INVESTIGATION OF ALABAMA'S STATE PRISONS FOR MEN

United States Department of Justice
Civil Rights Division

United States Attorney's Offices for the
Northern, Middle, and Southern Districts of Alabama

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I. INTRODUCTION

The Civil Rights Division and the three U.S. Attorney's Offices for the State of Alabama ("Department" or "Department of Justice") provide notice, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. §§ 1997 *et seq.* ("CRIPA"), that there is reasonable cause to believe, based on the totality of the conditions, practices, and incidents discovered that: (1) the conditions in Alabama's prisons for men (hereinafter "Alabama's prisons")[1] violate the Eighth Amendment of the U.S. Constitution; and (2) these violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights protected by the Eighth Amendment. The Department does not serve as a tribunal authorized to make factual findings and legal conclusions binding on, or admissible in, any court, and nothing in this Notice Letter ("Notice") should be construed as such. Accordingly, this Notice is not intended to be admissible evidence and does not create any legal rights or obligations.

Consistent with the statutory requirements of CRIPA, we write this Notice to notify Alabama of the Department's conclusions with respect to numerous constitutional violations, the facts supporting those conclusions, and the minimum remedial measures necessary to address the identified deficiencies.[2]

There is reasonable cause to believe that the Alabama Department of Corrections ("ADOC") has violated and is continuing to violate the Eighth Amendment rights of prisoners housed in men's prisons by failing to protect them from prisoner-on-prisoner violence, prisoner-on-prisoner sexual abuse, and by failing to provide safe conditions, and that such violations are pursuant to a pattern or practice of resistance to the full enjoyment of rights secured by the Eighth Amendment. The violations are severe, systemic, and 10(r)-1(e)]TJ 0 Tc 0 Tw (,l (,l (s)-01 Tw [BDC

insufficient maintenance and cleaning of facilities; the use of segregation and solitary

Ventress prisoner was punched so hard in the face by prisoners with shirts covering their faces that he was transported to an outside hospital for treatment. At Staton, a prisoner threatened a correctional officer with a knife measuring seven inches in length. And another prisoner reported that he had been sexually assaulted by a fellow prisoner after he had only agreed, in exchange for three store items, to lower his pants for that prisoner to view his buttocks while masturbating.

On Tuesday, at Fountain, a prisoner set fire to another prisoner's bed blanket while he was sleeping, leading to a fight between the two men. Officers searching a dormitory at Ventress found 12 plastic bags of an unknown substance, 79 cigarettes laced with drugs, two bags containing "cookie dough," and a bag of methamphetamine.

On Wednesday morning, a prisoner at Easterling was sexually assaulted inside of a segregation cell by an inmate. Four days prior, this same prisoner had been forced at knifepoint to perform oral sex on two other prisoners.

On Thursday, at Ventress, a prisoner was so severely assaulted by four other prisoners that he had to be transported to an outside hospital for treatment. A different Ventress prisoner reported being sexually assaulted.

At Bullock, a prisoner was found unresponsive on the floor by his bed and later died; his death was caused by an overdose of a synthetic cannabinoid. On Friday at Ventress, an officer observed a prisoner bleeding from the shoulder due to a stab wound; the prisoner was transported to an outside hospital for treatment.

These incidents in Alabama's prisons are just some of those reported in ADOC's own records during one week. And based on what we learned from our investigation and statements made by ADOC's head of operations, it is likely that many other serious incidents also occurred this week but were not reported by prisoners or staff.

II. INVESTIGATION

In October 2016, the Department opened a CRIPA investigation into the conditions in ADOC facilities housing male prisoners. The investigation focused on whether ADOC (1) adequately protects prisoners from physical harm and sexual abuse at the hands of other prisoners; (2) adequately protects prisoners from use of excessive force and staff sexual abuse by correctional officers; and (3) provides prisoners with sanitary, secure, and safe living conditions.

Five experienced expert consultants in correctional practices assisted with this investigation. Three of these experts are former high-ranking corrections officials with significant experience leading state and local corrections departments; the remaining two are nationally recognized experts in medical care and sexual safety in prisons. At least two of the experts accompanied us on site visits to Alabama prisons, interviewed ADOC staff and prisoners, reviewed documents, and provided their expert opinions and insight to help inform the investigation and its conclusions. The remaining experts reviewed documents and provided their

Laube v. Haley, 234 F. Supp. 2d 1227, 1245 (M.D. Ala. 2002); *see also Helling*, 509 U.S. at 33 ("That the Eighth Amendment protects against future harm to inmates is not a novel concept. The Amendment . . . requires that inmates be furnished with the basic human needs, one of which is reasonable safety.").

The Eighth Amendment applies to the States through the Due Process Clause of the Fourteenth Amendment and prohibits the infliction of "cruel and unusual punishments." *Estelle v. Gamble*, 429 U.S. 97, 101 (1976). The Eighth Amendment's ban on cruel and unusual punishments applies to the "treatment a prisoner receives in prison and the conditions under which he is confined." *Farmer*, 511 U.S. at 832; *Bass v. Perrin*, 170 F.3d 1312, 1316 (11th Cir. 1999). The conditions in Alabama's prisons are objectively unsafe, as evidenced by the high rate of prisoner-on-prisoner homicides and violence, including sexual abuse. Alabama is incarcerating prisoners under conditions that pose a substantial risk of serious harm, even when that harm has not yet occurred. Alabama is deliberately indifferent to that harm or serious risk of harm and it has failed to correct known systemic deficiencies that contribute to the violence. The deplorable conditions within Alabama's prisons lead to heightened tensions among prisoners. And, as a result, the violence is spilling over so that it is affecting not only prisoners, but ADOC staff as well.

