Expert Report of Eldon Vail

Dunn, et. al. v. Dunn, et. al.
The District Court of the United States
Middle District of Alabama
2:14-cv-601-MHT-TFM

Submitted: July 5, 2016

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Assignment ....

ASSIGNMENT[1]

consistent with the methodology employed by other experts in the field of corrections.

My work on this matter is ongoing. This report summarizes my current opinions given the available information I have reviewed to date. It is my understanding that a number of relevant documents requested by Plaintiffs' counsel have yet to be produced or were produced after the discovery cut-off date. If additional information is produced, I reserve the right to modify or supplement my analyses and opinions accordingly.

SUMMARY OF OPINIONS

It is my opinion that conditions within ADOC, as well as its operational practices, interplay to cause a direct harmful impact and risk of harm on the provision of medical and mental healthcare for prisoners currently housed in the ADOC.

First, the severe overcrowding in Alabama prisons results in living conditions that increase both the potential for violence and the need for prisoners to access healthcare. Every ADOC prison I inspected was dramatically underbuilt in physical plant capacity to safely house the number of prisoners in the living unit areas, including the toilet facilities. This is amplified by ADOC's routine practice of housing close-custody inmates in

open dormitories that are unsuitable for the safe housing of high-risk inmates.[3]

Second, the systemic and pervasive lack of authorized custody staffing prevents ADOC from ensuring prisoners are able to access necessary care. This problem is made worse by an astonishing vacancy rate of correctional officers to fill the ADOC's authorized correctional officer positions. The result is a very dangerous prison environment for the inmates, as well as an inability of custody staff to successfully interact with and support the healthcare objectives of the department.

The increased need for care caused by violence and other health-related issues stemming from overcrowding, combined with the inability of ADOC, because of a dramatic lack of custody staff, to ensure prisoners are able to access care, results in a current, ongoing and significant risk of serious harm to ADOC inmates living in Alabama prisons. It is quite simply a system in a state of perpetual crisis—a fact known and yet unaddressed by

that work group were limited due to "lack of funding".[4] In fact, the crowding problem is much the same as it was a decade ago when the Task Force was created.

QUALIFICATIONS

I am a former correctional administrator with nearly 35 years of experience working in and administering adult institutions. Before becoming a corrections administrator, I held various line and supervisory level positions in a number of prisons and juvenile facilities in Washington, in addition to serving as a Juvenile Parole Officer and pre-release supervisor. I have served as the Superintendent (Warden) of three adult institutions, including facilities that housed maximum, medium and minimum-security inmates. As a Superintendent I directly supervised the healthcare administrator in my institutions.

I served for seven years as the Deputy Secretary for the Washington State Department of Corrections (WDOC), where I was responsible for the operation of prisons and community corrections. I briefly retired, but was asked by the former Governor of Washington, Chris Gregoire, to come out of retirement to serve as the Secretary of the Department of Corrections in the fall of 2007. I served as the Secretary for four years, until I retired in

[4] ADOC Fiscal Year 2009 Annual Report, page 20.

2011.

As a Superintendent, Assistant Director of Prisons, Assistant Deputy Secretary, Deputy Secretary and Secretary, I was responsible for the safe and secure operations of adult prisons in the State of Washington, a jurisdiction

and the other third had little or no correctional experience but did have undergraduate or Master's degrees in psychology or other social services majors. The leadership of the program was also a hybrid of correctional and mental health staff, as well as psychiatrists and psychologists. This allowed the program to blend the two disciplines to make the program safe as well as effective in providing treatment to the mentally ill who were housed there. We provided psycho-educational treatment. Along with treatment from the primary clinicians, inmates were offered classes in areas such as anger management, symptom recognition, and medication management. The living unit itself was used as an environment to practice the skills being learned by the mentally ill inmates away from the pressures they can experience in a general population prison. We expected staff and inmates alike to model pro-social behavior. The design proved effective. According to researchers from the UW, "[p]articipants were substantially less symptomatic when they left the program than when they entered . . . . there was a significant improvement in major infractions and use of expensive resract3

As Assistant Director for Prisons in Washington, my responsibilities included oversight of mental health programs for all prisons in the State of Washington. Part of this assignment was to oversee the design of a capital project that more than doubled the size of Washington's largest program for the mentally ill. Taking what I had learned from my experience on McNeil Island, my primary focus was to design a housing continuum for the mentally ill that did not rely on over-classifying individuals as maximum security, and instead moved them through less restrictive levels of prison housing. We developed a design that allowed inmates to move through progressive custody levels from maximum to minimum and to avoid segregation whenever possible.

During my tenure as the Deputy Secretary, we created a specialized high-security treatment unit for the mentally ill inmates, where the inmates could be safely housed without significant levels of isolation and also receive robust treatment from mental health professionals. This unit was separate and apart from regular segregation units.

As Deputy Secretary and later as Secretary, I focused on providing proper treatment for the mentally ill in prison on a system-wide basis. The pioneering work of the McNeil program and Washington's correctional

programs for inmates placed in isolation have been extensively studied and guided by researchers from the UW.[7]

Shortly after becoming the Secretary of the Washington State Department of Corrections, I chose an administrator from outside the field of

spending one day at each facility. In March of this year, I returned to Alabama and spent one day at Easterling on the 16th and one day at Kilby on the 18th.

complete list of the material I have reviewed is offered as Exhibit 2 to this report.

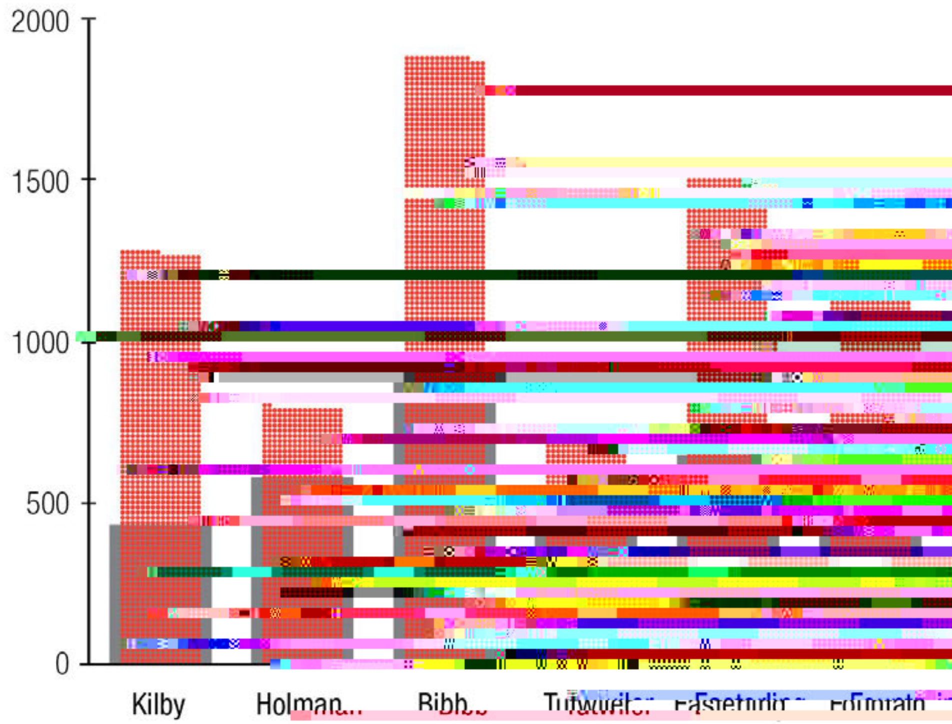
OPINIONS

The conditions and operational practices of ADOC have a direct harmful impact and risk of harm on the provision of medical and mental healthcare for prisoners within the custody of ADOC. Both overcrowding and inadequate staffing of correctional officers result in a violent, dangerous, and dangerously unhealthy prison environment in which ADOC custody

Population Figures March 2016

Capacity

Number of Inmates (one dot = one inmate)



SOURCE: ADOC MARCH 2016 MONTHLY STATISTICAL REPORT, FACILITY OPERATIONS

open-bay dorms designed for far fewer inmates. As a result, basic living space for each human being in their bunk areas is very restricted.

The following photo was taken at in the Kilby G/H dorm on the day of my inspection at that facility, March 18, 2016.

