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

EDWARD BRAGGS, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	CIVIL ACTION NO.
	)	2:14-CV-00601-MHT-TFM
JEFFERSON DUNN, in his official capacity as Commissioner of the Alabama Department of Corrections, et al.,	)	
	)	
Defendants.	)	

PLAINTIFFS' EMERGENCY MOTION FOR A TEMPORARY RESTRAINING ORDER OR PRELIMINARY INJUNCTION REGARDING PLACEMENT OF HIGH-RISK PRISONERS IN SEGREGATION

Since November 21, 2018, there has been an average of one suicide every 11.4 days in Alabama Department of Corrections ("ADOC"). There have already been two completed suicides in 2019 – just eighteen days into the year. ADOC's suicide rate in 2018 was higher than any previous year. If the current trend for 2019 continues, it will be by far the highest rate of suicide ADOC has ever recorded.

A year and a half ago, this Court held:

> ADOC's segregation practices perpetuate a vicious cycle of isolation, inadequate treatment, and decompensation. The skyrocketing number of suicides within ADOC, the majority of which occurred in segregation, reflects the combined effect of the lack of screening, monitoring, and treatment in segregation units and the dangerous conditions in segregation cells. Because prisoners often remain in segregation for weeks, months, or even years at a time, their decompensation may not become evident until it is too late—after an actual or attempted suicide.

> . . .
> Since September 2015, seven of eleven suicides within ADOC facilities happened in segregation units; of the four that have occurred since October 2016 (the current fiscal year), all but one involved a prisoner in segregation. As explained above, these suicide numbers are astounding compared to the national average across state prison systems. By subjecting mentally ill prisoners to its segregation practices, ADOC has placed prisoners with serious mental-health needs at a substantial risk of continued pain and suffering, decompensation, self-injurious behavior, and even death, and the court cannot close its eyes to this overwhelming evidence.

Braggs v. Dunn, 257 F. Supp. 3d 1171, 1245 (M.D. Ala. 2017). The Court found numerous practices to contribute to the extraordinary dangers associated with placing certain prisoners in segregation in ADOC. These practices continue and the risk continues to grow. The situation has become worse, not better, since the Liability Opinion. There have been twelve completed suicides since December 30, 2017.

Defendants Jefferson Dunn and Ruth Naglich have failed to take the steps necessary to keep the men and women in their custody safe. Despite being repeatedly told by the Court that people with serious mental illness should not be in segregation, Defendants continue to place many such people in segregation – either in units that are designated as "Restrictive Housing" or in units that are the functional equivalent of segregation. Defendants continue to place people who have repeatedly become suicidal in segregation back into segregation. Prisoners who are mentally ill are even more over-represented in segregation than they were at the time of the liability trial and continue to be placed in segregation for actions related to their mental health needs.

Defendants fail to provide the most basic monitoring of people in segregation. Defendants fail to do anything to learn from past suicides to prevent

additional suicides.

Many men and women remain at substantial risk of profoundly irreparable harm due to Defendants' failures to protect prisoners who are seriously mentally ill and/or decompensating in segregation from the most dire consequences of segregation. Pursuant to Fed. R. Civ. P. 65, Plaintiffs respectfully move this Court for a temporary restraining order or preliminary injunction to prevent further irreparable injury, including but not limited to, serious physical injury and death, to class members and prisoners at Tutwiler Prison for Women, who are entitled to relief through Plaintiff Alabama Disabilities Advocacy Program's organizational standing.

Plaintiffs are substantially likely to succeed on the merits of their claims that Defendants have been and continue to be deliberately indifferent to a substantial risk of serious harm to suicidal prisoners. The obviously irreparable harm threatened to Plaintiffs, class members, and prisoners at Tutwiler by Defendants' failures far outweighs the detriment that such an injunction or order may cause Defendants. The requested order or injunction will secure a measure of basic compliance with Plaintiffs' constitutional rights, will help protect against immediate threat to human life, and thus is in the public interest.

FACTUAL BACKGROUND

The Court heard evidence on the inadequacy of mental health care in ADOC over the course of a 31-day trial ending on February 1, 2017. The Court issued its Liability Opinion and Order as to Phase 2A Eighth Amendment Claim ("Liability Opinion") on June 27, 2017. *Braggs v. Dunn*, 257 F. Supp. 3d 1171 (M.D. Ala.

