis the extent of the inmate's injury at the hands of the corrections officers. Id.

Further, "once the necessity for the application of force ceases, any continued use of harmful force can be a violation of the Eighth and Fourteenth Amendments, and any abuse directed at the prisoner after he terminates his resistance to authority is an Eighth Amendment violation." Williams, 943 F.2d at 1576 (citing Ort v. White, 813 F.2d 318, 324 (11th Cir. 1987)). In addition to the Eighth Amendment standards applicable to the use of restraints, Fourteenth Amendment procedural due process considerations must be accounted for when the restraint is employed as punishment, defined as "a penalty administered after reflection and evaluation and intended to deter similar conduct in the future," distinct from restraints employed as immediately necessary "to bring an end to an ongoing violation." Id.

**D. Security, Supervision, and Protection From Harm**

The Supreme Court in Farmer made clear that inmates have a constitutional right to be protected from harm. Farmer, 511 U.S. at 832. Accordingly, corrections officials have a duty "to protect prisoners from violence at the hands of other prisoners." Farmer, 511 U.S. at 833 (internal quotation marks and citations omitted). Not every injury suffered by an inmate at the hands of another inmate, however, will constitute an Eighth Amendment violation. The inmate invoking the right must demonstrate that (1) he or she was "incarcerated under conditions posing a substantial risk of serious harm," and (2) that corrections officials were "deliberately indifferent" to the risk. Farmer, 511 U.S. at 834. A corrections official's failure to supervise inmates, particularly inmates known to be violent, may result in unconstitutional conditions of confinement where assaults between inmates occur due to the lack of supervision. Cottone v. Jenne, 326 F.3d 1352, 1360 (11th Cir. 2003).

**E. Safety and Sanitation**

The Eighth Amendment guarantees that prisoners will not be "deprive[d] . . . of the minimal civilized measure of life's necessities." Rhodes v. Chapman, 452 U.S. 337, 347 (1981). Accordingly, corrections officials are required to provide "reasonably adequate ventilation, sanitation, bedding, hygienic materials, and utilities (e.g., hot and cold water, light, heat, plumbing)." Chandler v. Baird, 926 F.2d 1057, 1065 (11th Cir. 1991) (citations omitted). Conditions will violate the Constitution when they pose an unreasonable risk of serious damage to an inmate's current or future health, and the risk is so grave that it offends contemporary standards of decency to expose anyone unwillingly to that risk. Helling v. McKinney, 509 U.S. 25, 33-35 (1993); Chandler v. Crosby, 379 F.3d 1278, 1289 (11th Cir. 2004).

**III. FINDINGS**

**A. Medical Care**

Our investigation revealed constitutional inadequacies in the level of care provided by MCMJ in responding to inmates' serious medical needs. In 2007, we shared with the County and the Sheriff the written findings and concerns of our expert medical consultant regarding the inadequate medical care at MCMJ. Information we have obtained since that time, however, strongly suggests that MCMJ has done little to correct the identified deficiencies.

Specifically, we found that MCMJ failed to provide adequate acute care, chronic care, treatment of infectious diseases, intake screening, and general access to medical care. As explained below, such deficiencies primarily result from inadequate staffing, lack of proper supervision, and the lack of adequate written medical policies and protocols.

#### 1. Acute Care

At the time of our tour in September 2003, MCMJ had failed to provide timely and appropriate responses to the acute medical needs of inmates. Three inmate deaths that occurred near that time exemplify these failures. Our expert medical consultant reviewed the medical circumstances surrounding the three inmate deaths and concluded that the lack of timely and appropriate response to the inmates' acute medical needs may have contributed to their deaths. For instance:

- In June 2002, an inmate complained of fever, shakes, and acute pain in her leg and foot. This inmate was not evaluated by a MCMJ physician. A licensed practical nurse examined her and found swelling, bruising, and sores. Generally accepted corrections medical practices call for a physician to evaluate any acute onset of leg pain to evaluate for blood clots or deep infection, which can pose a serious risk of harm. Instead, this inmate received an antibiotic and Motrin<sup>1</sup> by telephone order from the physician. Although MCMJ reports that this inmate was transported to the hospital at this time and then returned to MCMJ, there were no records of the hospital visit in the inmate's medical record. The next day, her leg was tender and warm, and she was so sick that she was incontinent of feces. She then went into cardiac arrest, MCMJ staff performed CPR, and she was transported to the hospital, where she died soon thereafter. This inmate's deep vein thrombosis was not timely recognized or treated.
- Another inmate upon arrival at MCMJ in December 2002 reported a history of high blood pressure and hepatitis C. The inmate was not evaluated or treated by a physician. Six days later, corrections staff took him to see the nurse because he was disoriented, shaking, and incoherent, which are signs of a

---

<sup>1</sup> "Motrin" is a brand name for the anti-inflammatory medication ibuprofen.



life-threatening emergency requiring immediate care. He did not receive immediate care, but instead the licensed practical nurse placed his name on the list to see a psychiatrist and sent him back to his unit. The next day corrections staff again took the inmate to the nurse after he was observed vomiting blood. He remained disoriented and had substantially elevated blood pressure. The nurse placed his name on the list to see the physician during regular sick call, six hours later. She left him alone for 90 minutes, and when she returned to the clinic she sent him to the hospital emergency room. The inmate died in the hospital. Timely medical treatment may have prevented this death.

- In August 2003, an inmate arrived at MCMJ with an acute trauma to his left eye and a paralysis of the right side of his face. He reportedly refused to see the physician, although his chart contained no signed refusal and no documentation of any attempt to convince him to agree to medical care. Even if the inmate refused medical care at intake, he should have been housed in the infirmary and observed. Instead, this inmate was placed in the general population. Five days later, when he requested medical care, his left eye was dilated, his speech slurred, and he was unable to walk. His condition had deteriorated to such an extent that he was sent to the hospital, where he was diagnosed with a heart valve infection – which could have caused his facial paralysis – congestive heart failure, and sepsis (infection of the blood). He died before he could receive surgery to replace his heart valve. If this inmate had received treatment several days earlier, his chance of survival would have been much higher.

Since our September 2003 tour, we have learned of at least six more in-custody deaths at MCMJ. In three of those cases, it is alleged that MCMJ's poor response to the inmates' serious acute medical needs contributed to the inmates' deaths.<sup>2</sup> We have requested the opportunity to examine the medical circumstances surrounding those deaths, but the County and the Sheriff have denied our request.

---

<sup>2</sup> We are equally concerned about the other three cases which are reportedly suicides, and discussed in section III.B.4 of this letter.

Furthermore, since our 2003 tour, we have learned of allegations regarding the MCMJ's inadequate treatment of serious injuries suffered by inmates while incarcerated at MCMJ. For example, in July 2005, an MCMJ inmate reportedly suffered serious spine and neck injuries after a fall during a work-shift. It is alleged that after waiting an hour to receive emergency medical treatment, the inmate was given aspirin to relieve his pain. Reportedly, no other treatment was provided, and no further medical appointments were scheduled, despite the inmate's request to see a physician. Allegedly, after several weeks, the inmate's condition worsened as he began to lose weight, become frail and non-ambulatory. By the time the inmate eventually saw a physician in a hospital, it is reported that his injuries had already begun to heal improperly and the inmate suffered permanent damage to his spine and neck.

We found that MCMJ's problems in providing acute medical care were caused or exacerbated by inadequate protocols, supervision, and training. The protocols for nurses did not provide adequate guidance regarding treatment of inmates who exhibited common acute symptoms. In addition, nurses did not receive training in taking medical history or in conducting physical assessments. Thus, the nurses had no guidance on when it was appropriate to seek a higher level of care from a physician.

## 2. Chronic Care

Generally accepted corrections medical practices require inmates with chronic conditions to receive ongoing, coordinated care and monitoring to prevent or minimize the progression of their diseases. After completing our 2003 tour, we concluded that MCMJ failed to identify and treat adequately inmates with chronic conditions such as asthma, diabetes, hypertension and HIV. The MCMJ did not separately track inmates with chronic diseases as required by generally accepted corrections medical practices. We therefore had to review medication administration records to attempt to identify inmates with chronic conditions. We found the number of inmates being treated for diabetes, hypertension, and asthma to be one-third of what is expected for jails in the United States.<sup>3</sup> This finding indicates that MCMJ was likely failing to identify inmates with chronic diseases,

---

<sup>3</sup> National Commission on Correctional Health Care, Health Status of Soon-to-Be-Released Inmates, [http://www.ncchc.org/pubs/pubs\\_stbr.html](http://www.ncchc.org/pubs/pubs_stbr.html) (last visited September 2, 2008).

which probably stemmed from an inadequate screening and assessment process discussed in further detail in section III.A.4 of this letter.