That ADOC's prisons are dangerous appears to be acknowledged at all levels. The following data highlights that danger. Alabama prisoners endure an extraordinarily high rate of violence at the hands of other prisoners. Based on the latest data available from the Department of Justice's Bureau of Justice Statistics, Alabama's prisons have the highest homicide rate in the country. In 2014, the national average homicide rate in prisons was seven homicides per 100,000 prisoners. During fiscal year 2017, ADOC publicly reported nine homicides in its men's prisons, which house about 16,000 prisoners (a rate of homicide of 56 per 100,000 prisoners). This is approximately eight times the 2014 national rate.

Our experts observed that, based on their experience, the amount of prisoner-on-prisoner violence in Alabama's prisons was much higher than other similar systems. Based on ADOC's publicly reported statistics, the number of prisoner-on-prisoner violent incidents has increased dramatically over the last five-and-a-half years.

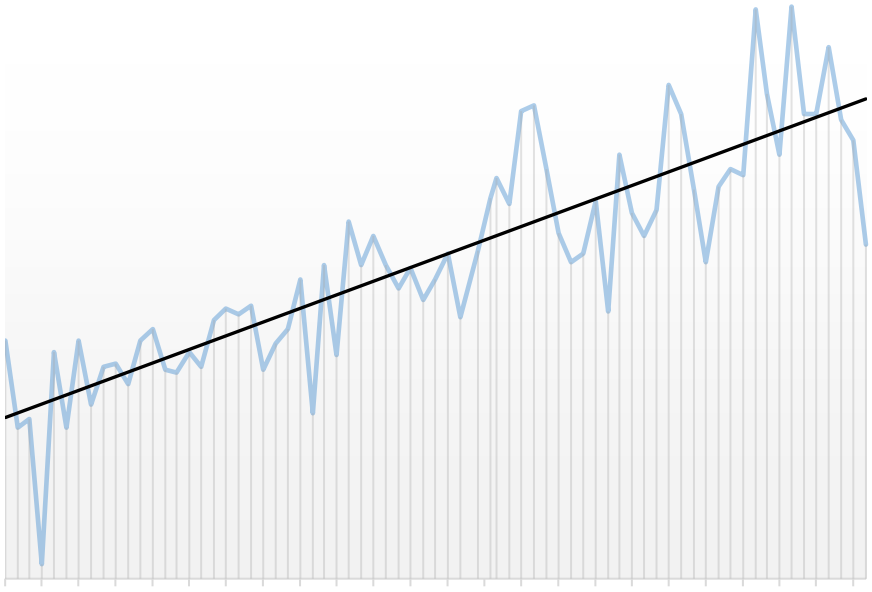

Chart 1: ADOC's reported instances of prisoner-on-prisoner violence

This increase in violent incidents has persisted and continued even after our investigation began. Our experts have consistently raised concerns about the levels of violence with ADOC leadership and suggested potential solutions throughout our investigation.

ADOC correctional staff are also harmed bywi7(

root and basic problem' contributing to the deplorable physiological and psychological effects of the Mobile County Jail . . .

28%; and Ventress—30%. Three others have less than 40%: Donaldson—35%; Staton—35%; and Kilby—36%. Only three remaining prisons also have correctional officer staffing levels over 40%: Elmore—41%; Limestone—56%; and Hamilton—75%. Hamilton A&I (which houses approximately 275 elderly and sick prisoners and is authorized for only 45 officers) at 75% staffing is still dangerously understaffed. A former ADOC warden stated that with this level of understaffing, "the convicts are in extreme danger and the correctional officers working there are in extreme danger." Correctional staffing levels have decreased over time as shown in the following chart:

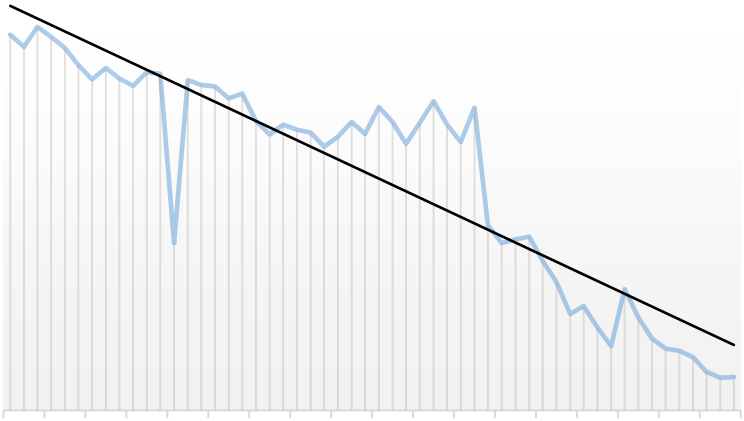

Chart 2: ADOC's reported correctional officer staffing levels

In reality, the deficit in the number of security staff working any given shift can be worse than 20% below required levels. For example, the Warden at Holman told us that, on any given day, she estimates that she has "probably 11" security staff, both officers and supervisors, per shift for the entire complex—a prison population of approximately 800. And the Warden at Bibb stated that he currently has only 66 assigned security staff, both officers and supervisors, covering approximately 1,800 prisoners over four shifts. Leadership at the facilities have used a variety of measures to fill the extreme shortages. These include mandated overtime, which allows supervisors to require that correctional officers stay an additional four hours past the end of their 12-hour shift.