2017).

The Court made numerous findings regarding the risk of harm from the practices of ADOC. Further the Court found that these practices had led to a "skyrocketing number of suicides within ADOC, the majority of which occurred in segregation." *Id*. at 1245. In the year and a half that has passed since the Court issued the Liability Opinion, the rate of suicides has increased, reaching what must be described as a state of emergency. Many of the risky practices relating to segregation continue unabated.

I. Defendants Have Failed to Ameliorate the High Rate of Suicide

People in the custody of ADOC commit suicide at a very high rate. Every year but one since 2015, there has been a very high – and growing – rate of completed suicides by the people in ADOC custody.

	Suicides	**Mid-Year Population (June 30)**	**Suicides per 100,000**	**Source**
2015	5	24,435	20.5	Pls. Ex. 1267, Jt. Exs. 324, 322, 328, 318, 329, 327, 326, 319 (2015 MHM Monthly Operating Reports) __
2016	9	23,832	37.8	Pls. Ex. 1267
2017	1	21,888	4.6	Ex. 12
2018	9	20,143	39.7	Ex. 12
Jan.1, 2019 - Jan. 18, 2019	2	20,195 (Oct. 2018)	118.8*	Ex. 12

*Annualized rate, assuming no further suicides in January.

As a comparison, the last reported average rate of suicide in state prisons for the country as a whole was 16 per 100,000 in 2014. *Braggs*, 257 F. Supp. 2d. at 1220. Defendants' expert Dr. Raymond Patterson testified during the liability trial

that he knew of no "prison system that has a suicide rate over 25 or 30 per 100,000." *Id*.

In ADOC, suicides overwhelmingly occur in segregation or segregation-like conditions. *Id*. at 1245. Of the eleven suicides that had occurred in the sixteen months leading up to the liability trial, eight had taken place in a segregation or restrictive housing unit, one in a holding cell, and two in closed mental health units. Pls. Ex. 1267 (Chart of Suicides, Sept. 2015-Dec. 2016). Of the twelve suicides that have taken place in ADOC in the last thirteen months, seven took place in segregation, one took place on death row (a segregation-like setting), two took place in general population, and the location of two have not been disclosed to Plaintiffs. Ex. 12 (Chart of Recent Suicides)

II. Defendants Continue to Place Prisoners Who Have Recently Become Suicidal In Segregation Back Into Segregation

During the liability trial, the Court heard evidence that:

> The follow-up care provided to many prisoners upon their release from suicide watch at ADOC is woefully inadequate. Both Dr. Haney and Dr. Burns observed multiple instances of prisoners who were released directly from crisis cells back into segregation, with little or no follow-up treatment in subsequent weeks. For example, experts observed that plaintiffs L.P., R.M.W., and C.J. and prisoner J.D. all had a pattern of cycling between crisis cells and segregation with little follow-up treatment after crisis-cell release. As explained further later, prisoners in segregation—even those on the mental-health caseload—have little access to meaningful treatment, due to severe staffing shortages that prevent prisoners from being brought out of their cells and a lack of group activities.

Braggs, 257 F. Supp. 2d. at 1231. Defendants continue to release prisoners from suicide watch to segregation, and to fail to follow up with them. Pls. Dem. Ex. 196.

Of the twelve people who committed suicide since December 2017, seven had

been on suicide watch or mental health observation within the month prior to their deaths. Ex. 12 (Chart of Recent Suicides). Of those seven people, Defendants have provided information about the location of only five of them. Four of those five were in segregation at the time of their deaths. *Id.*[1]

Further, ADOC continues the pattern seen during the liability trial of repeatedly releasing people from suicide watch or mental health observation to segregation, where, predictably, they decompensate and have to go back into a crisis cell. As shown in Exhibit 14, at least 25 people in ADOC have been placed repeatedly into crisis cells over the last six months and repeatedly discharged to segregation.