The issue of overcrowding is a known fact. State officials readily

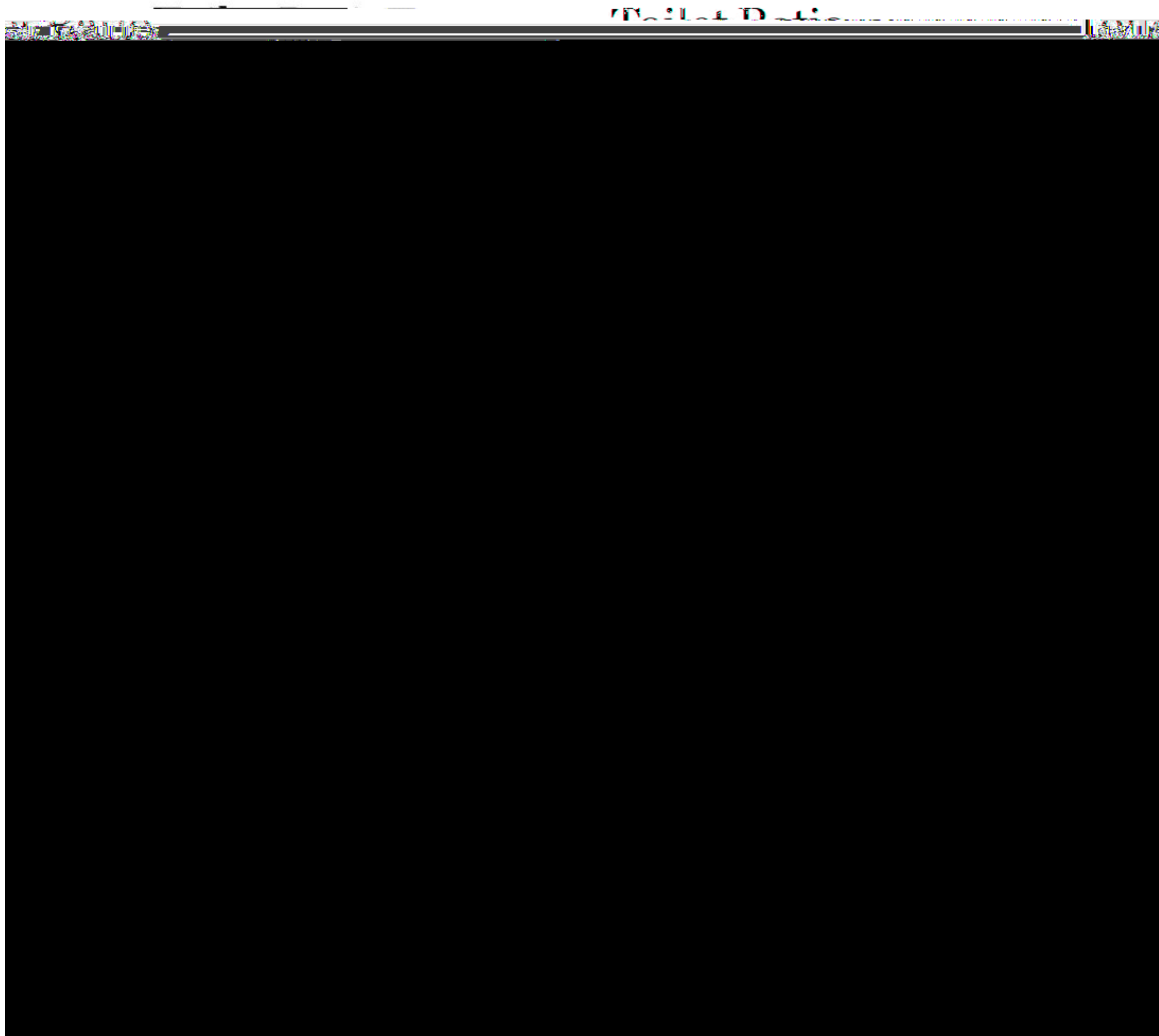
inmates, resulting in an occupancy rate of over 180%”.[11] Similarly, in a

prisons are inadequate to support the population required to use them. Second, there is not enough space to safely house close-custody inmates.

Inadequate Bathrooms

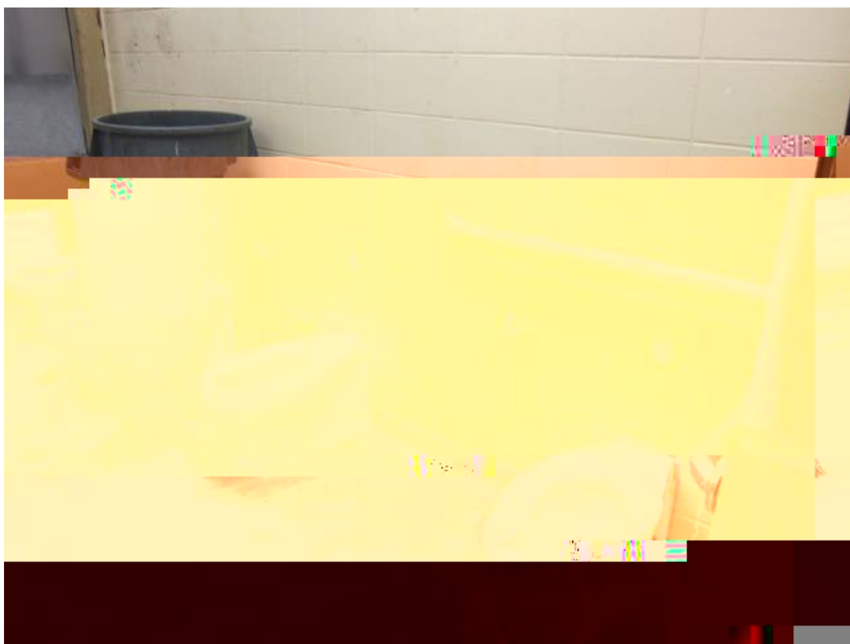
The bathrooms in ADOC prisons are inadequate to support the population required to use them. This likely produces competition for toilets, sinks and shower facilities, resulting in unnecessary tension in the ADOC population.

The American Correctional Association (ACA) established standards for the construction and operation of prisons and jails. Even if prison systems choose not to be accredited by ACA auditors, it is very common to look to the ACA for guidance dy Ai (T)4.003(h)-3.itoveovon tv tvishcti Aoar



Bibb: The Bibb dormitories house about 106 inmates. There are 4 toilets and 1 large urinal in each dormitory, for a ratio per inmate of about 1 to 21, even if all are functioning properly. The stress on this plumbing was

evident during my inspection. I noted 7 toilets that were broken or plugged, as well as 5 urinals that were leaking or otherwise not functional.



It is typical that facilities are cleaned before outside inspections occur. Inmates informed me that was the case at Bibb, which is where the photograph above was taken.

Holman: There were about 160 inmates in J Dorm the day I visited. There were 7 toilets and 6 urinals for a ratio of about 1 for each 16 inmates. In F dorm, which houses about 240 inmates, there were 16 toilets and 2 urinals, for a ratio of about 1 toilet for each 14 inmates.

Easterling: In the F-1 dorm at Easterling, which houses about 120 inmates, there were 5 toilets and 1 urinal, for a ratio of about 1 toilet for every 20 inmates. The situation was only slightly better in F-2 dorm. It has

the same bathroom set up as F-1 but only houses 110 inmates. C dorm also has the same bathroom set up but houses only about 90 inmates for a ratio of 1 toilet for every 15 inmates.

Kilby: In G dorm, there were 8 toilets and 1 urinal. I was told the dorm houses up to 199 inmates. That would be a ratio of 1 to 22. On the day of my inspections, I was told the dorm was holding 154 inmates, for a ratio

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Bibb: In A-1 dorm there were 9 showers for 106 inmates, for a ratio of 1 for 11 inmates. There were 5 sinks, for a ratio of 1 for every 21 inmates. Other dorms were basically the same.

Easterling: In dorms F-1 and F-2, which house 120 and 110 inmates respectively, there were 8 showers and 7 sinks, for ratios of 1 shower for every 15 inmates and 1 sink for every 17 inmates. Dorms C-1 and C-2 have the same shower and sink set up and house, respectively about 90 and 133 inmates. The shower ratio runs from about 1 for every 11 inmates in Dorm C-1 to 1 for every 16 inmates in Dorm C-2. The sink ratios were 1 to 17 in C-1 and 1 to 19 in C-2.

Kilby: In G dorm, which housed 154 inmates on the day of my inspection, there were 8 showers, for a ratio of 1 shower for every 19 inmates. H dorm housed 145 inmates and had the same shower set up for a ratio of 1 shower for every 8 inmates.

Like the toilets and the urinals, some of the showers and sinks were also broken and in disrepair, likely from overuse. Such extreme lack of

within the inmate population. Given that there are times of day, for example early in the morning or after inmates have been required to remain on their bunk during counts or unit inspections, when there is great competition for such facilities, it is predictable that weaker inmates will be last to access them and that the potential for violence is elevated as a result. These types of conflicts frequently result in prisoner-on-prisoner violence that leads to injuries and, again, increased need for medical care.