Chronic conditions are progressive, and require proper monitoring and treatment to prevent conditions associated with end-stage organ failure, such as blindness, heart disease, kidney failure, and lung disease. For example, generally accepted corrections medical practices require that asthmatic inmates receive peak flow monitoring to measure the volume of air flowing out of the lungs, which can reveal narrowing of the airways well in advance of an asthma attack. This monitoring should be done on a quarterly basis, or more frequently if the inmate is short of breath. However, at the time our tour, MCMJ did not conduct peak flow monitoring unless inmates provided their own peak flow meters.

Similarly, diabetic inmates did not receive simple laboratory tests of their insulin levels to monitor their status. As the example below illustrates, we found the monitoring of inmates with chronic conditions at MCMJ to be deficient.

- In August 2003, an inmate with diabetes reported a sudden onset of blurry vision, which indicates potential acute retinal disease that can lead to blindness without prompt evaluation and treatment. This inmate did not receive an adequate eye examination and had not been referred to an ophthalmologist at the time of our third tour, over one month later.

Several recent allegations regarding diabetic inmates suggest that the chronic care deficiencies present at MCMJ at the time our tour remain. For example, in 2005, an inmate who was Type I diabetic alleged that she made repeated requests for insulin and glucose tests. Corrections officers reportedly assumed that the inmate was "detoxing" from a drug addiction and denied all of the inmate's requests for medical attention, despite the inmate's insistence that she was not a drug-addict. After several days without insulin, the inmate's condition allegedly worsened to a life-threatening level. Reportedly, the medical staff at MCMJ transferred her to a local hospital and the inmate spent the next six days in the hospital, the first four days of which she remained in the intensive care unit.

Moreover, at the time our tour, MCMJ did not stock the basic medications necessary to treat chronic diseases such as asthma, diabetes, hypertension, major depression, and schizophrenia. As a result, inmates with chronic diseases routinely waited three to

five days from prescription to the administration of the first dose of medication. Such a period of time is unacceptably long in light of the severity of the issues. Other inmates with

chronic diseases waited longer to receive their medications, and some never received prescribed medications at all. For example:

- During one of our tours in 2003, an inmate was exhibiting severe respiratory compromise from acute and chronic asthma. Although she had been prescribed prednisone, a steroid that would reduce the inflammation in her lungs and allow her to breathe, she had not received the medication. Without prednisone, she was at risk of developing respiratory failure.

### 3. Infectious Diseases

We found that MCMJ did not adequately identify or treat infectious disease. Failure to adequately identify and treat infectious disease places inmates, staff, and the community at unnecessary risk of serious health problems. Our review of MCMJ records indicated MCMJ ordered purified protein derivative ("PPD") skin tests, which test for tuberculosis, for only about half of the inmates, and documented test results for less than 10 percent of inmates. Similarly, we found syphilis screening results in less than 10 percent of inmate records. Both PPD tests and syphilis screening are required by MCMJ policy and by generally accepted corrections medical practices. Furthermore, MCMJ has inadequate policies in place to recognize and prevent the transmission of blood-borne (e.g., HIV and viral hepatitis) and air-borne (e.g., tuberculosis) pathogens. For example, the policies failed to address post-exposure protocols for blood exposures, maintenance of respiratory isolation, and vaccination against Hepatitis B.

During our September 2003 tour, we concluded that MCMJ failed to treat properly inmates with tuberculosis. For example:

- We identified at least three inmates who were receiving a particular antitubercular medication - Rifampin - alone, a medication that should never be used without other antitubercular medications. Using Rifampin alone can result in the development of drug resistance, which not only threatens the health of the inmate, but also poses a serious public health danger.

- An inmate who had HIV was clearly receiving Rifampin in error. His prescription was written for Rifabutin, a medication used in late stage HIV; instead, he received Rifampin.
- The MCMJ also apparently failed properly to isolate inmates with potentially contagious tuberculosis. An inmate with suspected tuberculosis was housed in a reported negative pressure room, which is designed to contain contagious tuberculosis. Consistent with generally accepted corrections medical practices, such rooms must be tested monthly to ensure proper functioning. However, the room did not appear to be in operation and the health services administrator was not aware if the room had ever been tested. Such a failure places staff and other inmates in the infirmary at risk of tuberculosis infection.

Furthermore, our expert corrections medical consultant identified a widespread skin infection, which had not been identified by MCMJ medical staff. Numerous inmates exhibited large boils on various parts of their bodies that they contracted well after reception into MCMJ, and these inmates faced long delays in treatment. The MCMJ had not conducted cultures which likely would have assisted in identifying the outbreak, and MCMJ had not contacted local health officials to provide notice of the contagious infection or to receive assistance or guidance. The skin infection was likely *Staphylococcus aureus*, a bacteria that can cause septicemia (blood infection), myocarditis (heart valve infection), infections of the tissues surrounding the brain, and death.<sup>4</sup>

#### 4. Intake and Initial Assessment

When we evaluated MCMJ's intake process and initial medical assessments in 2003, we found that MCMJ failed to identify inmates with serious medical needs and thus put inmates at an unreasonable risk of harm. At MCMJ, corrections officers

---

<sup>4</sup> We note that at the Sheriff's request, we have provided technical assistance to MCMJ regarding the skin infections. We understand that MCMJ was working with the Mobile County Department of Health to address this outbreak. The MCMJ reports taking several measures to address this outbreak, including purchasing new laundry machines and cleaning inmate-occupied areas. The MCMJ did not, however, provide the Department of Justice information regarding the final status of the outbreak.

conducted intake screening as each inmate was received. However, the officers received no training concerning health screening, and many serious medical issues were ignored at intake. For example, the Jail Receiving Screening Form utilized by corrections officers failed to collect the following basic information: all current illnesses, past serious infectious disease, recent symptoms of infectious diseases, past mental illness, legal or illegal drug use, and specific drug withdrawal symptoms.

The MCMJ policy required a nurse to perform a supplemental medical history within 72 hours of each inmate's intake. For more than half of the current and recently-released inmates whose files we reviewed, MCMJ failed to comply with this policy, even for inmates with very serious medical needs. The health services coordinator confirmed that the medical clinic was not adequately staffed to review each inmate within 72 hours, and estimated that 30 to 35 percent of inmates are not seen within 72 hours of admission. Even if MCMJ complied with its own policy, 72 hours is too long a delay for an assessment of inmates with acute or chronic medical needs, continuity of medication requirements, or infectious diseases. Generally accepted corrections medical practices require that inmates with acute or chronic medical conditions be seen by a nurse within four hours of intake for evaluation and referral to a physician, if necessary.

Moreover, the 72-hour supplemental nursing assessment at MCMJ was inadequate to identify inmates' serious medical needs, as the assessment consisted of nothing more than recording basic vital signs. For example:

- An inmate incarcerated in August 2003 with diabetes did not have a documented blood sugar test on intake, which placed this inmate at risk of ketoacidosis, a potentially fatal complication of diabetes.

Although MCMJ policy was consistent with generally accepted corrections medical practices by requiring a complete health assessment to be conducted within 14 days of an inmate's arrival, we noted unreasonable delays in conducting these assessments and a lack of appropriate referrals. For example, during our September 2003 tour, an inmate reported that he was incontinent of urine, but was not referred to a physician for diagnosis and treatment.