III. Defendants Fail to Conduct Follow-Ups After Release from Suicide Watch or Mental Health Observation

Exacerbating the risk further, Defendants continue to fail to conduct follow-ups after people are released from suicide watch and mental health observation.[2] Although Defendants have been ordered to provide three follow-up mental health examinations over the month after a person is released from suicided watch (Doc. 1106-1 at 3), they routinely fail to conduct some or all of these follow-ups. *See* Pls. Dem. Ex. 196; Pls. Dem. 200; Dr. Kathryn Burns, Dec. 6, 2018, Trial Tr. 133:8-147:10. The purpose of these follow-ups is to determine whether the person who was recently in a mental health crisis, often a person who has engaged in self-harm or actually attempted suicide, is doing alright. As explained by Dr. Burns in the recent

[1] Only one of the seven men, John Barker, was clearly not in segregation at the time of his death. Plaintiffs do not know whether two of these seven men, Kendall Chatter and Roderick Abrams, were in segregation. *See* Ex. 12.

[2] The failure to conduct follow-ups after release from suicide watch violates the Interim Suicide Prevention Order, Doc. 1102-1.

monitoring proceeding, the transition out of suicide watch is a very dangerous time. Dr. Kathryn Burns, Dec. 6, 2018, Trial Tr. 129:16-130:1. Without the follow-ups, it is likely that those individuals who are not doing alright will be missed.

For example, John Barker suffered from Major Depressive Disorder, a Serious Mental Illness (SMI). Pls. Ex. 1758 at SPA_3342. He was released from mental health observation on August 27, 2018. Pls. Ex. 1758 at SPA_3356. He went into segregation on August 29, 2018. Pls. Ex. 1538 at ADOC0425171. He was still in segregation as of September 18, 2018. Ex. 6 (Sept. 18, 2018 Restrictive Housing Roster) It is unclear from his record when he was released from segregation. He had no follow-ups. *See generally* Pls. Ex. 1758. He committed suicide on September 22, 2018. Pls. Ex. 1759.

IV. Defendants Continue to Place Prisoners with Serious Mental Illness in Segregation and Segregation-Like Conditions

The Court recognized in the liability opinion that "one particular subset of prisoners with serious mental-health needs should never be placed in segregation in the absence of extenuating circumstances: those who suffer from a 'serious mental illness." *Braggs*, 257 F. Supp. 2d. at 1245. The Court explained the basis of this finding, citing both Defendant Naglich's testimony and the opinion of Dr. Burns:

> Dr. Burns credibly opined … those who suffer from serious mental illness should not be put in segregation as a general matter because prisoners with serious mental illness experience worsening symptoms in such an isolated environment, and because they are likely to have reduced access to treatment in segregation units. Burns added that, even when extenuating circumstances exist, segregation placements for such prisoners should still be short term, and access to necessary treatment must be provided.

Braggs, 257 F. Supp. 2d. at 1245-46.

In the time since the liability trial, the Court has repeatedly exhorted Defendants to stop placing people with serious mental illness into segregation. Dec. 12, 2017 R.D. Trial Tr. at 75:20-22; Ruth Naglich, Nov. 30, 2017, R.D. Trial Tr. at 55:1-62:3; Kristin Hollingsworth, February 28, 2018, R.D. Trial Tr. at 78:25-79:4; Ruth Naglich, Feb. 7, 2018, Trial Tr. at 92:18-95:6; Ruth Naglich, Feb. 7, 2018, Trial Tr. at 122:18-124:2. As explained by the Court, "There is a pressing issue [ ] if these people are in segregation, and if there are no extenuating circumstances, then they need to be immediately released or removed, I should say, from segregation to crisis cells or something. But they should not be in segregation." Feb. 8, 2018 R. D. Trial Tr. at 7:2-17.

Nonetheless, Defendants continue to place people with serious mental illness in segregation and to leave them there for prolonged periods. For example, on the November 13, 2018 Restrictive Housing Roster (Pls. Ex. 1971), 57 men and women *recognized on the roster* as having a serious mental illness, were in segregation, many having been there for extended periods:

Initials	**Days in Segregation**	**SMI Recognition**	**Page**
A.D.	27	SMI Flag, MH-2	ADOC0450422
D.W.	Unknown	SMI Flag, MH-2	ADOC0450423
B.A.	46	MH-2	ADOC0450423
S.J.	5	SMI Flag, MH-2	ADOC0450423
V.H.	17	SMI Flag	ADOC0450424
L.S.	9	SMI Flag, MH-2	ADOC0450425
K.R.	4	SMI Flag, MH-2	ADOC0450427
C.M.	4	SMI Flag, MH-2	ADOC0450427
D.T.	25	SMI Flag	ADOC0450443
C.S.	4	SMI Flag	ADOC0450444
R.H.	5	SMI Flag	ADOC0450445
J.W.	81	SMI Flag	ADOC0450445
A.D.	47	SMI Flag	ADOC0450448