[illegible] Inadequate Space to [illegible]

too great. It is my opinion that the ADOC prison system is dramatically underbuilt to house close-custody inmates which contributes to the level of violence in their prisons and, in turn, an increased need for medical care. It is tough to control an angry inmate when there is no cell to put them in.

be impossible to view anything going on unless it was happening near the front of each dorm. As a matter of inspection routine I usually enter every unit and make my way through it. Going into one of these "hot" dorms at Fountain, I noticed most of my escorts hanging back. I believe I was the only one to make it to the back of the dorm. When I got there I found inmates lounging and openly smoking cigarettes, a practice against the rules in the dormitories of the ADOC. There was also evidence of inmates smoking in the bathroom of the unit. In my opinion this is a simple example that I happened upon of how much inmates are able to control the dormitories due to lack of frequent and regular officer supervision. Given that this was a "behavior" dorm where inmates had been placed for punishment after committing acts of misbehavior, and given the lack of direct supervision by correctional officers, I am sure this is not the only rule the inmates were ignoring.

In my experience the lack of true cells for close-custody inmates or inmates who regularly violate prison rules has an impact on the operation of medium-security facilities as well. Some inmates in medium-custody need

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stronger high-risk close-custody prisoners can prey on weaker close-custody prisoners. This can and does give rise to the power of prison gangs, as inmates seek protection from other inmates by affiliating with a gang. Gangs are no small problem in ADOC prisons, a fact universally acknowledged by both staff and inmates.

state officials. Such violence predictably results in increased demand for medical care. As discussed further in Section B below, ADOC's severe understaffing creates barriers to inmates accessing that necessary care.

In March of this year, there were violent incidents at two ADOC prisons. Following these incidents, U.S News & World Report reported, "Alabama Governor Robert Bentley says prison uprisings will occur in other facilities in the state if the problems of overcrowding and understaffing aren't addressed".[20] I agree with the Governor. Overcrowding makes prisons more violent and more dangerous for both the staff and for the inmates. In my own experience, the overall violence and risk of disturbance is elevated when facilities are overcrowded.

In 1992, shortly after I was appointed the Superintendent of the McNeil Island Corrections Center, one of the living units at the facility—a stand-alone minimum unit—was at 200% of capacity and was housing in excess of 400 inmates in a unit designed for fewer than 200. On a Friday night before Labor Day, violence broke out and gang fights between black and Hispanic inmates spiraled out of control into a full-scale riot, resulting in

[20] AP, *Alabama Gov. Robert Bentley says prison uprisings will occur in other facilities in the state if the problems of overcrowding and understaffing aren't addressed*, U.S. News & World Report, http://www.usnews.com/news/us/articles/2016-03-15/the-latest-alabama-governor-visits-troubled-prison (March 15, 2016).

the death by stabbing of one prisoner and several others being injured. Staff abandoned their posts for their own safety, and it wasn't until dawn of the following morning that, with the help of the Washington State Patrol and tactical teams responding from other institutions, we regained control of the facility. Shortly thereafter, the population of the stand-alone unit was reduced to its design capacity. We had no similar events until the day the unit closed two decades later. We determined in our review of the riot that the "flash-point" for the riot was competition for access to recreation facilities (the weight pile), a conflict typical of an overcrowded prison. Overcrowded prisons, even at the minimum-security level, are more likely to explode than prisons that do not exceed the number of prisoners they were designed to hold.

The link between overcrowding and rising levels of prison violence is widely recognized by researchers throughout the field.

Dr. Craig Haney,[21] a psychologist and professor at the University of California at Santa Cruz, has written extensively on the impacts of overcrowding in prisons. In 2006, he published an article entitled *The Wages of Overcrowding* that summarizes much of the then-current research

[21] Dr. Haney is an expert in this case. I have worked with him in

on overcrowded prisons.[22] Several examples from his paper inform the discussion about the severe overcrowding and the resultant danger to prisoners in Alabama's prisons. First, he notes:

> …[w]here crowded conditions are chronic rather than temporary…there is a clear association between restrictions on personal space and the occurrence of disciplinary violations.[23]

Second, he states:

> …overcrowding means that there is less for prisoners to do, fewer outlets to release the resulting tension, a decreased staff capacity to identify prisoner problems, and fewer ways to solve them when they do occur… [Therefore,] overcrowded conditions in which prisoners have a significant amount of idle time can contribute to a higher level of prison rapes.[24]

Similarly, a senior researcher for the Federal Bureau of Prisons reports that,

> The major findings on which most prison researchers agree are (1) that prisoners housed in large, open bay dormitories are more likely to visit clinics than are prisoners in other housing arrangements (single-bunked cells, double-bunked cells, small dormitories, large partitioned dormitories); (2) that prisons that contain dormitories have somewhat higher assault rates

> based on sixty square feet per inmate have high assault rates.[25]

Unfortunately, these are precisely the conditions that exist in the Alabama Department of Corrections. I note that the conditions described by the Bureau of Prisons researcher parallel the dominant living unit design in the Alabama prisons I inspected—they are large, open bay dormitories housing significantly more inmates than they were designed to hold. The result is significant levels of violence within the ADOC.

ADOC Incident Reports[26]

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[25] Gees, Gerald G., *The Effects of Overcrowding in Prison*, University of Chicago, 1985.

[26] It is my understanding that Defendants were to produce "Incident Reports. With respect to Request No. 135 to ADOC, relating to incident reports of violent behavior including both self-harm and violence toward others, the State will produce all incident reports from all major institutions from January 1, 2014 through August 31, 2015. The search for responsive

As part of my assessment, I reviewed six months of Incident Report Logs for St. Clair (from Nov. 15, 2014 to May 15, 2015).[27] These logs confirm the danger that inmates face in that facility. During that period of time, the reports indicate that inmates were involved in 46 fights and 74 assaults, and 24 weapons were discovered. In my experience as a corrections practitioner and studying prison systems for the last several years, staff in any correctional facility never discover all weapons or every fight or assault. This is especially true in a facilevDya a4

The Incident Report Logs from Holman (February 1, 2015 to July 31, 2015)[29] reflect that it too is a dangerous place. For this time period, Holman reports 66 fights and 74 assaults, again numbers that likely underestimate the amount of physical conflict experienced by inmates at that facility.

While Tutwiler, being a prison for women, had lower reports of violence in their Incident Report Logs (November 13, 2014 to May 13, 2015)[30] than the male facilities, there were more incidents of violence than I would have expected based on my experience. Tutwiler recorded 28 inmates involved in fights and 17 assaults. As a former Superintendent (Warden) of a women's prison in Washington, what I found most startling was 25 Use of Force (UOF) events recorded at Tutwiler during that period. Given that there were 29 reported at Fountain, 12 at Holman and only four at St. Clair, the number at Tutwiler was surprisingly high. While I suspect that Holman and St. Clair may well be underreporting, 24 UOF events at a women's prison in six months makes me concerned about the officer's training and commitment to de-escalate situations and avoid the use of force whenever possible. I am confident that I did not have 24 UOF events during the two and a half years I was Superintendent of the Washington Corrections

4. Higher Levels of Violence Give Rise to Increased Needs for Healthcare

As reported by the Federal Bureau of Prisons, "prisoners housed in large, open bay dormitories [like those in the ADOC] are more likely to visit clinics than are prisoners in other housing arrangements."[31]

The need for greater medical care is not surprising where there is severe overcrowding and an increased potential for violence. The link between higher levels of violence and the rising need for healthcare in the Alabama prisons concern me. The level of violence in ADOC prisons was also of concern to ADOC's contract medical provider Corizon. In an email from the company Vice President Larry Linton, he asks one of his staff for an analysis of "trauma related costs" in 2012 and 2013.[32] After some

detected or reported. The analysis that was completed for Mr. Linton confirms my concerns. His analyst says, "I think this [referring to a spreadsheet attached to the email] should help support your strong suspicion that trauma related costs are rising."[34] I would note that the analyst specifically mentions open wounds, fractures and dislocations. The spreadsheet attached to the email recounts 48 wounds and 53 fractures, further evidence of the dangers inmates confined in ADOC prisons experience.