In addition, MMCJ did not properly identify and treat serious drug and alcohol intoxication and withdrawal symptoms,

placing inmates at risk of potentially life-threatening symptoms such as seizures and delirium. For example:

- In May 2003, MCMJ did not identify, evaluate, or treat an inmate at intake who was at risk of experiencing benzodiazepine withdrawal.<sup>5</sup> The inmate subsequently made at least seven requests for medical evaluation due to her withdrawal symptoms, but received no treatment for her potentially serious drug withdrawal.
- Another inmate, who was in restraints, apparently was suffering from alcohol withdrawal and had purple extremities, was sweating profusely, and was "jerking badly." A note in the inmate's medical file quotes the nurse as responding, "That's part of DTs and there isn't nothing we can do." Delirium tremens, a physical and mental disturbance caused by withdrawal from alcohol use after prolonged drinking - sometimes called the "DTs" - can cause serious hallucinations and potentially life-threatening seizures. By generally accepted corrections medical practices, this inmate should have received Librium, a medication helps prevent the symptoms of delirium tremens from worsening, as well as fluids, and close monitoring of his vital signs.

We have since learned that in February 2008, a MCMJ inmate died of an apparent drug overdose. The inmate was reportedly found unconscious in his cell on the same day he was arrested on drug possession charges. The MCMJ allegedly transported the inmate to the hospital where he was pronounced dead, and preliminary tests reportedly indicated the presence of drugs in his system. This recent death suggests that the problems we identified in 2003 have not been resolved, despite the fact that we provided the County and the Sheriff our expert medical consultant's written report in 2007.

##### 5. General Access to Medical Care

At the time of our tour, MCMJ's sick call process failed to provide adequate access to medical care. The MCMJ inmates

---

<sup>5</sup> Benzodiazepine is a medication that depresses the central nervous system and is used, for example, to treat certain seizure disorders and anxiety. Withdrawal from benzodiazepine can result in potentially life-threatening symptoms such as seizures and delirium if not appropriately treated.

accessed medical services by completing sick call requests.<sup>6</sup> Inmates reported making multiple requests before receiving medical care. Our review of medical files confirmed that many inmates made between two and six requests for treatment of serious medical needs before receiving care, such as the inmate in benzodiazepine withdrawal discussed above in section III.A.4. Other examples include:

- Medical staff failed to respond to three requests for care from an inmate with vaginal discharge. Failing to evaluate this inmate put her at risk of serious infection, and created a potential public health risk, as such symptoms are consistent with a venereal disease.
- In August 2003, an inmate complained he was incontinent of urine, which may be caused by an infection or a serious, but treatable, neurologic problem. There was no indication in his file that he was referred to a physician for treatment.

Additionally, at the time of our tour, MCMJ charged a \$10.00 co-payment for each visit to a licensed practical nurse. The MCMJ policy also required that indigent inmates be provided free medical care and MCMJ appeared to be implementing this policy. Nevertheless, while this policy does not violate inmates' constitutional rights, we are concerned that numerous inmates told us that requests for medical care by indigent inmates are ignored. Apparently this alleged practice of ignoring the medical requests of indigent inmates is so pervasive as to result in indigent inmates not requesting medical care for serious medical needs. We flag this finding because, although not a constitutional violation, the perception that indigent inmates will not be provided medical care is a barrier to accessing such care.

---

<sup>6</sup> Inmates submitted sick call requests to corrections staff, who delivered them to the medical unit. Allowing corrections staff to serve as gatekeepers for medical services potentially compromises timely access to medical care. We understand that the MCMJ has recently installed lock boxes for inmates to file grievances and we encourage a similar system for sick call requests.



6. Staffing

The above-noted deficiencies in acute care, chronic care, intake services, and identification and treatment of infectious diseases were likely caused or aggravated by inadequate medical staffing. At the time of our tour, MCMJ provided its 1,000 to 1,300 inmates with only 20 hours per week of physician staffing for their primary medical care needs. This is grossly insufficient to meet the acute and chronic needs of this large population, and health care provided to inmates was compromised by this significant shortage.<sup>7</sup> In addition, the nursing staff was inadequately supervised, which led to the deficiencies noted above in acute care, intake assessment, sick call, and medication errors.

**B. Mental Health Care**

Our investigation revealed that mental health services at MCMJ were grossly inadequate to meet the serious mental health needs of inmates. At the conclusion of our tours in 2003, our expert corrections mental health consultant identified specific concerns in MCMJ's delivery of mental health care. In 2007, we provided the County and the Sheriff with a written report prepared by our expert corrections mental health consultant outlining the mental health care deficiencies at MCMJ. Despite our several requests to revisit the facility and evaluate MCMJ's progress on improving the mental health care provided to its inmates, neither the County nor the Sheriff have provided us with access or any documentation to suggest that the deficiencies we identified in 2003 and 2007 have been addressed or corrected. In fact, three MCMJ inmate suicides that have occurred since 2003 strongly suggest the problems present at the time of our tour remain unresolved.

Specifically, we identified problems and deficiencies in intake screening; access to mental health care; assessment, management and treatment of mental illnesses; and suicide prevention. As explained below, such deficiencies result in part from inadequate mental health care staffing and the lack of a mental health care program, as well as inadequate policies and procedures.

---

<sup>7</sup> In the opinion of our expert corrections medical consultant, a facility of MCMJ's size requires a minimum of 60 hours per week of physician staffing to provide adequate medical care.

1. Intake and Initial Assessment

Failure to identify and respond appropriately to inmates' serious mental health needs can lead to significant medical deterioration, and in some cases can even lead to death by suicide. We found that MCMJ's intake process failed to identify adequately inmates with serious mental health needs.

Intake screening should be used to identify inmates with histories of mental health treatment, major mental illness, and suicide potential, as well as inmates who need psychiatric medications. As discussed above in section III.A.4 of this letter, corrections officers conducted initial intake screening on incoming inmates by filling out Jail Receiving Screening Forms. The officers received no training on mental health screening. In addition, the screening forms themselves did not require officers to gather adequate mental health information; for example, the forms lack screening questions regarding major mental illness or developmental disability.

The MCMJ also failed to record consistently or respond adequately to the mental health information in the screening form. The forms were often incomplete, completely blank, lacking pertinent information such as current medications, or contained no information about an inmate's mental health status or history. Other forms contained pertinent mental health information, but medical records indicated there was no, or significantly delayed, follow-up by MCMJ staff. For instance:

- The intake screening of one inmate in May 2003 revealed that he had possible suicidal ideation, yet some four months after his intake, there was no documentation that he was ever referred for, or received, an evaluation by MCMJ mental health care staff.
- Although an inmate in August 2003 was identified as potentially suicidal at intake, the inmate did not see the psychiatrist until 10 days later.
- One inmate's custody screening in July 2003 revealed a history of past mental problems, including a history of treatment with Zyprexa, an antipsychotic. Nevertheless, she was not seen by the psychiatrist for two months, by which time her condition had worsened to the point that she had become psychotic.

As will be discussed further below, we noted similar failures to identify or respond to inmates taking psychotropic medications. Such failures delay the continuity of medications and create a serious risk of harm for inmates with psychosis and mood disorders. Left untreated due to interrupted or discontinued medications, such inmates may harm themselves or others.

The first step in providing inmates with proper mental health care is identifying and diagnosing inmates with serious mental health needs. At the time of our tour, however, MCMJ significantly under-diagnosed serious mental illnesses. Without proper diagnoses, mentally ill inmates risk receiving inadequate or inappropriate medication and treatment, or no medication or treatment at all. This can lead to psychiatric decompensation, that is, the inmate's psychiatric symptoms can worsen and lead to depression, psychosis, or other acute problems. Such inmates are often subject to heightened victimization or to violent outbursts which can impact jail staff and other inmates.

As with inmates with chronic illnesses, MCMJ should, but did not, keep lists of inmates with mental health needs. Accordingly, we had to examine medication administration records to attempt to identify inmates with psychiatric needs. At the time of our tour, national studies indicated that approximately 16 percent of male inmates and 23 percent of female inmates can be expected to have a mental illness.<sup>8</sup> At MCMJ, however, only six percent of male inmates were being treated with psychotropic medications, which is about one-third of the number of male

---

<sup>8</sup> Paul M. Ditton, Bureau of Justice Statistics, Mental Health Treatment of Inmates and Probationers (1999), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (last visited September 2, 2008) (This study defined a "mentally ill" inmate as any inmate that "reported a current mental or emotional condition, or . . . reported an overnight stay in a mental hospital or treatment program."). We note that recent national studies illustrate a dramatic increase in population of jail inmates with mental health care needs. For example, Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf> (last visited September 2, 2008) reports that 75 percent of female jail inmates, and 63 percent of male jail inmates, have a mental health problem. This study defined an inmate with a "mental health problem" as any inmate that had "a recent history or symptoms of a mental health problem" within the prior 12 months.

inmates with mental illness typically found in jails in the United States. Seventeen percent of female inmates were on such medications, about two-thirds of the number of female inmates with mental illness typically found in jails in the United States. These findings indicate that many inmates in need of mental health care, particularly male inmates, likely were not identified and as a consequence did not receive necessary mental health treatment. Indeed, the problem of under-diagnosing mentally ill inmates at MCMJ is likely worse than we estimate, as our examination of the medication administration records to identify mentally ill inmates consequently excludes those mentally ill inmates who are not being treated with psychotropic medications.