In another stop-gap measure intended to address the extreme understaffing, officers are required to work oxymoronic "voluntary mandatory overtime," which requires officers to work

In fiscal year 2017, a correctional officer at St. Clair with a base pay of $38,426.60,

- A prisoner died in February 2018, from wounds he sustained four days earlier in a knife fight at Kilby. The autopsy details multiple stab wounds to the prisoner's head, abdomen, back, and arm. One stab wound extended "through the scalp and impact[ed] the skull and [was] associated with a depressed skull fracture 1/4 inch in diameter." The toxicological analysis report also revealed the presence of methamphetamine in his system. The incident report listed this prisoner's death as "Natural," despite the original incident report narrative describing an altercation with a weapon. Though ADOC reported the death as "Natural," the autopsy report definitively states that manner of death was "homicide."

- In November 2017, a prisoner was rushed to a hospital from Elmore with a brain bleed. Prior to the transfer, the prison's health care unit had refused to provide medical attention to the prisoner—even though he was "bleeding from his head"—because he appeared to be "under the influence." At the hospital, he ultimately required emergency brain surgery. Further investigation revealed that another prisoner had physically assaulted the decedent. The incident report does not detail how the assault occurred. Approximately one month later, following readmission, the hospital informed ADOC officials that the prisoner died. ADOC classified the death as "InmateN(a)4(t)yd ( )T

2. The Excessive Number of Deaths Due to Violent, Deadly Assaults Demonstrates that ADOC Is Unable to Adequately Keep Its Prisoners Safe.

Our investigation revealed that an alarming number of prisoners are killed by other prisoners using homemade knives. The knives used in these assaults are frequently long and sharp, thus able to easily penetrate the victim's body and puncture vital organs. Several prisoners who were stabbed to death also had been stabbed in past incidents. ADOC, with the knowledge that previously stabbed prisoners were at risk for further violence, took no

prisoners. And, in October 2016, while the victim was housed at Fountain, a correctional officer witnessed a different prisoner repeatedly stabbing him.

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- In February 2017, a prisoner died two days after being assaulted by several prisoners at Elmore. An incident report described the prisoner as being "laid out on the floor" of the dormitory with a serious injury. The I&I Investigative Report indicates that the prisoner was fighting with another prisoner and was hit in the head, knocked out, and fell so that he hit his head again on the floor. The unconscious prisoner had to be carried to the health care unit and taken by helicopter to a local hospital where he died two days later. Elmore's incident report classified the prisoner's death as "Inmate Death –

government and its officials are not free to let the state of nature take its course." *Farmer*, 511 U.S. at 833.

Courts have held that protecting prisoners from violence requires adequate supervision and staffing. *Alberti*, 790 F.2d at 1225-28 (upholding district court's order requiring specific staffing and hourly visual inspections by guards to address high violence and sexual assault at jail);

- In January 2018, a Holman prisoner came to the gate of his housing unit, bleeding. He had been stabbed 22 times, including to his chest, upper arm, thigh, back, buttock, foot, and face, by six other prisoners.

- In January 2018, a cubicle officer at Holman noticed a prisoner walking towards the shower area covered in blood. He had been attacked by two prisoners with a knife, resulting in a facial laceration that severed an artery. The prisoner had to be airlifted to an outside hospital due to arterial bleeding.

- In December 2017, at Holman, a cubicle officer observed a prisoner standing at the housing unit gate bleeding from his arm and chest. The prisoner had been assaulted and stabbed by multiple prisoners, suffering puncture wounds to his back, chest, arm, and head, as well as lacerations to his arm and head. Due to the severity of his injuries, the prisoner had to be airlifted to an outside hospital.

- In November 2017, a Holman prisoner was stabbed in the head, back, shoulders, and both arms and legs. He had to be transported to an outside hospital for emergency surgery. An officer only became aware of the stabbing when he heard several prisoners banging on the cell bars and shouting to get his attention, then saw other prisoners carrying the victim, who was bleeding profusely, toward the unit's door.

- In November 2017, at Holman, a cubicle officer observed a prisoner walking towards the gate of an open dormitory with blood on his clothing, and called for assistance. When officers arrived, they found a prisoner with a bloody face. The prisoner, and another witness to the assault, confirmed he had been stabbed in the eye and beaten by two prisoners for resisting a sexual assault. The victim was sent by ambulance to an outside emergency room.

- In October 2017, St. Clair officers noticed a prisoner leave his unit and enter the prison yard wearing only a blanket and socks. Only then did staff discover that the prisoner "had been assaulted and severely beaten," appearing to have been bound and taped around his hands, ankles, mouth, and head, and had a fresh burn mark on his face.