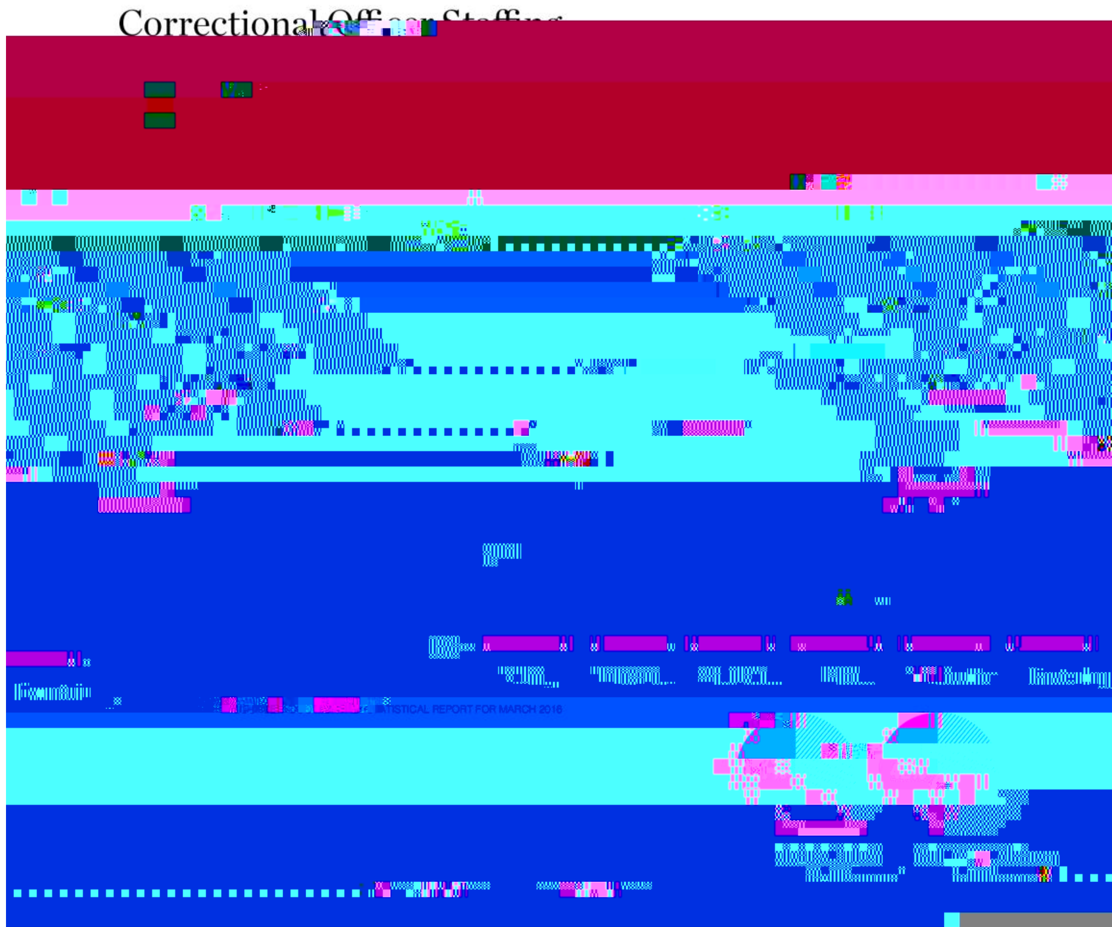
The spreadsheet attached to the email shows that overall emergency costs between 2012 and 2013 increased by 79%. Individual trips to the emergency room increased by 56% in that time frame, and the average cost of a trip to the emergency room increased by 14%, further evidence of the Corizon vice president's suspicion that trauma events were increasing the costs to his company. Certainly, avoidable increases in demand for medical attention that are occasioned by violence related to overcrowding divert resources from other types of care necessary within ADOC.

B. INADEQUATE STAFFING: Alabama prisons are severely understaffed, resulting in a dangerous environment for inmates as well as an inability of custody staff to successfully interact with and support the healthcare objectives of the ADOC.

[34] ADOC0249154.

employees[37] for 18,000 inmates and most of those positions were constantly full.

The level of custody staffing in the system is even more alarming than ADOC's overall staffing figures:



(Holman: 45.8%, Kilby: 65.5%, St. Clair: 50.6%, Tutwiler: 46.9%, Bibb: 33.8%, Easterling: 39.8%, Fountain: 31.5%).[38]

[37] As a result of the global financial crisis of 2008, I had to reduce staffing from 9,000 by 1,200 positions, closing three institutions between 2009 and 2011. Nonetheless, my staffing ratios were higher ratio than those of ADOC.

[38] ADOC Monthly Statistical Report for March 2016.

These numbers are astonishing to me. With the exception of Kilby and barely at St. Clair (where the vacancy rates are astounding, but slightly less so in comparison to other ADOC prisons), over half of the authorized correctional officer positions at the other four facilities are unfilled. At Fountain and Bibb, only about a third are filled. Such dramatic correctional officer vacancy rates have important consequences for the safe and secure operations of prisons, including the safety of both staff and prisoners. The ADOC has known about this problem for many years.

The warden at Tutwiler explained the problem succinctly: When asked during his deposition how many staff he had, Warden Barrett directly responded by saying, "not enough", simply acknowledging what everyone knows and what he has to try to manage on a daily basis.[39]

ADOC's History of Inadequate Staffing Levels

The chronic shortage of correctional staff has been a focus for the ADOC in its Annual Reports going back a decade.

[39] Deposition of Bobby Barrett, Feb. 29, 2016, page 10, lines 17-20.

> 24-hours a day, providing security for prisoners in transit, or fulfilling other important but distracting functions. Accordingly, it is not uncommon for a single Correctional Officer to be supervising up to 250 - 300 medium or higher level prisoners for an extended period of time. At the time of this writing, the problem is getting worse.[40]

The situation has been in a near-constant decline ever since. In 2007 and 2008, ADOC had around an 18% staffing shortage, and the shortage was

more sparse and more buried: "…[W]hile handing the challenges of prison crowding, security and administrative staff shortages and strict budgetary demands…," 40.8% custodial officer shortage (2012)[44]; "Staffing shortages continue to challenge th 2 h emaM 4 do an

experienced on a daily basis in the state's prisons.

2. ADOC does not Have Enough Staff to Properly Supervise Prisoners

The ADOC is insufficiently staffed to properly supervise inmates, which is critical both to preventing inmate violence and also to ensuring inmates have adequate access to healthcare. Staff simply cannot be multiple places at once. Officers may be faced with the need to transport someone to a medical unit while they also have the responsibility to supervise inmates in an open bay dormitory with 250 inmates or more. It is very likely that the nature of the medical problem may well seem of secondary importance to the correctional officer when faced with the prospect of not maintaining supervision of a dormitory.

But the problem in the ADOC facilities is even worse. In many cases correctional officers are not regularly in the dorm where the inmates reside. In some cases there are simply not enough officers on duty to assign one to each dorm. When that is the practice at the facility, it establishes a norm that the officer's presence in the dorm is not necessary since unsupervised dorms are sanctioned by the prison administration when they do not have enough staff to place at least one officer in the dorm. As noted in more detail below, inmates consistently report that there are not enough officers to supervise the

individual officer's performance and overall institution safety. If medical emergencies arise at night, there is not adequate staff to ensure that those

Date/Shift	Officers Short	# of Officers on Overtime
2/29 Day shift	1 short	8 on O.T.
3/1 Day shift	3 short	8 on O.T.
3/2 Day shift	0 short	6 on O.T.
3/3 Day shift	4 short	5 on O.T.
3/4 Day shift	1 short	8 on O.T.
3/5 Day shift	1 short	8 on O.T.
3/6 Day shift	1 short	8 on O.T.
3/7 Day shift	3 short	5 on O.T.

The night shift at Easterling was similar to the day shift, showing one to three officers short each shift and overtime required for between four and eight officers.

The workload and stress caused by working too many hours with too few fellow staff can also cause officers to cut corners. In the deposition of Brenda Fields, Clinical Operations Associate for MHM,[51] she talked about reviewing the records of someone on suicide watch at Limestone, a facility I

checks because you don

officers don't know about it." He said he had recently witnessed a fight that went on for about 30 minutes, but the officer didn't respond because he was asleep in the cube.[55] An inmate held in segregation (which is located down the hall from the regular dorm with no direct staff supervision) told me that sometimes officers check on him only every three or four hours.

At St. Clair multiple inmates told me that sometimes when there is a problem with a cell partner, one prisoner e l

must supervise two dorms. She further stated that she did not trust any of the officers but was afraid to rock the boat and feared retaliation for agreeing to speak with me. Others complained that dormitories are frequently short staffed, which impacts access to the yard for exercise and recreation and to the medical clinic for medical treatment.