This observation was corroborated by reviewing individual inmate records, which indicated widespread under-diagnosis of mental illness. For example:

- One inmate's intake screening in June 2003 did not indicate any mental illness. Although he was placed in administrative segregation for suicidal ideation the day after being taken into custody, his 72-hour nursing assessment also did not indicate any mental illnesses and he did not see the psychiatrist until after he submitted a request over two weeks later. The psychiatrist concluded the inmate had a bipolar disorder and prescribed the antipsychotic medication Zyprexa.
- Another inmate's intake assessment in June 2003 did not note any mental health care concerns, but a nursing assessment twenty days later revealed that the inmate had a history of treatment with the psychotropic medications Prozac and Ritalin. The intake assessment failed to identify this inmate's mental health care needs, and thus delayed any mental health treatment the inmate may have required.

## 2. Access to Mental Health Care

In September 2003, we found that MCMJ did not provide adequate access to mental health care. Inmates typically made numerous requests to see the psychiatrist, and were faced with significant delays in response to their requests. Our review of records indicated that the delays ranged from weeks to many months, even for inmates with very serious mental health needs. We also noted many instances where follow-up care ordered by MCMJ mental health staff did not occur. For example:

- An inmate with a documented diagnosis of Schizoaffective Disorder<sup>9</sup> and a history of treatment with four antipsychotic medications made five written requests in July 2003, to see the psychiatrist before she was seen, five weeks after her arrival at MCMJ.
- In July 2003, a nurse made a referral for an inmate to see the psychiatrist due to depression. Almost two months later, he still had not seen the psychiatrist and had become suicidal. It still took an additional three weeks for the inmate to receive an initial psychiatric evaluation.
- In April 2003, a nurse referred an inmate for a psychiatric consult as a result of the inmate's fearfulness, hyperactivity, and sleeplessness, but this inmate was not seen by the psychiatrist until three weeks after the nurse's referral. These delays are far too long, and are a substantial departure from generally accepted corrections mental health practices, especially when inmates are experiencing acute mental health symptoms. Without adequate access to mental health care, serious mental health needs may go undiagnosed and mentally ill inmates who present a risk of harm to themselves and others may be left untreated.

All of the information we have collected since our review of the records strongly suggests that this problem continues. Appropriate, timely mental health treatment is critical to regulate the symptoms of mental illness and to minimize psychiatric decompensation.

### 3. Assessment, Diagnosis, and Treatment

Our investigation revealed that when MCMJ identified and responded to inmates with serious mental health needs, it failed to provide adequate treatment. All aspects of the mental health care delivery system were inadequate, including assessment and diagnosis, treatment planning, and pharmacological interventions. These problems, as will be discussed below, were exacerbated by

---

<sup>9</sup> Schizoaffective Disorder is a condition in which a person meets the criteria for both schizophrenia and a mood disorder. Such a person may experience psychosis such as hallucinations or delusions commonly associated with schizophrenia, while concurrently experiencing symptoms of depression.

inadequate psychiatric staffing. In addition, MCMJ did not provide non-psychiatric mental health care services, such as group therapy or other services provided by social workers, counselors, or other mental health care workers.<sup>10</sup> Providing these types of services are in accordance with generally accepted corrections mental health practices.

Additionally, many psychiatric progress notes lacked diagnoses, which are essential to determining the appropriate treatment for an inmate's mental health needs. For example:

- In May 2003, one inmate was treated with several psychotropic medications but did not have a specific psychiatric diagnosis.
- Another inmate who entered MCMJ in April 2003, had significant periods of self-injurious behavior, including head-banging and swallowing glass, but never received any psychiatric diagnosis. Nonetheless, he was treated with increasing doses of antipsychotic medications.
- Still another inmate was treated with antipsychotic medications, although he had no history of treatment for mental illness or other clear indications of the need for antipsychotic medication. Antipsychotic medications have a number of potentially serious side-effects, including tardive dyskinesia.<sup>11</sup> Failing to appropriately diagnose inmates with mental health needs, but treating them with psychotropic medications, is grossly inappropriate and unnecessarily places inmates at risk of harm.

Moreover, MCMJ frequently prescribed Elavil, an antidepressant medication, to address inmates' sleeping difficulties. Elavil has significant and potentially serious side effects, and can be lethal in overdose. Elavil therefore should not be used for sleep disturbances without appropriate evaluation or medical assessment.

---

<sup>10</sup> Reportedly, MCMJ has hired a psychiatric nurse who accompanies the psychiatrist to MCMJ for six hours a week.

<sup>11</sup> "Tardive dyskinesia" is a potentially irreversible movement disorder characterized by repetitive involuntary movements.

Inmates also experienced serious delays in receiving psychiatric medication. For example:

- One inmate in June 2003 waited 23 days after intake, including five days after seeing the psychiatrist, before receiving two psychotherapeutic drugs, Remeron and Buspar.
- Another inmate went at least three weeks without treatment with the psychotropic medications that she had been taking when she arrived at MCMJ, and had no documented psychiatric evaluation.

Delays in the continuity of psychiatric medications pose a serious risk for mentally ill inmates, and may cause the inmate to experience psychotic decompensation or cause the inmate to harm himself or others.

We further identified inmates who received no treatment for their psychiatric needs. For instance:

- One inmate's initial assessment, which occurred three weeks after his arrival in March 2003, revealed a history of treatment with the antipsychotic medications Zyprexa and Thorazine during a recent prior incarceration at the MCMJ. Despite this recent history, five months later, when we examined his medical chart, he had not been evaluated by the psychiatrist or received psychotropic medication.
- Another inmate in July 2003 requested a psychiatric evaluation to continue his treatment for depression. At the time of our examination of this inmate's medical chart, almost three months later, the inmate had not been seen by a psychiatrist and had received no psychiatric treatment.

#### 4. Suicide Prevention

At the time of our tour, MCMJ failed to provide adequate assessment, monitoring, and housing of suicidal inmates. Suicide is a form of mental illness constituting a serious medical need for which MCMJ must provide adequate treatment. We have learned that at least three MCMJ inmates committed suicide since our September 2003 tour. According to a recent public statement by the MCMJ Warden in the Mobile-Register, "about six inmates a year

attempt suicide, and about one a year is successful."<sup>12</sup> One suicide a year is approximately twice the national average for facility the size of MCMJ.<sup>13</sup> Thus, it would appear that MCMJ has not resolved its very serious suicide prevention problem.

All three of the recent suicides were reportedly hangings, two of which allegedly occurred with bedsheets. Two of the three suicides occurred within three months of each other. The most recent suicide was committed by a male inmate who at the time of his arrest at his home, according to police, doused himself with gasoline and threatened to set himself afire in front of his wife and children. Despite this conduct at the time of his arrest, it does not appear that the inmate was put on suicide watch at MCMJ until four days after intake. More troubling still, the inmate was reportedly removed from suicide watch by medical staff prior to his death.

As noted above, we observed unreasonable delays in providing mental health care to suicidal inmates in MCMJ. In addition, MCMJ did not assess properly the severity of an inmate's suicide risk and did not provide treatment specific to the inmate's risk of suicide. Instead, suicidal inmates were frequently asked to sign behavioral contracts promising not to harm themselves. These contracts were simply forms that state that the inmate "promise[s] not to harm myself while incarcerated at the Mobile County Jail." After an inmate signed a contract, the inmate was usually placed in the general population without any suicide precautions. These contracts are not an adequate method of preventing suicide or self-harm and appear to provide a false sense of security for staff, and an excuse not to monitor regularly inmates who sign the contracts.