N.H.	Unknown[3]	SMI Flag	ADOC0450449
J.T.	11	SMI Flag	ADOC0450450
J.C.	22	SMI Flag	ADOC0450450
J.R.	11	SMI Flag	ADOC0450451
B.L.	11	SMI Flag	ADOC0450451
G.J.	33	SMI Flag	ADOC0450451
M.M.	2	SMI Flag, MH-2	ADOC0450453
D.S.	25	MH-2	ADOC0450454
F.R.	1	SMI Flag	ADOC0450455
D.C.	71	MH-3	ADOC0450456
J.S.	75	MH-2	ADOC0450460
B.W.	294	SMI Flag	ADOC0450460
M.T.	4	SMI Flag	ADOC0450461
S.W.	15	SMI Flag, MH-2	ADOC0450462
T.J.	15	SMI Flag, MH-2	ADOC0450462
Q.M.	5	MH-2	ADOC0450463
G.W.	28	SMI Flag, MH-2	ADOC0450463
S.M.	28	MH-2	ADOC0450463
A.H.	33	SMI Flag, MH-2	ADOC0450463
M.M.	18	SMI Flag, MH-2	ADOC0450464
A.D.	22	SMI Flag, MH-2	ADOC0450464
B.O.	34	SMI Flag, MH-2	ADOC0450464
F.J.	21	SMI Flag, MH-2	ADOC0450464
M.H.	21	SMI Flag, MH-2	ADOC0450464
C.C.	7	SMI Flag	ADOC0450464
R.Y.	61	SMI Flag	ADOC0450464
K.H.	49	SMI Flag	ADOC0450464
C.S.	4	SMI Flag	ADOC0450464
R.C.	22	SMI Flag	ADOC0450464
R.B.	27	SMI Flag	ADOC0450464
J.S.	7	SMI Flag	ADOC0450464
T.J.	8	SMI Flag, MH-2	ADOC0450465
C.B.	14	SMI Flag, MH-2	ADOC0450465
M.W.	21	SMI Flag	ADOC0450465
K.C.	5	SMI Flag, MH-2	ADOC0450465
P.D.	91	SMI Flag	ADOC0450465
J.S.	160	SMI Flag	ADOC0450465
L.N.	7	SMI Flag, MH-2	ADOC0450465
A.F.	0	SMI Flag, MH-2	ADOC0450465

[3] Although the Nov. 13 Restrictive Housing Roster gives no date for the start of N.H.'s time in segregation, the Oct. 30 Restrictive Housing Roster, which shows him in the same cell, indicates that he was placed in segregation on Sept. 21, 2018. Pls. Ex. 1749 at ADOC0441608.

L.B.	32	SMI Flag	ADOC0450465
J.B.	18	SMI Flag	ADOC0450466
R.S.	8	SMI Flag	ADOC0450466
L.C.	284	SMI Flag	ADOC0450466
J.B.	15	SMI Flag, MH-2	ADOC0450467

Further, this listing does not include locations where prisoners are kept in housing units that function as segregation but are not designated as "Restrictive Housing." For example, as discussed during the monitoring hearing, Y Unit at Donaldson is considered a segregation unit by those who work there, but persons who are housed in Y Unit are not included on the segregation rosters. *See* Ruth Naglich, Nov. 8, 2018 Trial Tr., 20:16-21:14, 25:17-26:3; Pls. Ex. 1681 at ADOC0440327-331. Similarly, Paul Ford was held for approximately a month under conditions equivalent to segregation in O Unit at Kilby, but O is not included on the segregation rosters. Ex. 4 (ADOC Emails re: Paul Ford) at 1.

Despite the Court's repeated instructions that persons with serious mental illness should not be in segregation, Defendants continue to place such persons in segregation and to leave them there, sometimes for months.