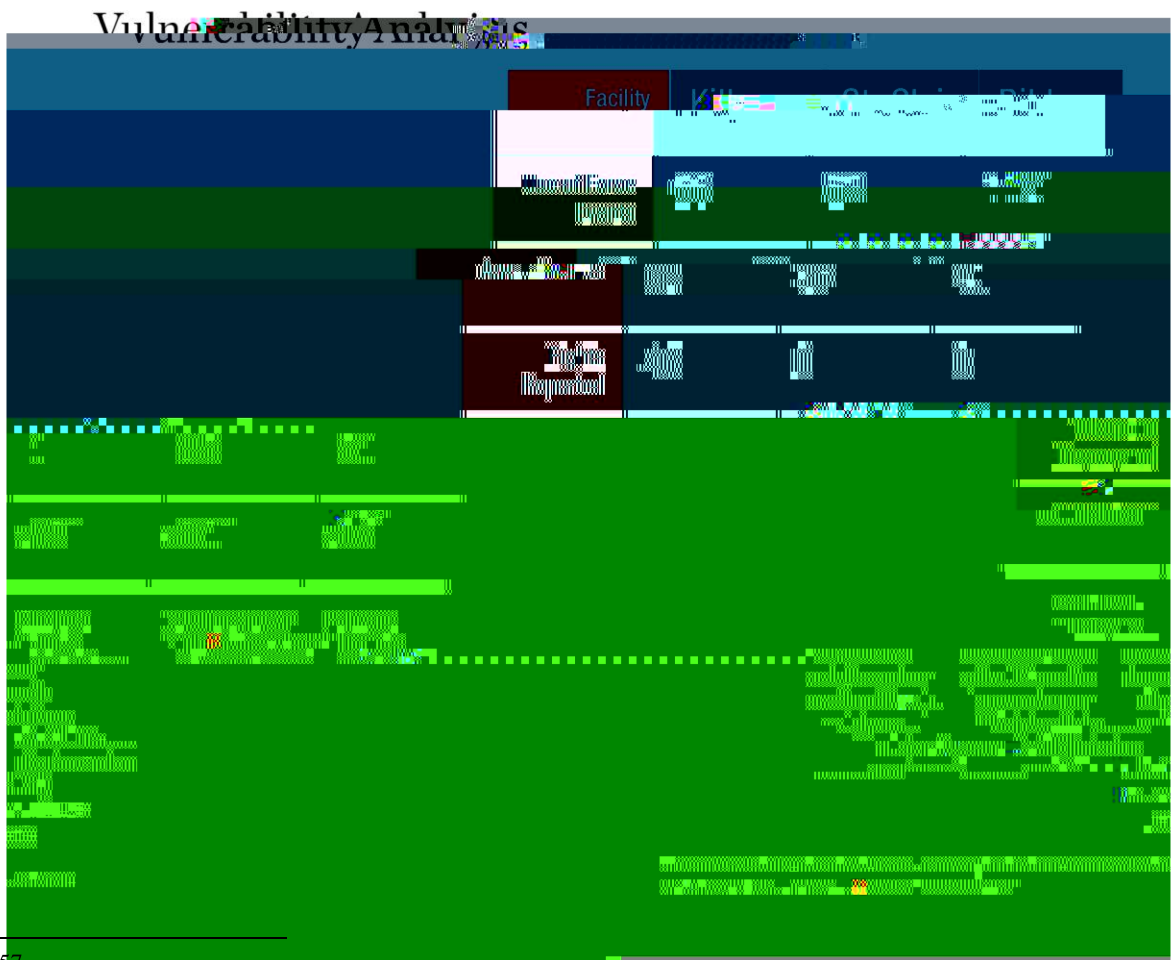
Two other themes also emerged as consistent reports in many of the confidential interviews. One, there is a level of profound idleness in ADOC facilities. Many of the [illegible]

hear the full and complete story if they are to provide effective treatment interventions.

Some corrections officials believe and teach that one should not believe anything an inmate says. I am not one of them. It is true that sometimes inmates do not tell the truth but it is equally true that sometimes they do. I have conducted several hundred confidential interviews with inmates in the states of California, Arizona, New York, Mississippi, North Carolina, Illinois, New Jersey and Georgia in the last four years. I also spent 35 years working in corrections, about half that time working the floor or as a Superintendent (Warden). I know my way around inmates and assess credibility based on the entire story relayed or not relayed to me by the individual prisoner. I look for consistency within the reports of individual inmates, whether or not the inmate will take the bait from a question I ask to embellish something they had already told me, as well as consistency between the reports I receive from multiple inmates. If I had any question about the credibility of a particular inmate, I did not recount his version of events here.

ADOC Records

The ADOC has a process whereby sometimes some prisons have a "Vulnerability Analysis" conducted by staff from other facilities. These reports reveal that the auditors express concerns and evidence of the dangerous nature of the ADOC prisons that I have been documenting in this section of the report. I share critical samples from those reports as follows[57]:



[57] 041714 Vulnerability Analysis – Kilby CF. 041814 Vulnerability Analysis – St. Clair CF. 041714 Vulnerability Analysis – Bibb April 2014. Both St. Clair and Bibb reported zero fights on their vulnerability analysis. Those figures are simply not believable, particularly based on my observations about the out-of-control nature of both facilities. This deficiency points to potentially severe under-reporting and undermines the quality of the data.

Inadequate Staffing Results in Inadequate Monitoring of Segregation

Insufficient staff results in critical areas of the prisons not being properly monitored. In most prisons, there are segregation or isolations units for certain prisoners. Segregation, by definition, houses the highest risk prisoners in the facility. The conditions for prisoners in segregation increase

Unfortunately, this type of monitoring rarely happens in Alabama prisons.

Captain Peters, the segregation Captain for St. Clair, said in his

two rovers instead of six for his three segregation units.[65] The Captain's testimony is consistent with what inmates at St. Clair told me about infrequent checks of inmates in segregation cells.

The accounts of the inmates I interviewed are also consistent with the records I have reviewed from the St. Clair segregation units—the required checks are not regularly occurring. In my review of 13 of those segregation logs made available to me for St. Clair, I did not find a single shift where segregation checks were made according to ADOC policy and as defined by Captain Peters in his deposition, "They are supposed to be doing a round through the block every 30 minutes". [66] Segregation checks are rarely identified in the logs at all, a practice that diverges from what I have seen in every other jurisdiction where I have reviewed segregation logs. Instead I found in every log I reviewed, gaps where officers did not even enter the unit for 90 minutes[67], 80 and 97 minutes[68], and 106 and 122 minutes[69]. I did not see a single shift in any facility when the officers consistently make the 30 minutes checks.

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[65] Ibid, page 125, lines 11-20.
[66] Ibid, page 122, line 19-20.
[67] ADOC 104039-104040; ADOC 104250-104251.
[68] ADOC 104053-104054.
[69] ADOC 104186-104187.

My observations regarding security checks in segregation was confirmed in 2014 when an outside team conducted a Security Audit at St. Clair. The auditors report states:

> There is specific language in the Standard Operational Procedure concerning security checks being conducted every thirty (30) minutes; however, these checks are not being conducted.[70]

A Security Audit was also conducted at Holman, and the auditors identified a similar problem with segregation security checks at that facility.

> Non-Compliant – the current SOP for Segregation does not give a time frame for observation checks, it was also noted that staff were not doing routine checks in the segregation unit. Logs in the Death Row unit indicated that this was not being done

for suicide and self-harm, thus the need for frequent checks as required by the ACA standard. I believe Dr. Haney is addressing this issue in his report in this case.

In some facilities, the failure of staff to check segregation units is likely exacerbated by the location of each segregation unit within the facilities. For example, during my inspection of Bibb in the fall of 2015, I

He said that checks of his cell by correctional officer generally occurred every three or four hours, depending on who was on duty.

As a long-time correctional administrator who spent considerable time focusing on the conditions of confinement and appropriate use of segregation, these segregation units at Bibb are terrifying and should not be used unless officers are assigned to be directly adjacent to those cells when occupied by inmates.

3. Staffing Levels Prevent Custody Staff from Supporting the Healthcare Needs of Prisoners in the ADOC

The lack of sufficient numbers of correctional officers is an ongoing barrier to the delivery of healthcare in the ADOC.

This is documented at Holman numerous times. An MHM Monthly Report described this concern, "Difficulty with ADOC staffing. Unable to get some inmates down for BMI monitoring. Logs being utilized, however, timing is an issue due to staffing."[74]

In the deposition of Lesleigh Dodd, MHM's site administrator at Holman (who has also done work at Fountain), she acknowledges difficulties with correctional officer shortages and the impact on inmates who need injections.[75] She also described the effects of insufficient ADOC custody staff to meet both the requirements of medical and mental health.[76]

Cheryl Harvey is a nurse practitioner who works for the mental health contract provider at Holman and Fountain. In her deposition, she too described the impact of too few correctional officers on providing timely appointments with inmates.[77] Ms. Harvey also confirmed the accuracy of the contractors' monthly reports that describe struggles accessing prisoners due to officer shortages at Fountain.[78]

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[74] ADOC044537.

[75] Deposition of Lesleigh Dodd, Feb. 18, 2016, page 150, line 16 – page 151, line 21.

[76] Ibid, page 197, lines 6-12.

[77] Deposition of Cheryl Harvey, Mar. 7, 2016, page 76, line 21 – page 22, line 13.