Additionally, we found that MCMJ improperly monitored suicidal inmates. We specifically brought this urgent matter to the attention of MCMJ during our tour. Suicidal inmates who refuse to sign behavior contracts are housed in the medical unit or in the "suicide wedge." Although we note that corrections staff performed adequate 15-minute checks of inmates in the

---

<sup>12</sup> Dan Murtaugh, Jail to Revamp Suicide Cells, Mobile-Register, May 30, 2007, at B1.

<sup>13</sup> Bureau of Justice Statistics, Deaths in Custody Statistical Tables: Local Jail Deaths 2000-2005, <http://www.ojp.usdoj.gov/bjs/dcrp/tables/jailstab3.htm> (last visited September 8, 2008) (average annual suicide rate for 2000 - 2005 is 45 per 100,000 local jail inmates).



suicide wedge, the physical attributes of the cells in the suicide wedge presented dangers to inmates. The cells had solid metal doors and thus their interiors, as well as inmates in the cells, were not directly visible to corrections staff. The cells had not been modified to remove sharp edges or other items that could be used for self-harm. Many cells had writing on the walls, indicating that suicidal inmates had access to writing utensils that could be used for self-harm. In addition, inmates in the suicide wedge did not receive regular and periodic evaluations by mental health staff. Some inmates who had been placed on suicide watch were never seen by a psychiatrist.

The MCMJ relied on an inmate "buddy system" to monitor suicidal inmates housed in both the medical area and in the suicide wedge as a supplement to the monitoring by corrections staff. These inmates sat with and monitored suicidal inmates. While this is an acceptable procedure, MCMJ must provide adequate monitoring, training, and select inmates who can be relied upon to perform this service. We found that MCMJ provided little or no training to these inmate workers and some showed little motivation or interest in performing their duties.

#### 5. Policies and Procedures

The failures of MCMJ's mental health services were caused in part by MCMJ's lack of adequate policies and procedures, as well as its failure to implement some policies and procedures that appear to be adequate. A number of MCMJ policies and procedures did not address fundamental components of the topic they cover. For example, the policy regarding suicide prevention did not include instructions on how to assess suicide risk. Similarly, the policy on the use of forced psychotropic medications was silent on basic tenets of the use of forced psychotropics, such as duration of use and monitoring of the inmate. Other MCMJ policies on mental health appear adequate, yet in practice the policies were ignored. For example, the policy on chemically dependent inmates required MCMJ to refer these inmates to an outside treatment center. The actual practice revealed that numerous chemically dependent inmates were not referred for treatment; in fact, chemically dependent inmates were not properly identified, and many received no treatment from MCMJ, which is a substantial departure from generally accepted corrections mental health practices.

## 6. Staffing

The absence of sufficiently qualified mental health staff at MCMJ contributed significantly to the inadequacy of mental health care. At the time of our tour in September 2003, the MCMJ psychiatrist was required by contract to provide on-site services six hours per week. Six hours a week is grossly inadequate and insufficient to address the mental health care needs of MCMJ's inmate population, which ranges from 1,000 to 1,300 inmates. As stated above in section III.B.1, national studies suggest that approximately 16 percent of male inmates and 23 percent of female inmates can be expected to have a mental illness.<sup>14</sup> Further, despite having a psychiatrist under contract, our review indicated that there were weeks, and sometimes months, with no psychiatric coverage at all. The inadequate psychiatry schedule also directly contributed to the failure to provide inmates with timely psychiatric medications.

The lack of adequate psychiatric staff caused MCMJ to rely on improperly trained staff to identify and address inmates' psychiatric needs. For example, MCMJ used untrained corrections officers to conduct intake screening, which contributed to the failure to identify initially inmates with psychiatric problems. This problem was compounded by MCMJ's reliance on licensed practical nurses who lacked psychiatric training, which contributed to the failure to identify inmates in need of immediate psychiatric care. Such care is crucial in preventing psychiatric decompensation and potential harm to self or others.

---

<sup>14</sup> Paul M. Ditton, Bureau of Justice Statistics, Mental Health Treatment of Inmates and Probationers (1999), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhtip.pdf> (last visited September 2, 2008). This study defined a "mentally ill" inmate as any inmate that "reported a current mental or emotional condition, or . . . reported an overnight stay in a mental hospital or treatment program."). Again, we note that recent national studies illustrate a dramatic increase in population of jail inmates with mental health care needs. For example, Doris J. James and Lauren E. Glaze, Bureau of Justice Statistics, Mental Health Problems of Prison and Jail Inmates (2006), <http://www.ojp.usdoj.gov/bjs/pub/pdf/mhppji.pdf> (last visited September 2, 2008) reports that 75 percent of female jail inmates, and 63 percent of male jail inmates, have a mental health problem. This study defined an inmate with a "mental health problem" as any inmate that had "a recent history or symptoms of a mental health problem" within the prior 12 months.

### C. Use of Restraints

We found that MCMJ's use of four- and five-point restraints,<sup>15</sup> raised significant concerns. In appropriate circumstances, the proper use of such restraints is an effective tool to prevent inmates from harming themselves or others. However, we concluded that MCMJ's monitoring of restrained individuals to be constitutionally deficient, and found serious concerns regarding MCMJ's decisions to apply such restraints. We shared these concerns with the County and the Sheriff in 2003 and in 2007.

#### 1. Monitoring of Restrained Individuals

Restraining inmates, although necessary at times, is a dangerous activity for both inmates and staff because of the force that may be necessary to restrain the inmate. Restrained inmates must be monitored appropriately. The dangers of inadequate monitoring were evidenced by the July 2000 death of a restrained MCMJ inmate from complications caused by necrotizing fasciitis, commonly referred to as "flesh-eating bacteria." According to the Mobile County Special Grand Jury Report regarding this incident, during the 14 days this inmate was at MCMJ, he was stripped naked, handcuffed, and shackled almost continuously. The inmate was reportedly restrained because he clogged the toilet with his clothes, causing it to overflow, and also spread excrement on himself and the cell. Typically, the limbs of a person infected with necrotizing fasciitis will swell and may develop a purplish rash within three to four days of infection. Within four to five days, an infected person will experience critical symptoms, during which the body will go into toxic shock and the person may lose consciousness. Thus it appears that either checks were not performed or, if they were performed, no action was taken. Although this incident occurred several years ago, it informs our review of the MCMJ's current policies and practices regarding the use of restraints. Indeed, the Special Grand Jury Report concluded that "a massive systemic failure in the administration of the Mobile County Metro Jail resulted in" this inmate's death.

Although MCMJ revised its policies following this incident, at the time of our tour, MCMJ policies regarding checks of

---

<sup>15</sup> Using four-point restraints means the inmate is placed in a prone position and his or her arms and legs are secured. Five-point restraints also includes restraining the inmate's head.

restrained inmates' welfare ("welfare checks") were inadequate. The revised policies required welfare checks every 15 to 30 minutes, but only required a check of the restrained inmate's extremities for visible injuries. Although some inmates were restrained in the medical clinic, MCMJ did not require checks of vital signs, range of motion, neurological condition, or other physiological checks of the restrained inmate's condition, which are required by generally accepted corrections practices. The limited evaluation required by MCMJ is a substantial deviation from generally accepted corrections practices and unreasonably places inmates at risk of harm. For example, an inmate in restraints who appeared to have delirium tremens - a physical and mental disturbance caused by withdrawal from alcohol use after prolonged drinking - apparently received no treatment for this condition and did not have his vital signs monitored. In addition, restrained inmates may go into respiratory distress, which may be interpreted as agitation or resistance and would not be revealed by a simple check of the inmate's extremities for visible injuries.

The paucity of documentation regarding welfare checks of restrained inmates at MCMJ raised serious concerns that these checks were not performed or were not performed with sufficient frequency to protect inmates from harm. Documenting the basis and duration of the use of restraints and the condition of the restrained inmate is generally accepted corrections practice. However, the only documentation of the basis for, and duration of, the use of restraints by MCMJ were brief notations on the Inmate Restraint Log. The MCMJ policy does not require documentation of welfare checks or the health condition of the restrained person, although we noted a few checks on the Inmate Restraint Log. For example, a welfare check for one restrained inmate was noted at 3:56 p.m., and there was a notation that the inmate was briefly released from restraints to eat at 5:10 p.m., then restrained again at 5:25 p.m. The log does not indicate any other welfare checks were performed, although generally accepted corrections practices require range of motion, neurological and vital signs checks every 15 minutes. In addition, in a number of instances the first notation that an inmate had been placed in restraints occurred when staff noted a welfare check.