V. Defendants Continue to Place High Numbers of Prisoners with Mental Illness in Segregation

In the Liability Opinion, the Court found that "mental-health staff largely have rubber-stamped ADOC's decisions to send mentally ill prisoners to segregation. . . Even when MHM has recommended against placing a particular prisoner or a group of mentally ill prisoners in segregation, there is evidence that ADOC has ignored such input." *Braggs*, 257 F. Supp. 2d. at 1240. The Court further found:

> [M]entally ill prisoners are overrepresented in ADOC segregation. While only 14 % of the ADOC population is on the mental-health caseload, mentally ill prisoners make up 21 % of those in segregation.

> Looking at individual facilities year by year, most facilities' segregation units have a far higher rate of mentally ill prisoners compared to the general population: throughout 2014, 2015, and 2016, Bibb, Easterling, Kilby, St. Clair, Staton, and Ventress each had a disproportionately high number of mental-health patients in segregation; Holman and Limestone's segregation population also had a disproportionately high number of mental-health patients more than half of the time period. Only four of the 12 major male facilities—Bullock, Donaldson, Fountain, and Hamilton—did not have disproportionate numbers of mental-health patients in segregation for most of the three years. *See* Pl. Dem. Ex. 127, Overrepresentation of the Mentally Ill in Segregation, 2014–2016 (doc. no. 1126–8).

Braggs, 257 F. Supp. 2d. at 1241 (footnote omitted).

Despite the Court's findings, Defendants continue to place high numbers of prisoners with mental illness in segregation. In fact, since the time of the Liability Trial, Defendants have increased the number prisoners with mental illness they place in segregation. *See* Pls. Dem Ex. 168; Ex. 13. In 2016, 224 prisoners with a mental-health code of 1 or 2 were in segregation on average. In 2017, this number shot up to 266, and continued to exceed the 2016 average with 246 prisoners in 2018. *Id.* The current number of prisoners with mental illness in segregation is even more shocking when compared to the 2012 average of 173 prisoners with a mental-health code of 1 or 2.

Based on the latest data,[4] roughly one-quarter of the segregation population has a mental-health code of 1 or 2. *Id*. In 2016, prisoners with a mental-health code of 1 or 2 made up 18% of the segregation population. In 2017 and 2018, that number shot up to 24% and 25% respectively. *Id.* Not only have Defendants not heeded the Court's warnings of the dangers of putting prisoners with mental illness in

[4] Specifically, data produced by Defendants of the segregation population in 2017 and 2018. *See* Ex. 13.

segregation, they have increased the sheer number of prisoners with mental illness that fill their segregation cells. *See Braggs*, 257 F. Supp. 2d. at 1245 ("By subjecting mentally ill prisoners to its segregation practices, ADOC has placed prisoners with serious mental-health needs at a substantial risk of continued pain and suffering, decompensation, self-injurious behavior, and even death . . .").

Prisoners with a mental-health code of 1 or 2 are increasingly overrepresented in the segregation population. In 2012, prisoners with a mental-health code of 1 or 2 were 11.1% of the overall prison population and 15% of the segregation population. Ex. 13. In 2016, prisoners with a mental-health code of 1 or 2 represented 15% of the overall prison population and 18% of the segregation population. *Id.* In 2017 and 2018, prisoners with a mental-health code of 1 or 2 comprised 16.7% and 18% of the prison population respectively and 25% and 24% of the segregation population respectively. *Id.*

After the Court's findings in the Liability Opinion, one would expect a sharp decrease in the percentage and sheer number of prisoners with mental illness in segregation, but in fact, the exact opposite has occurred. Notwithstanding the findings made by the Court, Defendants continue to place prisoners with mental illness in segregation at a deadly, ever-increasing rate. *See id.*

VI. Defendants Continue to Fail to Monitor Prisoners in Segregation

The Court also found in its Liability Opinion that ADOC was not adequately monitoring people housed in segregation. As explained by the Court:

> [O]fficers cannot constantly walk near the cells and are generally unable to monitor what is going on inside. This means that mentally ill prisoners in segregation—including those identified as mentally ill, those with

> undiagnosed mental illnesses, and those who develop mental illness while in segregation—are at a heightened risk for decompensation without anyone noticing.

Braggs, 257 F. Supp. 2d. at 1239. The Court further held that "[c]orrectional expert Vail credibly opined that ADOC lacked enough correctional staff to conduct monitoring rounds in segregation every 30 minutes—the level of monitoring in segregation units necessary to keep prisoners safe from self-harm and suicide." To the contrary there was evidence suggesting that "no segregation checks were done for multiple hours." *Id*.