[78] Ibid, page 187, line 19 – page 20, line 188, line 19; page 223, lines 11-19; and page 228, line 17 – page 231, line 6.

The Medical Advisory Committee (MAC) minutes for Fountain further detail their difficulties:

not being told when it is time for KOP to be issued."[86] And, "When meds (chronic meds) are order (sic) for new intake inmates someone is turning them away from pickup (sic) their meds."[87]

At Tutwiler, among other problems, the problems with pill call were the focus of MAC meetings over a period of several months with healthcare staff continuously and repeatedly reporting their concerns in several different meetings.

> Staff not calling the inmates to health care at the appropriate time or they were letting them come down at the wrong times.[88]
>
> Officers will not call for pill call.[89]
>
> Still issues with pill call and officer behavior.[90]
>
> Still problems with pill call.[91]
>
> "Officers are doing a horrible job with watching pill line."[92]
>
> Offsite appointments are being missed.[93]
>
> Issues with not getting inmates to their

[86] Dunn (Corizon)_0253441.
[87] Dunn (Corizon)_0253727.
[88] Dunn (Corizon)_0254372.
[89] Dunn (Corizon)_0254344.
[90] Dunn (Corizon)_0254381.
[91] Dunn (Corizon)_0254377.
[92] Dunn (Corizon)_0254347.
[93] Dunn (Corizon)_0254348.

> appointments on time.[94]

From the multidisciplinary mental health meeting minutes at St. Clair:

> Delays of inmates being seen by mental health are
> due to officer shortage.[95]

> transportation issues.[102]
>
> Discussion of a problem with inmates getting their insulin on time. The Captain said he would educate the supervisor on the importance of inmates getting their insulin.[103]
>
> 1 inmate missed an outside appointment due to transportation issues.[104]

At Easterling the MAC minutes document the request for a solution to inmates being late for off-site appointments.[105]

In her deposition, Ms. Fields reports problems with groups and programs for inmates on the mental health caseload being canceled at Limestone due to "not having enough officers".[106]

The transportation problems have a very real effect on the medical

Impact of Segregation on Prisoners' Mental Health

The importance of mental health staff regularly checking on and

The records show the same problem at St. Clair. The Quality Improvement Reports at St. Clair note that, "Due to limited ADOC officer coverage, we are unable to provide segregation rounds"[114] and, "Mental Health has not been able to provide segregation rounds and groups because of officer shortage issues."[115]

The difficulty doing regular segregation rounds is documented at Holman in the multidisciplinary mental health meeting minutes in 2014,[116] and in the MAC minutes a year later.[117] The MHM Monthly Report comments for Holman say, "Staff states it is difficult to do Seg rounds due to lack of officers as well."[118] In her deposition, Nurse Harvey, nurse practitioner at Holman, confirms this report.[119]

challenges moving inmates to mental health appointments [121] and the difficulties coordinating with officers not assigned to mental health. [122]

At Bibb, the MAC minutes reflect concern by the medical staff for their own safety. A staff member talked about two medical staff being

that the inmate can ask for, complete and then hand back a sick call form to the officer so it can be forwarded to medical staff.[134] Given what my observations and what I have established in this report, that sometimes there

The failure to adequately supervise and screen prisoners also creates a risk for infectious diseases to spread rapidly in a facility. From the Easterling MAC meeting minutes multiple cases of scabies were reported. [137] Easterling appears to have suffered an outbreak of scabies over several months last year. There is also an inquiry by the Alabama Department of Health regarding scabies outbreak at Easterling dated December of 2014.[138]

Similarly, multiple cases of scabies were reported at Fountain,[139] and Tutwiler reported an increase in scabies.[140]

St. Clair also suffered an infectious disease outbreak. In a series of emails[141] from the Alabama Department of Public Health, Division of TB Control, the Department of Public Health express frustration at their inability to gain the cooperation of the Warden regarding testing staff for tuberculosis. There is a reference to the Warden being "rude," including that he "growled"

spending just a half day here. Most of those days were after lunch and DOC was conducting count and feeding during that time, so the hospital was

Those efforts, though, have been unsuccessful and today the understaffing problem is still not solved. There has been past litigation about mental health treatment in male facilities in ADOC, but as other experts will report, deep and systemic problems remain. The most fundamental problem is that the ADOC has about twice as many inmates than they are able to safely and humanely manage. They have less than half the custody staff needed to supervise these inmates. Their facilities are underbuilt and decaying. Inmates exist in conditions that I would expect to find in a developing country, not in a prison in the USA.

exndl

Three officers should be assigned for every two medium-custody dorms. At least one of those officers must stay in the dorm when inmates are present to supervise the inmates. At least one officer needs to move in and out of the two assigned dorms to provide backup and support to the primary dorm officer.

These officers must be trained in the principles of Direct Supervision. This will help the officers better understand their roles and help them develop the skills to properly supervise the inmates. When officers are in the dorms and are properly trained, conflicts can be detected before they erupt into violence and can often be prevented.

The ADOC should seek outside review of their current segregation population to see if that population can be reduced. The National Institute of Corrections (NIC) provides technical assistance grants that may be available to fund this work. I am sure the ADOC is familiar with the resources available from the NIC. The VERA Institute of Justice [143] and Segregation Solutions [144] are other low or no cost options. It is highly likely that a close examination of segregation practices in the

The mentally ill should be prohibited from placement in segregation absent exigent circumstances. The mentally ill need to be in secure treatment units and not in regular segregation cells.

The ADOC needs to solve the problem of missed medical and mental health appointments. I recommend that facility-by-facility, line officers and -

on inmate health and safety as described above, and reducing operating costs. Washington saved hundreds of thousands of dollars in garbage fees.

The ADOC must establish a grievance system for non-medical grievances. Alabama is the only state that I am aware of that does not have one. A grievance system that actually works and is perceived by the inmates as a legitimate vehicle to solve problems will make their institutions safer, reduce inmate violence, and in turn improve inmate health. I do not know of another state in this country that operates without a grievance system for inmates.

As difficult as some of these recommendations might sound to implement, the ADOC faces even greater prob19(o)-2.9r3()-3157.001(o)-2353.996(I)-59(t)-2

the problem of overcrowding I have great fear that they will leave their staff in unsafe working conditions and leave their inmates in the current situation of significant risk of serious harm.

Eldon Vail

Exhibit 1

ELDON VAIL

1516 8th Ave SE
Olympia, WA. 98501
360-349-3033
Nodleliav@comcast.net

WORK HISTORY

Nearly 35 years working in and administering adult and juvenile institutions, and probation and parole programs, starting at the entry level and rising to Department Secretary. Served as Superintendent of 3 adult institutions, maximum to minimum security, male and female. Served as Secretary for the Washington State Department of Corrections (WADOC) from 2007 until 2011.

Secretary	WADOC	2007-2011
Deputy Secretary	WADOC	1999-2006
Assistant Deputy Secretary	WADOC	1997-1999
Assistant Director for Prisons	WADOC	1994-1997
Superintendent	McNeil Island Corrections Center	1992-1994
Superintendent	WA. Corrections Center for Women	1989-1992
Correctional Program Manager	WA. Corrections Center	1988
Superintendent	Cedar Creek Corrections Center	1987
Correctional Program Manager	Cedar Creek Corrections Center	1984-1987
Juvenile Parole Officer	Division of Juvenile Rehabilitation	1984
Correctional Unit Supervisor	Cedar Creek Corrections Center	1979-1983
Juvenile Institution Counselor	Division of Juvenile Rehabilitation	1974-1979

SKILLS AND ABILITIES

Ability to analyze complex situations, synthesize the information and find practical solutions that are acceptable to all parties.

A history of work experience that demonstrates how a balance of strong security and robust inmate programs best improves institution and community safety.

Leadership of a prison system with very little class action litigation based on practical knowledge that constitutional conditions are best achieved through negotiation with all parties and not through litigation.

Extensive experience as a witness, both in deposition and at trial.

Experience working with multiple Governors, legislators of both parties, criminal justice partners and constituent groups in the legislative and policymaking process.

Skilled labor negotiator for over a decade. Served as chief negotiator with the Teamsters and the Washington Public Employees Association for Collective Bargaining Agreements. Chaired Labor Management meetings with Washington Federation of State Employees.

HIGHLIGHTS OF CAREER ACCOMPLISHMENTS

Successful settlement of the Jane Doe class action law suit, a PREA case regarding female offenders in the state's prisons for women.

Led the nation's corrections directors to support fundamental change in the Interstate Compact as a result of the shooting of 4 police officers in Lakewood, WA.

Dramatically improved media relations for the department by being aggressively open with journalists, challenging them to learn the difficult work performed by corrections professionals on a daily basis.