The limited content of the welfare checks that were documented reinforces our concerns regarding the scope of the welfare checks performed by MCMJ. For example, most such notations simply indicated "checked," without further elaboration. This does not reflect an adequate evaluation of the physical condition of the restrained inmate and places inmates at risk of harm.

## 2. Application of Restraints

At the time of our 2003 tour, MCMJ policy provided that officers may use restraints as a "preventative measure" if the officer believed the inmate was a threat to himself or herself or to others. The MCMJ policy did not require supervisory approval for the use of restraints, although the Inmate Restraint Log did have a column to record the name of the supervisor who was notified of the use of restraints. There were numerous examples of the use of restraints for medical purposes, such as for potentially suicidal inmates. Although MCMJ policy required physician approval for the use of restraints for medical reasons, it did not require documentation of the physician's basis for approving the restraints. Thus, we were not able to evaluate whether physician approval was obtained or if the use of restraints was appropriate.

The notations on the Inmate Restraint Log provided only cursory descriptions of the basis for the use of restraints, such as "breaking sprinkler" or "suicidal." In addition, the log was frequently incomplete, and commonly failed to note the date and time that restraints were applied or were removed. In fact, upon our request for completed restraint logs for a one-year period, MCMJ could only provide completed Inmate Restraint Logs for ten non-consecutive days.

Even based on this extremely limited documentation, it was clear that MCMJ utilized restraints successively on the same individuals for extended periods of time, raising concerns regarding the need for the use of restraints. Indeed, our expert corrections consultants noted that the frequency of the use of restraints at MCMJ was atypically high for a jail of its size. Inappropriate use of restraints can be dangerous for both inmates and staff, and MCMJ's failure to document and review the use of restraints was inconsistent with generally accepted correctional practices and put inmates at risk of harm.

The prolonged and successive use of restraints is an improper practice and indicative of a failure to manage disruptive or mentally ill inmates. For example, a particular inmate at MCMJ was placed in five-point restraints in May 2003 for "breaking sprinkler head" at 11:30 p.m. and remained in restraints until 8:30 a.m. the following morning. The inmate was again placed in five-point restraints for "breaking sprinkler head" at 9:15 a.m. and was not released until 6:00 p.m. This inmate was placed in five-point restraints a third time for "breaking sprinkler head" at 6:39 p.m. and the date and time of his release from restraints was not noted. This cyclical use of

five-point restraints indicates that MCMJ failed to either identify and treat an inmate who possibly had serious mental health needs or, if he was not mentally ill, to manage appropriately this inmate's behavioral issues.<sup>16</sup>

**D. Security, Supervision, and Protection From Harm**

During our tours, we found that MCMJ failed to protect inmates from harm adequately. We noted a high, and increasing, level of inmate-on-inmate violence at MCMJ. For example, in 2003, MCMJ reported 89 fights in four months, an increase of 36 percent over the same period in the prior year. While this statistic alone does not evidence a pattern or practice of deliberate indifference to inmate-on-inmate violence, it is an example of the deficient security practices that subject MCMJ inmates to an unreasonable risk of harm. Our expert corrections consultant concluded that the increasing inmate-on-inmate assaults stem from a variety of deficient MCMJ practices.

Specifically, our review revealed that MCMJ failed to: take adequate measures to limit the introduction of contraband into the facilities; classify inmates appropriately based on their anticipated in-custody behavior; and supervise inmates adequately. Such failures significantly increases the risk of violence, placing both inmates and staff at risk of serious harm. The security, supervision, and protection from harm deficiencies at MCMJ were exacerbated by a lack of adequate policies, procedures, training, and staffing.

1. Control of Contraband

Inmates reported a significant problem with contraband, including illegal drugs, at MCMJ. Our review of MCMJ documents, such as Shakedown Forms, confirmed these reports. The shakedowns revealed inmates possessed various shanks, razors, bleach, and other contraband. For example:

---

<sup>16</sup> Furthermore, our review of MCMJ records did not indicate that this inmate's limbs were exercised during this period of time. Failure to attend to a restrained inmate's physical needs during such extensive periods of restraint, such as the range of motion of the inmate's arms and legs, can cause serious medical harm.

- A shakedown conducted in one wedge<sup>17</sup> in February 2002, revealed six razors/shanks, a maintenance screw tip, two metal ceiling pieces, and an ink pen for tattooing, along with other contraband items.
- Similarly, a shakedown of a pod<sup>18</sup> in April 2003, uncovered 13 containers of bleach, which could be used as a weapon.

We also noted some inadequate responses to the discovery of contraband. For example, in April 2002, when staff found an inmate smoking marijuana, the only action indicated in the file was the suspension of the inmate's commissary privileges for one week.

Despite the apparent presence of significant amounts of contraband, MCMJ conducted too few shakedowns. Indeed, although the Cell Condition Check List, last modified in 1999 at the time of our 2003 tour, contained a directive from the MCMJ Warden that shakedowns should be performed once per week, our review indicated they were performed significantly less frequently. One potential source of this problem is a lack of sufficient staffing. According to MCMJ policy, inmates are to be taken to the recreation yard during shakedowns of entire housing wedges, a procedure that requires intensive staffing. However, both MCMJ staff and records indicated that staffing shortages have largely prevented MCMJ from allowing inmates to use the recreation yard, and consequently resulted in fewer shakedowns.

## 2. Classification of Inmates

Adequate classification systems are a fundamental component of providing a reasonably safe environment in a corrections institution. The primary goal of a classification system is to predict in-custody behavior so that appropriate security measures can be utilized to minimize the risk of violence. Generally accepted corrections practices for classification systems utilize a variety of objective, behavior-based factors to determine the

---

<sup>17</sup> A wedge is designed to house 16 inmates. However, MCMJ routinely exceeds this number and therefore it is unclear the total number of inmates housed in this wedge at the time of the shakedown.

<sup>18</sup> Pods housing male inmates consist of six eight-cell wedges. Pods housing female inmates consist of two twelve-cell wedges.

appropriate level of custody. Typically, inmates are divided into high, medium, and low custody, and thereafter receive the appropriate level of freedom and staff supervision for that classification level.

In contrast to generally accepted corrections practices, MCMJ inmates were housed based almost exclusively on whether they have been convicted or whether they are charged with a felony or a misdemeanor. At the time of our tours, male inmates were separated into six groups,<sup>19</sup> and were still housed based primarily on their legal status, not on whether they were objectively dangerous. Female inmates were reportedly separated into two groups, misdemeanants and all others, but our review revealed that female inmates were housed according to available space.<sup>20</sup>

Although the MCMJ classification form collected various behavior-based information, this information was not utilized to classify inmates. Such practice unreasonably increases the risk of harm by failing to perform a meaningful evaluation of anticipated behavior, particularly violent behavior. The MCMJ failed to separate adequately predatory inmates from vulnerable inmates. For example:

- One inmate repeatedly stabbed another inmate in June 2002, with a pen while incarcerated at MCMJ causing multiple puncture wounds to the inmate's head, arms, and back and requiring treatment at a hospital emergency room. However, during a subsequent incarceration at MCMJ in August 2003, the assailant was housed in the protective custody wedge with MCMJ's most vulnerable inmates. This inmate was moved to

---

<sup>19</sup> Specifically: 1) inmates charged or convicted in the federal system; 2) inmates convicted of felonies in the state system; 3) inmates charged with "low" and "medium" felonies; 4) inmates charged with "high" felonies; 5) inmates charged with or convicted of misdemeanors; and 6) special management inmates (including sex offenders and disciplinary and protective segregation). We understand that since our tours, the U.S. Marshal's Service has clarified that MCMJ is not required to separate federal inmates from other inmates. However, this does not impact the lack of an adequate behavior-based classification system.

<sup>20</sup> Since our tours, MCMJ reports that it has begun housing some female inmates in the Barracks.



disciplinary segregation after altercations with another inmate and staff.

- In another incident in July 2003, an inmate was taken to the disciplinary wedge because he had just been involved in a fight with another inmate. However, he was not isolated, but was placed in a cell with an inmate. He assaulted this inmate almost immediately, and the assaulted inmate required hospital treatment for a cut above his eye.