- In September 2017, at Easterling, a prisoner was attacked in the prison yatsoner l.14 TD ( )Tj EMC

- In April 2017, a Bibb prisoner was stabbed in the back and left temple while asleep, and had to be airlifted to an outside hospital. This prisoner had a history of drug debts and had previously tested positive for drugs. His attacker explained that the victim owed him a $200 debt and was not going to pay, so he "got it in blood."

- In February 2017, an Elmore prisoner was killed because of a failed drug transaction. Multiple prisoners attacked the victim while he lay asleep in bed, then he was dragged on a blanket to the common room, where a correctional officer eventually discovered him. He was airlifted to an outside hospital for emergency surgery due to a brain hemorrhage. He died two days later.

Yet another pattern that emerges is the prevalence of contraband, especially homemade weapons, which appear to be very easy for prisoners to produce or procure. Many of the incidents already described demonstrate the widespread availability of such weapons, as do the following, which also illustrate just ho2(hi4(j)-2(us)10(, w)2, w)2-1(C[(Y)-[16(yt)-2(o pr)3)]TJ thi4(pons)-1(,

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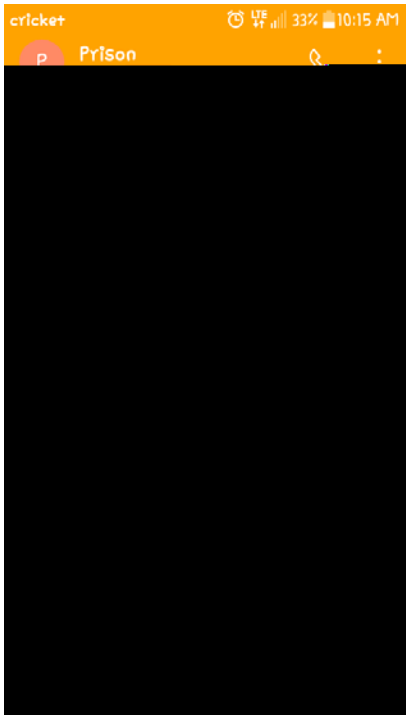
- In April 2018, a drug treatment counselor at St. Clair reported to a captain that a prisoner feared for his safety because of debts he owed to gang members. The captain questioned the prisoners he had named, all known gang members, who denied the allegations. The prisoner who made the report was disciplined for intentionally creating a security/safety/health hazard and placed in restricted housing for admititig t

threatened with rape. His mother later called to report that she was being extorted by a prisoner at Ventress who texted her photos of a prisoner's genitals from a cell phone. Through texts, he threatened to chop her son into pieces and rape him if she did not send him $800. In February 2018, the inmate called our toll-free line and affirmed what his mother had reported. The following screenshots were sent to us:



The prisoner refused to provide the names of the prisoners who were extorting him. ADOC then required the victim to provide a urine sample and moved him to restricted housing while giving him a disciplinary action for intentionally creating a Security/Safety/Health Hazard.

7. Access to Dangerous Weapons Contributes to Serious Violence.

ADOC does not effectively control the introduction, manufacture, and use of weapons.

We interviewed a former ADOC warden who discussed with us the dangerous staffing levels at the prisons. He called the staffing levels "barbaric" and concluded that both prisoners and correctional officers in Alabama's prisons "are in extreme danger." Less than a month before we notified Alabama of our investigation, a correctional officer, Kenneth Bettis, was killed at Holman. Officer Bettis was stabbed in the head by a prisoner while working in the dining hall. The prisoner was angry that Officer Bettis refused to allow him to get a second food tray. At the time, he was the only officer working inside the cafeteria. Shortly after his death in 2016, correctional officers at all facilities were issued stab vests for their protection. Despite the addition of stab vests, correctional staff continue to be harmed by prisoner violence, as the examples listed below show:

- In March 2018, at St. Clair, seven prisoners surrounded a correctional officer with homemade knives drawn. One prisoner cut the officer in his stomach with a knife before help arrived and the prisoners were handcuffed.

- In March 2018, at Fountain, several correctional officers were performing a contraband search. They informed a prisoner that they were going to pat search him, and he refused. He cut the officer with a knife.

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the drug trade in Alabama's prisons. Agents of ADOC's I&I Division, including the I&I Director, stated that "drugs are the biggest problem in prison" because prisoners are "wigging out" and harming others. One ADOC investigator stated that "drugs are the biggest driver of violence in Alabama's prisons." Another investigator saw five or six prisoners laid out in a hallway at Bullock after smoking the same drug and thought it looked like "triage in a warzone."

The presence of synthetic cannabinoid, frequently referred to as 5F-ADB, within Alabama's prisons presents a particularly serious health risk for prisoners. According to the World Health Organization's Expert Committee on Drug Dependence, this substance can cause "severe and fatal poisoning," and its effects may include "rapid loss of consciousness/coma, cardiovascular effects . . . , seizures and convulsions, vomiting/hyperemesis, delirium, agitation, psychosis, and aggressive and violent behavior."