EDUCATION AND OTHER BACKGROUND INFORMATION

Bachelor of Arts - The Evergreen State College, Washington – 1973

Post graduate work in Public Administration - The Evergreen State College, Washington - 1980 and 1981

National Institute of Corrections and Washington State Criminal Justice Training Commission - various corrections and leadership training courses

Member of the American Correctional Association

Consultant for Correctional Health Care Executive Curriculum Development, an NIC training program, 2012

Guest lecturer on solitary confinement, University of Montana Law School in 2012

On retainer for Pioneer Human Services from July 2012 - July 2013

On retainer for BRK Management Services from September 2012 – April 2013

Guest Editorial, Seattle Times, February 22, 2014
http://www.seattletimes.com/opinion/guest-opinions-should-washington-state-abolish-the-death-penalty/

CURRENT ACTIVITIES

Serve on the Board of Advisors for Huy, a non-profit supporting Native American Prisoners

Registered Agent for the Association of State Correctional Administrators (ASCA) in Washington

Retained as an expert witness or correctional consultant in the following cases:

- ,
  No. 08-CV-1196 JAM EFB
  United States District Court, Eastern District of California,
  Declarations, March 4, 2013, May 15, 2013 and June 7, 2013
  Deposed, July 9, 2013
  Case settled, October 2014

- ,
  No. CV 12-06010 PHX-NVW
  United States District Court of Arizona
  Declarations and reports, November 8, 2013, January 31, 2014, February 24, 2014, September 4, 2014
  Deposed, February 28, 2014 and September 17, 2014
  Case settled, October 2014

- ,
  No. 6:11-CV-06417-TC
  United States District Court, For the District of Oregon, Eugene Division,
  Expert report, March 29, 2013
  Case settled, May 2013

- ,
  No. 3:13-cv-05222-BHS
  United States District Court, Western District of Tacoma
  Case settled, February 2014

- No. 2:90-cv-0520 LKK JMP P
  United State District Court, Eastern District of California,
  Declarations, March 14, 2013, May 29, 2013, August 23, 2013 and February 11, 2014
  Deposed, March 19, 2013 and June 27, 2013
  Testified, October 1, 2, 17 and 18, 2013

- ,
  No. 1:11-cv-02694-SAS
  United States District Court, Southern District of New York
  Interim settlement agreement reached February 19, 2014,
  Case settled, March 2016

- ,
  No. 3:13-cv-326 TSL JMR
  United States District Court for the Southern District of Mississippi, Jackson Division
  Report, June 16, 2014

- ,
  No. 3:10-cv-663 DPS-FKB,
  United States District Court for the Southern District of Mississippi, Jackson Division
  Memo to ACLU and Southern Poverty Law Center, March 14, 2014, filed with the court
  Reports to the court August 4, 2014 and February 10, 2015
  Testified, April 1, 2 and 27, 2015

- No. CV-77-00479-PHX-NVW,
  United States District Court of Arizona
  Declaration, November 15, 2013
  Testified, March 5, 2014
  Declaration, April 1, 2016

- No. 13-CV-0564 (MAD)(ATB)
  United States District Court, Northern District of New York
  Reports, April 19, 2014 and December 12, 2014

- No. 5:13 CT-3201-BO
  United States District Court, Eastern District of North Carolina,
  Western District
  Special Master appointment November 18, 2013
  Expert Report, January 14, 2014
  Testified, March 21, 2014

- No. 3:12-cv-3042
  United States District Court, Central District of Illinois,
  Springfield Division
  Report, August 16, 2014
  Testified June 29, 2016

- ,
  No. CV12-02376-PHX-PGR
  United States District Court of Arizona
  Reports, February 14, 2014 and May 12, 2014
  Deposed, July 30, 2014

- Case # 11094090C
  Malheur County, Oregon

- No. CV-14-25-BU-SHE
  United State District Court for the District of Montana,
  Butte Division

- No. CV-01333-RSM
  United States District Court,
  Western District of Washington at Seattle
  Report, May 29, 2014
  Deposed, June 27, 2014

- Case 2:14-at-00575
  United States District Court, Eastern District of California,
  Sacramento Division
  Declaration, February 26, 2016
  Deposed June 3, 2016

- No. 2:14-cv-00601-WKW-TFM
  United States District Court, Middle District of Alabama
  Declarations, September 3, 2014, April 29, 2015 and
  June 3, 2015

- No. 2:14-cv-01679-MCE-KJN,
  United States District Court, Eastern District of California,
  Sacramento Division
  Declaration, August 27, 2014, Report, December 5, 2014
  Deposed, December 15, 2014

- No. 5:13-cv-14356-RHC-RSW
  United States District Court, Eastern District of Michigan,
  Southern Division

- Case 4:12-cv-04698-JSW
  United States District Court, Northern District of California
  Declaration, March 16, 2015
  Deposed May 4, 2015
  Case settled, October 2015

- Case No: GC14008381—00
  General District Court of the County of Stafford
  Report, January 12, 2015
  Pardon granted

- Case No: 4:14-cv-03037
  United States District Court, Southern District of Texas,
  Houston Division
  Report, March 3, 2015

- Case 4:15-cv-00250-DCB
  United States District Court for the District of Arizona
  Reports, December 4, 2015 and March 10, 2016

- Civil No. 2:13-cv-00393-PMW
  United States District Court, Central Division,
  State of Utah
  Report, April 28, 2015
  Deposed, July 28, 2015

- Civil Action No 14-3166
  United States District Court, Eastern District of New York
  Report, August 14, 2015

- Civil Action No. 4:14-cv-1698
  United States District Court, Southern District of Texas,
  Houston Division
  Report, August 5, 2015
  Deposed, December 2, 2015

- Civil Action No. 07-CV-1298
  United States District Court, Central Division of Illinois,
  Peoria Division
  Case settled, December 2015

- No. CR–09–0322–AP
  Testified, March 28, 2016

- No. CV 12-280-TUC-CKJ
  United States District Court for the District of Arizona
  Report, February 1, 2016
  Deposed, February 25, 2016

- Case No. 15-2-22078-1 SEA
  Superior Court for the State of Washington, King County

- Retained by Sacramento County Sheriff to evaluate housing units in the Sacramento County jails, including maximum custody, segregation and protective custody
  Report, June 27, 2016

- o

  Case No. 415-cv-00253 E.D. MO
  United States District Court, Eastern District of Missouri
  Report, January 8, 2016

- o

  Case No. 1:15-cv-00688
  United States District Court for the District of Delaware

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  United States2t Court for the District of Delawa1152ourt or the DistSUct

  Report, January 8, 2016 o

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA

JOSHUA DUNN, ET AL.,	)	
	)	
Plaintiffs,	)	
	)	Civil Action Number:
v.	)	
	)	2:14-cv-00601-MHT-TFM
JEFFERSON DUNN, ET AL.,	)	
	)	
Defendants.	)	

Materials Relied Upon to Form Opinions in *Dunn v. Dunn*

In forming my opinions, I relied upon the following: 1) materials produced in discovery (listed below); 2) scholarly

FW TRAUMA RELATED COSTS
HOLMAN – MMM
KILBY – MMM
ST. CLAIR – MMM
TUTWILER – MMM
ADOC044631-044661 – Easterling
ADOC045516-045599
ADOC065321-065403 Easterling Jobs_Redacted
Dunn(Corizon)_11077
Dunn(Corizon)_20314
Dunn(Corizon)_20326
RFP 009 Easterling Segregation
SOP 006-01 - Easterling1
SOP 006-04 - Easterling1
041714 Vulnerability Analysis - Kilby CF
RFP2 AEO
RFP2 conf
ADOC044822-044880 – Kilby
ADOC045906-046010
ADOC046184
ADOC065512-065548 Kilby Jobs_Redacted
Dunn(Corizon)_13060
Dunn(Corizon)_13062
KilbyFire and Emergency Evacuation2011 1
KilbySOP V-14 1998 1
KilbySOP V-14 Emergency Drill 1
KilbySOP V-14 Emergency Plan 1
KilbySOP V-2 Emergency Inmate Housing 2010 1
KilbySOP V-2 Emergency Inmate Housing 2015 1
StatonSOP D-03-Emergency Procedures - Hazardous Chemicals-Man Made Disasters1
2008ADOC Emergency Operations Manual-Hurricane Appendix- May 08-(2)
2012ADOC Emergency Operations Manual-Hurricane Appendix- May 2012
BIBB JOBS
BULLOCK JOBS
DONALDSON JOBS
EASTERLING JOBS
FOUNTAIN JOBS
HOLMAN JOBS
KILBY JOBS
LIMESTONE JOBS
MOBILE WORK RELEASE JOBS
ST. CLAIR JOBS