While the factors considered in an objective classification system include whether the inmate has been convicted of the current offense and the nature of that offense, numerous other behavior-based factors also must be considered. As there are violent misdemeanor offenses<sup>21</sup> and misdemeanor arrestees and offenders who have known predatory histories, as well as the fact that there are many non-violent felonies, basing custody levels solely on an inmate's legal status does not adequately predict in-custody behavior. A meaningful classification system is even more important in crowded facilities like MCMJ. For example, our expert corrections consultant noted that it is safer for staff and inmates for MCMJ to increase the population density of low or medium custody inmates, rather than high custody inmates. An appropriate classification system would permit MCMJ to allocate scarce space and resources appropriately to provide a reasonably safe environment. Without such a classification system, inmates and staff at MCMJ face an unacceptably high risk of harm.

### 3. Supervision

We found that MCMJ failed to supervise inmates adequately. The MCMJ is a remote-supervision jail, in which staff observe inmates from a control area and are separated by glass walls from the inmates in the six wedges.<sup>22</sup> An officer assigned to the control area cannot leave the post, except in emergencies, and therefore floor officers are needed as additional security staff

---

<sup>21</sup> Some examples of violent misdemeanors include the following: assault in the third degree, Ala. Code § 13A-6-22 (2007); sexual abuse in the second degree, Ala. Code § 13A-6-67 (2007) (includes sexual contact with a person who is legally incapable of consent for reasons other than age); and reckless endangerment, Ala. Code § 13A-6-24 (2007).

<sup>22</sup> This is in contrast to direct-supervision jails, where staff are stationed in the housing unit.

to inspect the pods, perform shake-downs for contraband, and ensure inmates' safety.

The MCMJ policies required a welfare check of the inmate population every 30 minutes. However, such checks were only occasionally noted in the pod logs, which raised concerns that they were not being conducted. In addition, there were no guidelines for the conduct of such checks and no consistent documentation of what staff observed during such checks. Such inadequate supervision practices place both inmates and staff at risk. For example, in April 2002, three inmates were assaulted in their cell by two other inmates, with one of them suffering bruising to his neck, face, and arm and a split lip. Although the cells at MCMJ are in the line of sight of the pod officer's station, security staff did not notice the assault in the cell, and the assault was only brought to light when one of the assaulted inmates approached an officer.

The floor officers at MCMJ were required to inspect the condition of each pod once per shift. However, staff failed to identify many deficiencies during these inspections. For example, during one of our tours in 2003 we noted that several windows to the outside of the facility were cracked or had holes in them, and had apparently been broken for some time. This poses a significant security risk.

The MCMJ's security regarding escape prevention is also of concern. We have learned that in 2007, a 19-year-old female inmate at MCMJ allegedly attempted an escape, and reportedly was only discovered when she was badly cut trying to climb the razor fence surrounding the facility. It appears that MCMJ does not know how this inmate made her way outdoors to be in a position to charge the fence, or why she was not discovered until she had suffered an injury on the fence.

#### 4. Policies, Procedures, Training, and Staffing

The deficiencies we identified in security administration at MCMJ stemmed in large part from a lack of adequate policies, procedures, training, and staffing. The MCMJ policies did not adequately address the operation of the facility. For example, as noted above, the policies regarding facility inspections and inmate welfare checks did not establish standards for these evaluations and did not provide for a systematic mechanism to address deficiencies identified by staff, thereby greatly reducing their efficacy. Similarly, MCMJ policies did not provide for adequate documentation of significant events, such as

the use of force, the use of restraints, and facility inspections.<sup>23</sup>

In addition, although the corrections officer who was in charge of inmate discipline at the time of our tour in 2003 was striving to administer discipline fairly, the disciplinary procedures at MCMJ had significant problems. While these problems did not violate the Constitution, our expert corrections consultant noted that they significantly increased the tension in the facility and fostered inmate-on-inmate violence.

The MCMJ policy allowed for informal "sanctioning" of inmates, including locking-down inmates for up to 72 hours with no opportunity for the inmate to be heard or appeal the decision.<sup>24</sup> Our review indicated that the same type of violation would at times be referred for formal disciplinary proceedings, and other times the inmate would be sanctioned informally. While not a constitutional violation, we flag these practices because they give the perception that discipline is imposed arbitrarily, which increases the risk of inmate-on-inmate violence.

We observed that MCMJ staff did not receive adequate training. At the time of one of our tours, a number of the corrections officers hired in the last few years did not receive pre-service training. In addition, until recently, MCMJ staff were not receiving any in-service training.<sup>25</sup> Thus, a number of officers only received training through the Field Training Officer ("FTO") program, where officers are paired with an experienced officer for two weeks. In addition, we identified significant deficiencies with the FTO program. The MCMJ did not have written procedures governing the selection of FTOs, to ensure that FTOs are exemplary officers and demonstrate an interest, knowledge, and ability to train new officers in MCMJ

---

<sup>23</sup> The MCMJ reports that, following our tours, it developed an unusual occurrence form and an use-of-force form, which are centrally filed and reviewed. We have been unable to verify this information.

<sup>24</sup> The MCMJ reported that, following our tours, it had modified the sanction process. Reportedly, MCMJ no longer conducts informal discipline unless the inmate signs a written waiver of the hearing. We have been unable to verify this claim.

<sup>25</sup> We understand the MCMJ has since offered some in-service training and plans to offer pre-service and additional in-service training.

policies and procedures. The FTO program also did not describe the knowledge, skills, and abilities that trainees must demonstrate and simply listed the topics to be covered, such as "Cell Inspections" and "Sick Call/Sick Slip." Similarly, MCMJ did not document the performance of the trainees in these topics and FTOs simply noted the date the topic was covered with the trainee.

Other corrections officers did receive pre-service training, but the curricula we reviewed indicated the training provided was inadequate. The MCMJ training materials revealed that not nearly enough training was devoted to critical jail functions. For example, the training on the use of restraints and transporting prisoners was last revised in 1991, and did not adequately address the procedures for applying restraints. Moreover, the training was apparently a lecture format, with no practical component.

Staff reported, and our review corroborated, that MCMJ did not have adequate numbers of corrections staff. The MCMJ corrections staff worked a large amount of overtime. For example, it spent \$1.5 million on overtime for corrections staff in 2002. Yet the Jail still lacked sufficient staff to operate the facility. The staff vacancy rate in 2003 was reportedly 28 percent. The heavy use of overtime also raised concerns about officer fatigue, which can increase the risk of harm to inmates and staff.

The MCMJ also provided inadequate access to exercise, which is a significant mechanism corrections facilities use to decrease inmate aggression. The MCMJ had no indoor exercise facilities and, by its own admission, made limited use of its outdoor exercise yard. The MCMJ did provide some very limited outdoor recreation, and so did not violate the Constitution, but the very limited recreational opportunities raised tensions and thereby fostered inmate-on-inmate violence. Appropriately structured and supervised exercise provides an important outlet for inmate aggression, and thus, is an important inmate management tool. Furthermore, regularly scheduled exercise provides a privilege that staff can take away from an inmate for sustained rule violations. However, MCMJ's outdoor yard was utilized on only 45 days in 2002. Although MCMJ apparently has improved access somewhat since that time, it was still significantly limited at the time of our tour.

**E. Safety and Sanitation**

Although conditions at the Barracks were significantly better than at the Jail at the time of our tour in 2003, safety and sanitation conditions at both the Jail and the Barracks posed a significant risk of disease and injury to inmates and staff. We identified deficiencies in the areas of insect and rodent control, physical plant, fire safety, and general sanitation and safety. Similar to the security administration deficiencies discussed above, the safety and sanitation failures were exacerbated by the crowded conditions at the Jail. In 2007, we provided the County and the Sheriff a written report prepared by our expert corrections safety and sanitation consultant outlining our concerns.

1. Insect and Rodent Infestation

We found that there was a significant insect and rodent infestation at the Jail. We observed rodent droppings and a live rat in the kitchen during the height of lunch preparation. Insects and rodents in the kitchen area can spread food-borne illnesses, such as by carrying salmonella bacteria.<sup>26</sup> We also saw ants and unidentified black bugs throughout the Jail. Insects can spread disease and, given the general sanitation problems, insect bites can become infected. As discussed in section III.A.3, we noted an outbreak of a skin infection at MCMJ.