A review of autopsies from 2017 and the first half of 2018 revealed that the substance was present in many facilities, including Bibb, Bullock, Draper, Elmore, Fountain, and Staton. An I&I investigation into a prisoner death at Bullock in December 2016 revealed that these drugs were readily and cheaply available inside the prison. Indeed, a review of autopsy reports from prisoner deaths dating December 2016 through August 2018 revealed that at least 22 were caused by "synthetic cannabinoid toxicity" overdoses. And since we opened our investigation into Alabama's prisons, the problem has become worse—there were three deadly overdoses in 2016 and nine in 2017. The first half of 2018 (after which ADOC stopped producing documents to us) was especially deadly; during that timeframe, at least 10 deaths were attributed to synthetic cannabinoid toxicity.

To the extent contraband is introduced by staff, it is contributing to the problem. ADOC staff, who are not screened for contraband upon entry to a prison, have been consistently identified by ADOC leadership as contributing to the contraband problem. Requiring all individuals—management and line staff—to be screened at entry, would ensure ADOC takes seriously the need to prevent and address contraband within Alabama's prisons.

Often, ADOC's incident reports list the cause of overdose deaths as "Natural," and although autopsies later reveal the true cause of death, ADOC does not centrally collect or track these autopsies and is thus unable to distinguish overdose deaths from other non-homicide deaths and to fully understand the deadly effects of such dangerous contraband within its system. The following are only a few examples of the deaths associated with synthetic cannabinoid:

- In May 2018, a prisoner at Fountain died of synthetic cannabinoid toxicity. Incident reports list the cause of death as suspected drug overdose. Approximately two years before his death, this same prisoner was stabbed at Holman in a drug-related altercation.

- In March 2018, at Easterling, a prisoner died from the "[t]oxic effects of 5F-ADB." The incident report, which listed his death as accidental, stated that a correctional officer on a security check observed the prisoner lying on his bed. The officer tapped him on the shoulder but received no response. Despite efforts to resuscitate him, the prisoner was pronounced dead within an hour.

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(Suboxone) in November 2015 while at Staton, and again on May 14, 2017 when he was at Elmore. He was also caught at Staton with Suboxone on his person in January 2017.

- In October 2017, a prisoner at Kilby died of an overdose from an unknown drug. The prisoner was found face down and unresponsive on the floor next to his bed. A piece of plastic containing a white powder, initially identified as "no-show," was found next to him. The prisoner was taken to the Kilby emergency room where he was pronounced dead.

Synthetic drugs and methamphetamines have also been mentioned in the autopsies of homicide victims. In 2018 alone, autopsies revealed the presence of synthetic drugs in two victims, methamphetamines in two others, and one prisoner who had both synthetic drugs and methamphetamines in his system.

Many of the prisoners we interviewed painted a portrait of a system where drugs are ubiquitous, dangerous, and contribute to violence. Over 70% of the prisoners we interviewed specifically mentioned the prevalence of drug use within the prisons. Many prisoners thought that part of the danger from drugs is that drug usage leads to drug debts, which leads to violence and sexual abuse when prisoners are unable to pay. Prisoners at different facilities reported seeing other prisoners smoke something, "wig out," fall on the ground, pass out, or vomit. A common theme in our interviews of prisoners was that correctional officers observe the drug use and take no action.

It is difficult to know the exact number of prisoners using drugs in Alabama's prisons, as drug tracking and testing is inconsistent. In 2017, there were over 375 incident reports documenting prisoners possessing drugs, but many of these reports reflect that more than one prisoner was in possession of drugs. Many prisoners referred to the drug problem as an "epidemic." In fact, several prisoners we interviewed had either been stabbed by someone "wigging out" on drugs, or had stabbed another prisoner while on drugs. One shift commander said that more than once a day she encounters a prisoner passed out or acting violently after using drugs. Two shift commanders of death row and segregation at Holman estimated that 50-60% of their prisoners were using drugs. One shift commander over general population at Holman estimated that 95% of that facility's prisoners were using drugs.

There are varying explanations for how the drugs are getting into ADOC's prisons. During one facility tour, leadership admitted that drugs were arriving a variety of ways—through staff, from prisoners returning from other places, individuals throwing bags over the fence, and

made $75,000 bringing in contraband and his accomplice, a prisoner, made $100,000. Clearly, current ADOC policies have been unable to control or limit the drug trade in its prisons.

E. ADOC Is Not Adequately Protecting Prisoners from Sexual Abuse by Other Prisoners.

Sexual abuse in Alabama's prisons is severe and widespread, and is too often undetected or prevented by ADOC staff. We reviewed over 600 incident reports from late 2016 through April 2018 that ADOC classified as "Sexual Assault – Inmate-on-Inmate." The majority of these incident reports described sexual abuse allegations of forced anal or oral sex. Medical examinations and ADOC investigations substantiate a significant number of the allegations of sexual abuse. In reviewing hundreds of reports, we did not identify a single incident in which a correctional officer or other staff member observed or intervened to stop a sexual assault. Because of inadequate supervision, correctional officers do not observe the rampant sexual abuse, they do not intervene, and the cycle of abuse continues. As such, ADOC fails to protect prisoners from the harm of sexual abuse. *Farmer*, 511 U.S. at 833 (holding that prison officials have a duty to protect prisoners from violence at the hands of other prisoners, including sexual assault).