STATON JOBS
TUTWILER JOBS
VENTRESS JOBS
TRADE SCHOOL CHART
PROGRAM INFORMATION
Vulnerability Analysis – Fountain CF
Vulnerability Analysis – Holman CF
Fountain Jobs
Holman Jobs
Memorandum to Security Staff
Corizon Policy: Access to care
Corizon Policy: Infection Control Program
Corizon Policy: Information on Health Services
Corizon Policy: Healthy Lifestyle Promotion
Corizon Policy: Chronic Disease Services
Corizon Policy: Restraint and Seclusion
Holman Sick Call Summary – March 2015
Skin Infection Tracking Log – April 2013
Fountain Emergency Procedures
Fountain Fire Safety and Evacuation Plans
Fountain Weather Related Disasters
Holman Security Audit
Holman Fire and Emergency Evacuation Procedures
Post Orders / Health Care Unit Security Officer
Fountain Health Services Audit – May 10, 2011
Audit and Re-Audit Results – 2011 and 2012
Fountain Job List
Holman Job List
ADOC facilities duty post logs
Bibb-MAC
Dept of Health – Easterling
Dept of Health
Easterling-MAC
Fountain Security Audit
Fountain-MAC
Holman-MAC
Kilby-MAC
Security Audit – Emails
St. Clair Security Audit
Tutwiler-MAC
Vulnerability Analysis – Fountain CF
Vulnerability Analysis – Ventress CF

Vulnerability Analysis – Bibb April 2014
Vulnerability Analysis – Hamilton A & I
Vulnerability Analysis – Hamilton CBF
Vulnerability Analysis – Holman CF
Vulnerability Analysis – Kilby CF
Vulnerability Analysis – Limestone CF
Vulnerability Analysis – Staton CF
Vulnerability Analysis – Elmore CF
Vulnerability Analysis – St. Clair CF
Vulnerability Analysis – Camden CBF
Vulnerability Analysis – Donaldson CF
Vulnerability Analysis – Loxley CF
Vulnerability Analysis – Red Eagle CF
Vulnerability Analysis – Bullock CF
Vulnerability Analysis – Mobile CBF
2011 Vulnerability Analysis – Hamilton A&I
2012 Vulnerability Analysis – Hamilton A & I
Security Audit Cover letter (Donaldson)
Donaldson Security Audit
St. Clair Security Audit
St. Clair Security Audit Findings
Holman - Security Audit 09-2011 – Printed
BIBB STANDARD OPERATING PROCEDURES
DONALDSON STANDARD OPERATING PROCEDURES
EASTERLING STANDARD OPERATING PROCEDURES

BULLOCK MONITORING FIRE EMERGENCY PROCEDURES
BULLOCK SOP EMERGENCY PROCEDURES OUTLINING EMPLOYEE DUTIES AND RESPONSIBLITIES
DONALDSON 2-4 EMERGENCY PROCEDURES IN CASE OF RIOT OR DISTURBANCE
DONADLSON 2-6 EMEREGENCY PROCEDURES FOR SEVERE WEATHER
DONALDSON 2-07
DONALDSON 2-08
DONALDSON 2-11
DONALDSON 2-15
DONALDSON 2-16
DONALDSON 4-026 TRANSPORTATION OF INMATES
DONALDSON 7-001 EMERGENCY PROCEDURES IN CASE OF RIOT OR DISTURBANCE
DONADLSON 7-002 EMERGENCY PROCEDURES FOR SEVERE WEATHER
DRAPER EMERGENCY FIRE PROCEDURES
DRAPER EMERGENCY HOUSING
DRAPER EMERGENCY WEATHER PROCEDURES
ELMORE 901 – EMERGENCY PROCEDURES POWER FAILURE 1
ELMORE 902 – RIOT MAJOR DISTURBANCE PLAN 1
ELMORE 904 - EMERGENCY LOCKDOWNS 1
ELMORE 905 – MONITORING FIRE AND EMERGENCY PROCEDURES1
ELMORE 906 – FIRE AND EMERGENCY EVACUATION PROCEDURES1
ELMORE 907 – SEVERE WEATHER PLAN1
ELMORE 908 – SHELTER-IN-PLACE PROCEDURES FOR CHECMICAL-BIOLOGICAL CONTAMINATION1
FOUNTAIN09-02 EMERGENCY PROCEDURES – FOUNTAIN JOD1
FOUNTAIN09-06 FIRE SAFETY AND EVACUATION PLANS (2) – FOUNTAIN – JOD1
FOUNTAIN09-17 WEATH(EC)5. Tm [(SH)5.996(EL)15(T)E.8Q0B1Tj /TTFTH(EC)504 Tf UC 327.41 8TT2 11.

ADOC Health Services Manual
MHM February 2016 monthly report
ADOC039224-ADOC039232-RFP 9
ADOC039316-ADOC039337 RFP3
ADOC039373-ADOC039374-RFP 9
ADOC039375-ADOC039417-RFP 2-ATTORNEYS' EYES ONLY
ADOC039387-ADOC039394 RFP9 AEO
ADOC039403-ADOC039409 RFP12 AEO
ADOC039418-ADOC039426 RFP3 conf
ADOC039427-ADOC039437-RFP 9
ADOC039438-ADOC039448-RFP 9
ADOC039449-ADOC039453 RFP2 AEO
ADOC039454-ADOC039458 RFP2 AEO
ADOC039459-ADOC039462 RFP2 AEO
ADOC039463-ADOC039475 RFP12 AEO
ADOC039476-ADOC039492 RFP2 conf
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ADOC039532-ADOC039535 RFP2 AEO
ADOC039536-ADOC039542 RFP2 AEO
ADOC039543-ADOC039550 RFP2 AEO
ADOC039551-ADOC039556 RFP2 AEO
ADOC039557-ADOC039559 RFP2 AEO
ADOC039560-ADOC039568 RFP2 AEO
ADOC039569-ADOC039578 RFP2 AEO
ADOC039579-ADOC039582 RFP2 AEO
ADOC039583-ADOC039585 RFP2 conf
ADOC039586-ADOC039590 RFP2 conf
ADOC039591-ADOC039593 RFP2 conf
ADOC039594-ADOC039596 RFP2 conf
ADOC039597-ADOC039599 RFP2 AEO
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ADOC039703-ADOC039706 RFP2 AEO
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ADOC039709-ADOC039711-RFP 2
ADOC039712-ADOC039714-RFP 2
ADOC039715-ADOC039717-RFP 2
ADOC039718-ADOC039720-RFP 2

ADOC062010-ADOC062016-RFP 5
ADOC062017-ADOC062050
ADOC062051-ADOC062059-RFP 3
ADOC062060-ADOC062061-RFP 10
ADOC062062-RFP 5 - Razor email
ADOC062063-ADOC062067-RFP 5 – razors
ADOC062068-RFP 5 –

ADOC062068-RFP 5 –

Donaldson2-11
Donaldson2-15
Donaldson2-16.sop
Donaldson4-026 Transportation of Inmates
Donaldson7-001 Emergency Procedures in case of Riot or Disturbance
Donaldson7-002 Emergency Procedures for Severe Weather
DraperEmergency Fire Procedures
DraperEmergency Housing
DraperEmergency Weather Procedures
Elmore901 - Emergency Procedures Power Failure1
Elmore902-Roit-Major Disturbance Plan1
Elmore904-Emergency Lockdowns1
Elmore905-Monitoring Fire and Emergency Procedures1
Elmore906-Fire and Emergency Evacuation Procedures1
Elmore907-Severe Weather Plan1
Elmore908-Shelter-In-Place Procedures for Chemical -Biological Contamination1
Easterling Correctional Facility, REG/SOP Mis2.95002(ee)y07812(e a)7.9912( )]eather Plan1

KilbySOP V-2 Emergency Inmate Housing 2010 1
KilbySOP V-2 Emergency Inmate Housing 2015 1
LimestoneSOP D-10 -- Emergency Procedure National Guard-Reserve Activation 1
LimestoneSOP D-13 -- Emergency Evacuation1
LimestoneSOP D-4 --Severe Weather 1
LimestoneSOP D-5 -- Emergency Procedures for Power Failure 1
LimetsoneSOP D-12 -- Winter Storm Operations1
MMM – Chart
Second Amended Complaint
SOP 006-01 - Easterling1
SOP 006-03 - Easterling1
SOP 006-04 - Easterling1
State of Alabama Department of Corrections Incident Reports
StatonSOP D-02 - Emergency Procedures Riot or Disturbances1
StatonSOP D-03-Emergency Procedures - Hazardous Chemicals-Man Made Disasters1
StatonSOP D-13 - Emergency Situation Weather1
StatonSOP D-21 - Fire Drills1
StatonSOP D-28 - HUR(s1)3.2DC /C2_2D3.279( )998(atTd [Sta)- 78T(U)505(e of) 5(e of) . Pnc)7.9998(atTd EP