2. Physical Plant

Following our tours in 2003, MCMJ took a number of steps to reduce the inmate population and reported that, as of December 3, 2003, the inmate census had been reduced to 1,006 inmates; 817 in the Jail, and 189 in the Barracks. Unfortunately, this trend did not continue, and the Jail presently remains dangerously overcrowded. Since the start of our investigation, we have received many allegations of inmates being forced to sleep on the floor of their cells due to overcrowded conditions; some inmates sleeping just inches from toilets and sinks, including an inmate that was allegedly non-ambulatory.

At the time of our tour, there were a number of plumbing problems at the Jail, although we did not identify such problems

---

<sup>26</sup> We understand that following our tours, MCMJ has instituted periodic pest control visits covering the entire facility. We have been unable to verify this assertion.

at the Barracks. We observed inoperable showers and toilets throughout the Jail facility. For example, we observed numerous leaking toilets, including in cells with inmates sleeping on the floor near the leaks. In addition, we measured hot water temperatures above 120 degrees, which create a scalding threat to both inmates and staff. For example, the shower water temperature in one of the female units measured 130 degrees, which can cause burns in less than 30 seconds. These water temperatures allow inmates to harm themselves, accidentally or intentionally, and provide a weapon for inmates who want to harm others.

### 3. Fire Safety

We identified several deficiencies in MCMJ fire suppression and evacuation systems and procedures. For example, there were no sprinkler heads over the ovens in the kitchen or behind the dryers in the Jail, two places where fires are likely to originate.<sup>27</sup> We also identified deficiencies in evacuation systems and practices. For example, one fire door took over two minutes to open and another could not be opened by staff. Additionally, MCMJ has inadequate procedures to evacuate the facilities in the event of an emergency. We also noted several exit lights that were not working, impeding evacuation in the event of a fire.

### 4. General Sanitation and Safety

Many of the showers contained mildew and mold. Moreover, the laundry facilities do not adequately sanitize the clothing, which increases the risk of transmitting infectious diseases, such as skin infections.<sup>28</sup> In addition, the sink in the laundry room did not have a vacuum breaker to prevent back-flow from contaminating the potable water system.

Chemical safety was also inadequate at MCMJ. For example, we observed a container in the medical clinic marked "bleach"

---

<sup>27</sup> We note that MCMJ retained a new sprinkler-maintenance contractor shortly before our first tour, who was reportedly working to correct these problems. The MCMJ reported that, following our tours, it has worked with the Fire Marshal to identify and correct fire safety problems and conducted fire safety training.

<sup>28</sup> We understand that since our tours, MCMJ has acquired new washing machines.

that actually contained an ammonia-based chemical. Such mislabeling poses a significant risk of harm to inmates and staff because it may lead to accidental mixing of chlorine and ammonia-based chemicals, which releases highly toxic chlorine gas. In addition, inmate workers in the laundry were using corrosive chemicals without protective equipment such as goggles to prevent injury.<sup>29</sup>

#### **IV. RECOMMENDED REMEDIAL MEASURES**

In order to address the constitutional deficiencies identified above and protect the constitutional rights of inmates, MCMJ should implement, at a minimum, the following measures:

##### **A. Medical Care**

1. Revise intake procedures and the Jail Receiving Screening form to screen incoming inmates adequately. Ensure that a qualified medical professional reviews all screening on a timely basis.
2. Develop and implement a policy to ensure that a qualified medical professional completes a timely health appraisal of each inmate.
3. Develop and implement chronic disease policies and procedures that adequately identify inmates with chronic diseases and ensure adequate and timely monitoring of, and follow-up care for, inmates with chronic diseases.
4. Develop and implement adequate policies and procedures regarding the identification and treatment of contagious diseases such as tuberculosis and syphilis.
5. Develop and implement procedures to assure timely and appropriate access to medical care through sick call.
6. Develop and implement protocols specifying the appropriate response[s] to common acute symptoms.
7. Develop and implement policies and procedures that ensure timely and appropriate delivery of prescription medications.

---

<sup>29</sup> The MCMJ reports that, following our tours, it has taken various measures to address chemical safety issues.

8. Continue working with the Department of Health to prevent, diagnose, and treat the outbreak of skin infections. Develop and implement policies and procedures to address the likely causes of the outbreak and to treat infections.
9. Provide sufficient staffing to ensure that inmates' serious medical needs are met.

**B. Mental Health Care**

1. Revise intake procedures and forms to screen adequately incoming inmates for mental health issues. Ensure that a qualified mental health professional reviews all screening on a timely basis.
2. Ensure that staff conducting intake screening are trained adequately.
3. Develop and implement procedures to ensure inmates with mental health needs receive timely assessment by a qualified mental health professional.
4. Develop and implement policies and procedures to ensure timely and adequate responses to inmate requests for mental health care.
5. Ensure adequate on-site psychiatry coverage, and ensure adequate on-site supervision of mental health staff.
6. Develop and implement policies and procedures that ensure adequate monitoring and follow-up treatment of inmates with mental illness.
7. Develop and implement adequate suicide screening policies and procedures.
8. Ensure that inmates receive psychotropic medications in a timely manner and that inmates have proper diagnoses for each psychotropic medication they receive.

**C. Use of Restraints**

1. Develop and implement a policy regarding the application of restraints that requires immediate prior written approval, if practicable, of the use of restraints for medical purposes by a qualified medical professional or immediate prior written supervisory approval, if practicable, for uses of restraints for security purposes, other than the use of



routine restraints for transporting inmates, such as handcuffing.

2. Develop and implement a policy regarding monitoring restrained inmates that requires adequate checks of the physical condition of restrained inmates, and adequate documentation of the use of restraints, including the basis for and duration of the use of restraints and the performance and results of welfare checks on restrained inmates.

**D. Security, Supervision, and Protection From Harm**

1. Develop and implement an objective, behavior-based classification system that separates inmates in housing units by classification levels.
2. Develop and implement written procedures for conducting and documenting security inspections and inmate welfare checks, including specific criteria for such evaluations and a systematic procedure for correcting any deficiencies identified.
3. Provide adequate corrections officer staffing and supervision to ensure inmate safety.
4. Develop and implement appropriate training for corrections staff addressing security administration and providing for proficiency testing.
5. Develop and implement policies governing the conduct of shakedowns that increase the frequency and identify the scope of shakedowns in order to minimize inmates' access to dangerous contraband.
6. Develop and implement policies requiring adequate documentation and investigation of significant events, including use of force by staff and instances of inmate-on-inmate assault.

**E. Safety and Sanitation**

1. Ensure regular and periodic cleaning and maintenance of all housing areas, including toilets and showers. Ensure regular and periodic insect and rodent control measures are performed.

2. Ensure proper operation of all fire detection and suppression systems. Develop and implement adequate evacuation procedures, including emergency door inspections.
3. Adjust the hot water in all housing areas to safe temperatures.
4. Develop and implement proper chemical safety measures.

#### **V. CONCLUSION**

We note again in conclusion the extraordinary and unexpected step taken by the County and Sheriff to cease all communications with the Department of Justice regarding this investigation, and the negative inferences we drew regarding the present status of the conditions at MCMJ in light of this action. Nevertheless, we once again invite the County and Sheriff to discuss with us the remedial recommendations we presented in this letter, with the goal of remedying the identified constitutional violations without resort to litigation.

In the event we are unable to reach a resolution regarding the above identified constitutional violations, we are obligated to advise you that the Attorney General is authorized to initiate a lawsuit pursuant to CRIPA, 49 days after receipt of this letter, to correct identified deficiencies or otherwise protect the rights of the inmates incarcerated at MCMJ. 42 U.S.C. § 1997b(a)(1). If you have any questions regarding this letter, please contact Shanetta Y. Cutlar, Chief of the Civil Rights Division's Special Litigation Section, at (202) 514-0195.

Sincerely,

*/s/ Grace Chung Becker*

Grace Chung Becker  
Acting Assistant Attorney General

cc: Lawrence M. Wettermark, Esq.  
Attorney for the Mobile County Commission

James B. Rossler, Esq.  
Attorney for the Mobile County Sheriff's Department

Michael W. Haley  
Warden  
Mobile County Metro Jail

Deborah J. Rhodes  
United States Attorney  
Southern District of Alabama