1. Sexual Abuse Is Highly Prevalent in ADOC Correctional Facilities.

ADOC documents a high level of sexual abuse within Alabama's prisons. ADOC produced 313 incident reports classified as "Sexual Assault – Inmate-on-Inmate" from the year 2017. ADOC produced 257 such incident reports from 2016. Many of the incident reports confirm that ADOC substantiated the allegations. Indeed, in 2016, the Survey of Sexual Victimization data that ADOC publicly reported pursuant to the National Standards for the Detection, Prevention, and Punishment of Prison Rape, 28 C.F.R. § 115 ("PREA standards"), confirmed that ADOC substantiated nearly 25% of all allegations of "inmate-on-inmate nonconsensual sexual act."[6] ADOC substantiated over 30% of allegations of "inmate-on-inmate abusive sexual contact."[7] Nationwide, prisons substantiate an average of 6.3% of allegations of

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[6] Ala. Dep't of Corrs., Survey of Sexual Victimization, 2016, at 2, http://www.doc.state.al.us/docs/PREA/SSV2016.pdf. The number of substantiated incidents is likely even higher, as the investigations for 20% of the allegations of "Nonconsensual Sexual Acts" had not yet been completed at the time of publication. *Id.* "Nonconsensual Sexual Acts" are defined as:

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"inmate-on-inmate nonconsensual sexual act," and 11.7% of allegations of "inmate-on-inmate abusive sexual contact." In its Survey of Sexual Victimization data for 2017, ADOC reported substantiating only 1 out of 162 allegations of "inmate-on-inmate nonconsensual sexual act" and only 1 out of 65 allegations of "inmate-on-inmate abusive sexual contact." In ADOC's 2017

immobilizing an individual or rendering him unconscious, which makes him vulnerable to sexual abuse. For example:

- In March 2018, a prisoner at Holman reported that he had been raped after he had passed out from smoking "flakka." He awoke to one prisoner punching him in the eye and then four or five prisoners put a partition around his bed and took turns raping him.

- In February 2018, a prisoner at Bibb reported to a mental health professional that he had been raped. At approximately 1:00 a.m. in a dormitory unit, an unidentified prisoner propositioned him to smoke a marijuana cigarette. While smoking, the victim "became incoherent" and awoke with the unidentified prisoner penetrating him from the rear.

- In December 2017, a prisoner at Limestone reported that two prisoners attempted to force him to perform oral sex, which resulted in a physical altercation, with a third prisoner coming to his aide. The incident was substantiated and the incident report notes that when one of the assailants was interviewed following the altercation, he had slurred speech and smelled of alcohol.

- In January 2017, a prisoner at Donaldson reported that a prisoner offered him a cigarette and, upon smoking it, he began "to feel funny and could not move." Two prisoners then took him into the shower and sexually assaulted him. ADOC substantiated this incident.

- In January 2017, a prisoner at Draper reported that he had voluntarily used methamphetamine and blacked out. When he regained consciousness, he was experiencing anal pains and other prisoners indicated that he had been sexually assauered him a

- In February 2018, a prisoner at Staton reported that the night before, two prisoners had held knives to his neck while a third prisoner forced him to perform oral sex. The victim alleged that the whole dormitory was aware of the attack. The victim was escorted to the health center for a medical examination and then transferred to a holding cell while the alleged assailants remained in the dormitory. There is no mention of a search for weapons.

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3. Deficiencies in ADOC's PREA Screening and Housing Contribute to the Unsafe Environment.

The unsafe environment created by ADOC's deficient supervision and overcrowding is exacerbated by failings in ADOC's PREA screening, classification, and housing of prisoners. The PREA standards require that all prisoners be assessed during intake screening and upon transfer to another facility for their risk of being sexually abused by, or sexually abusive toward, other prisoners. 28 C.F.R. § 115.41(a). The PREA standards also require that ADOC use information from the risk screening "to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive." 28 C.F.R. § 115.42(a).

While ADOC has basic policies in place to conduct PREA risk screenings, ADOC fails to use the information from the screenings to house prisoners safely and, even if an appropriate housing assignment is made, the classification system is defeated by lax supervision that allows prisoners to wander throughout the prison facilities without authorization. ADOC's knowledge of, and failure to comply with the PREA standards, is further evidence of ADOC's subjective recklessness with regard to prisoner safety. *Farmer*, 511 U.S. at 843; *see also Crawford v. Cuomo*, 796 F.3d 252 (2d Cir. 2015) (finding PREA and other such legislative enactments to be reliable evidence of contemporary standards of decency, and thus relevant in evaluating whether specific acts of sexual abuse or sexual harassment rise to an Eighth Amendment claim).

ADOC classification staff reported that the initial classification determines only a prisoner's security level, which informs his assignment to a particular prison. Once he arrives at the prison, an Inmate Control Services officer assigns the prisoner to a housing unit and bed. While the Inmate Control Services officer should have access to a prisoner's classification and screening information, it is unclear how and if this information is used, especially given the degree of overcrowding at some ADOC prisons. Documents provided from a PREA audit at Draper indicated that for three quarters of 2016, Draper had zero occurrences of a prisoner screening for risk of victimization or abusiveness, and did not use the PREA screening information for three quarters of 2016. At some facilities, ADOC case managers conduct the initial PREA screening. At Bibb, we noted that the screening setting was not private, so other prisoners could hear confidential information a prisoner reported during his screening, which could discourage prisoners from answering truthfully. When conducting and scoring the screening, case managers had no access to a prisoner's previous screening results. ADOC's PREA audits demonstrated a need for corrective action in the adequacy of PREA risk screening 3 (c)4 (on)-10 (

standards include several provisions specifically aimed at increasing sexual safety for LGBTI prisoners.

ADOC is refusing or failing to comply with the PREA standards. For example, only one of the PREA Compliance Managers we interviewed on-site was able to give specific information about the LGBTI prisoners housed at that prison. The other PREA Compliance Managers had little or no information about LGBTI prisoners. If ADOC's PREA Compliance Managers have no knowledge of the vulnerable prisoners within the population, they cannot comply with their duties to provide a reasonable level of safety to those prisoners.

Regardless of whether prisoners receive a safe housing assignment based on an

In addition, ADOC's incident reports confirm that many allegations are declared "unsubstantiated" on the basis that the victim declined to press criminal charges or otherwise cooperate with the investigation, which is not a sufficient reason for reaching such a conclusion in an administrative investigation. For example:

- In February 2018, a prisoner at Bibb notified the facility PREA Compliance Manager that he had been "forcibly sexually assaulted" two days prior and that he had not bathed, so the perpetrator's semen was still inside him. The prisoner was examined by the facility nurse and upon completion of the medical examination, the prison physician advised that the prisoner should be transported to an outside hospital for a Sexual Assault Kit. Although the prisoner named his rapist, the incident report confirms that upon conclusion of the investigation, the victim "stated that he did not desire to prosecute and signed a waiver of prosecution. Therefore, this allegation is unsubstantiated."

- In May 2017, "several" prisoners reported to a captain that two other prisoners were held and assaulted in a dormitory unit at Fountain over the weekend by a group of four

the victim's refusal to prosecute, but go on to state that a "sexual abuse incident review" was conducted and no "further action" would be taken. Indeed, despite the high number of sexual abuse reports documented by ADOC, there is no record of meaningful corrective action to address the problem in ADOC's prisons.

5. ADOC Discourages Reporting of Sexual Assaults.

Many ADOC incident reports reflect conduct that likely discourages additional reports of sexual abuse. As discussed above, ADOC has a tendency to dismiss claims of sexual abuse by gay prisoners as consensual "homosexual activity" without further investigation, implying that a gay man cannot be raped. Some victims are given a Release of Liability to sign after reporting sexual abuse.

In other cases, in addition to the trauma of a sexual assault, the victim is subjected to disciplinary action for facts he discloses as part of the investigative process. For example, in February 2017, a prisoner at Donaldson reported that he had been raped two days earlier, and named his assailant. He was transported to the Sexual Assault Nurse Examiner Clinic for an assessment and returned to Donaldson at approximately 10:00 PM. The next morning at 4:45 AM, he was interviewed by the PREA Compliance Manager and stated that he was in debt to the prisoner who had raped him and several other prisoners, but "was adamant" that he had been sexually assaulted. The PREA Compliance Manager advised the victim that he would receive a disciplinary action for "Intentionally Creating a Safety, Security and/or Health Hazard" for admitting that he had accrued debt to other prisoners.

- In April 2018, a prisoner at Bullock reported that over three days, he had endured

infrastructure." He has said that over 70% of the prisons "are well beyond their useful life and

risk from the very fact that the risk was obvious." *Id*. at 842. In other words, "an official responds 'in an objectively unreasonable manner if he knew of ways to reduce harm but knowingly declined to act or if he knew of ways to reduce the harm but recklessly declined to act.'" *Johnson v. Boyd*, 701 F. App'x 841, 847 (11th Cir. 2017) (quoting *Rodriguez v. Sec'y for Dep't of Corrs.*, 508 F.3d 611, 620 (11th Cir. 2007)).

In determining whether conduct violates the deliberate indifference standard of the Eighth Amendment, there must be persuasive evidence of the following: (1) facts presenting an objectively substantial risk to prisoners and awareness of these facts on the part of the officials charged with deliberate indifference; (2) the officials drew the subjective inference from known facts that a substantial risk of serious harm existed; and (3) the officials responded in an objectively unreasonable manner. *Doe v. Ga. Dep't of Corrs.*, 248 F. App'x 67, 70 (11th Cir. 2007); *Marsh*, 268 F.3d at 1028-29.

ADOC has long been aware that conditions within its prisons present an objectively substantial risk to prisoners. Yet little has changed. As early as 1975, a federal court enjoined ADOC from accepting any new prisoners, except escapees and those who had their paroles revoked, into four of its prisons until the population in each was reduced to design capacity. *James v. Wallace*, 406 F. Supp. 318 (M.D. Ala. 1976). In 2011, that same court found that ADOC facilities were understaffed and overcrowded. *Limbaugh v. Thompson*, No. 2:93cv142 460.68TnT-4 (if

In April 2014, the Equal Justice Initiative ("EJI") urged ADOC to investigate, among other violence, the fatal and non-fatal stabbings that were escalating at St. Clair. Following another homicide in June 2014, EJI renewed its formal request that ADOC address the violence. In the face of ADOC's inaction and yet another homicide, in October 2014, a group of prisoners incarcerated at St. Clair filed a class action lawsuit in federal court. The suit alleged an extraordinarily high rate of violence at St. Clair, including six homicides in the preceding three years. The plaintiffs asserted that the violence in the severely overcrowded facility could be traced to poor management, noncompliance with protocols and procedures, the prevalence of drugs and other contraband, and corruption. Three years later, in November 2017, the plaintiffs and ADOC reached a settlement. ADOC promised many reforms in the settlement. For instance, ADOC promised to ask the Alabama Legislature for funding to install video cameras for monitoring at the prison. ADOC did not make good on that promise. By June 2018, ADOC had not satisfied several of the settlement requirements. The parties went back into mediation in June 2018—only eight months after ADOC made all of its promises to reform St. Clair.

ADOC management is acutely aware of the substantial risk of harm caused by its critically dangerous understaffing. Alabama officials, from the Governor to ADOC's Commissioner, have recently reiterated that overcrowding and understaffing continue to plague the system. In ADOC's most recent Annual Report, Commissioner Dunn even highlighted "critical shortages in correctional officer staffing" as a major challenge. And, in early 2019, he explicitly acknowledged the direct link between the levels of violence in Alabama's prisons and the understaffing: "We are still down to 50 percent or lower staffing at many facilities. There's a direct correlation between the shortage of officers and violence."

Due to the extreme staffing shortages, correctional officers are tired, and there are simply not enough individuals to adequately and safely staff Alabama's prisons. Incident reports from 2017 reveal numerous instances of correctional officers not showing up for work or refusing to work mandated overtime. We also found numerous incident reports where correctional officers were found sleeping in cubicles, in hospitals, and in perimeter security vehicles. These security problems have persisted despite ADOC's awareness of our investigation and our numerous on-

In other ongoing litigation, ADOC has admitted that its prisons are dangerously understaffed. In *Braggs v. Dunn*, the plaintiffs sued ADOC for failing to provide adequate medical and mental health care, and for discriminating agains

A. Immediate Measures

1. Understaffing and Overcrowding. ADOC should:

- Immediately deploy resources to staff and electronically monitor the perimeters of Alabama's prisons and assist in screening anyone entering facilities.

- Within one month, consult a nationally recognized expert, approved by the Department, with experience realigning low-risk, nonviolent prison inmates to local oversight, to assess such feasibility in Alabama.

- Within two weeks, contact the Acting Director of the National Institute of Corrections ("NIC") to arrange a joint conversation among ADOC, NIC, and the Department to discuss the areas in ADOC prisons that need immediate attention. Within the confines of its fiscal resources, NIC will provide follow up with an action plan of both sequential and overlapping elements to address the areas that need immediate attention, consistent with the Department's findings. Any direct technical assistance that is able to be provided by NIC will be done at no cost to the state of Alabama. NIC will also identify other federal resources that may be available to Alabama in addressing the identified issues.

- Within time frames identified with NIC, properly screen, hire, and fully train 500 corrections officers. Determine how many of these new officers will be assigned to each facility, based on current vacancy rates. Within six months, in consultation with NIC, staff prisons with at least 500 additional individuals to provide security.

- Within six months, commission a study to examine the feasibility of transferring prisoners to non-ADOC facilities in numbers sufficient to provide adequate staffing for the remaining prisoners.

- Within six months, assess the leadership skills of all Wardens (I, II, and III) and institutional coordinators, in a process overseen by

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- Within one month, consult with a nationally recognized expert, approved by the Department, to determine other methods of detecting illegal drugs and other contraband being brought into the facilities, for those drugs that will not be detected by metal detectors. Include recommended measures in ADOC policy on screening.

- Within six months, implement any reasonable additional screening procedures for illegal drugs and other contraband that cannot be detected by a metal detector.

- Within two months, provide adequate medical treatment, using evidence-based treatment, for all prisoners detoxifying as illegal drugs and other contraband are reduced and eventually eliminated from the facilities.

4. Sexual Abuse.

   ADOC should:

- Immediately reviseJ 0.5i1p (ont)--2 (s)-’(r)3 (s)-1 d(vi)-2 (s)-1(c)4(vi)-2poulier procers1-6 (t1v

units by classification levels in order to protect prisoners from unreasonable risk of harm.

- Discontinue the use of "behavior modification" dormitories ("Hot Bays") unless mental health professionals play a role in both the assignment of prisoners to such placements and are involved in the treatment provided.

- Ensure that every prisoner-on-prisoner assault is documented and investigated, and that staff is trained on how to prevent and address such incidents.

- Comply with PREA and its implementing regulations, the National Standards to Prevent, Detect, and Respond to Prison Rape (28 C.F.R. §§ 115 *et seq.*).

- Develop and implement a policy on prevention, detection, reporting, and investigation of prisoner-on-prisoner and staff extortion of prisoners and their families.

- Develop a written institutional plan to coordinate actions taken in response to an incident of physical abuse, sexual abuse, and/or extortion among staff first responders, medical and mental health practitioners, investigators, and facility leadership.

- Develop an effective substance abuse disorder program.

- Develop and implement an effective grievance process. In the event that a grievance is filed against a staff member, the submission process must allow for options of submission that are neither seen by, nor referred to, the staff member who is the subject of the complaint.

- Develop and implement a plan to prevent prisoners from entering housing units other than the ones to which they are assigned.

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this letter. 42 U.S.C. § 1997c(b)(1)(A). Please also note that this Notice is a public document. It will be posted on the Civil Rights Division's website.