The failure to conduct monitoring rounds continues. *See* Grantt Culliver, Feb. 9, 2018 Trial Tr., 20:13-26:13; Eldon Vail, Feb. 13, 2018 R.D. Trial Tr., at 186:13-192:14; Pls. Dem. Ex. 169. Notably, then-Associate Commissioner Culliver testified that the reason correctional officers do not do rounds as required by policy and basic correctional standards is that there are not enough officers. Grantt Culliver, Feb. 9, 2018 Trial Tr., 20:13-23. The number of officers has declined significantly since the liability trial. *Compare* Pls. Ex. 121 *with* Doc. 2192-1.

The risk created by the lack of monitoring cannot be overstated. The Court heard testimony that on the morning Robert Martinez hanged himself at St. Clair, no officer came into the cell block for hours. A.A., Apr. 23, 2018, R.D. Trial Tr., 204:5-10. Even once a runner spotted Mr. Martinez hanging, he had to wait until officers came to the unit about twenty minutes later to inform them. Id. at 204:22-206:19.

VII. The Harms of Defendants' Failure to Ameliorate the Risk

Twelve people have committed suicide in ADOC in just over one year. Their final days and months demonstrate the human cost of Defendants' failures to address the risks posed by their practices. The final months of two of these persons' lives are discussed below.

A. Billy Lee Thornton

Billy Lee Thornton hanged himself in a segregation cell at Holman Correctional Facility on February 26, 2018. Pls. Ex. 1488, Billy Thornton Incident Report at ADOC0421089. He later died of his injuries at a hospital on March 2. *Id.* On April 23 and April 24, this Court heard testimony from several witnesses about the circumstances of Mr. Thornton's death as part of the evidence in the remedial trial on segregation. *See generally* Cynthia Stewart, April 23, 2018 Trial Transcript; Lance Pace, April 24, 2018 Trial Transcript.

Holman's Warden, Cynthia Stewart, testified regarding Mr. Thornton's movements into and out of crisis cells in the months preceding his death. Cynthia Stewart, April 23, 2018 Trial Tr. at 4:9-9:5. As his medical records indicate, he had previously attempted suicide by hanging in segregation at Holman on December 27, 2017. Pls. Ex. 1489, Billy Thornton Medical Records at ADOC0420855. He was moved to a crisis cell at Fountain for further observation. Pls. Ex. 1490, Billy Thornton Movement History at ADOC0420706. He was returned to segregation at Holman on January 3, 2018. *Id.* at ADOC0420705. Warden Stewart testified that she had no knowledge of Mr. Thornton's previous suicide attempt at the time of its occurrence. Cynthia Stewart, April 23, 2018 Trial Tr. at 7:6-20, 15:16-17:21. Nor did she learn about it in her review of his completed suicide in March. *Id.* at 9:14-

12:14. Mr. Thornton was again placed on Mental Health Observation on February 22, 2018 at Fountain, before being returned to Holman on February 23. Pls. Ex. 1490, Billy Thornton Movement History at ADOC0420705.

Notably, Warden Stewart testified that Mr. Thornton was not placed on Acute Suicide Watch following his December 2017 suicide attempt. Cynthia Stewart, April 23, 2018 Trial Tr. at at 24:10-25:1. Instead, he was placed on Mental Health Observation in violation of the Parties' Interim Order on Suicide Prevention, which specifies that a person engaging in self-injurious behavior must be placed on Acute Suicide Watch with constant watch precautions. *Id.* at 24:10-28:22; *see* Doc. 1106-1, (Interim Agreement Regarding Suicide Prevention Measures) at 1-2. Persons on Mental Health Observation are not subject to constant watch procedures, and their status is not reported to the Court or the Plaintiffs under the Interim Order. Doc. 1106-1, Interim Agreement Regarding Suicide Prevention Measures at 4-5 (indicating that ADOC must provide monthly reports to the Court and Plaintiffs' counsel regarding persons on suicide watch who are acutely or nonacutely suicidal.). Moreover, Mental Health Observation logs for Mr. Thornton's time at Fountain did not reflect staggered intervals and showed periods where observers did not fill in their initials or any activity code, suggesting possible log falsification. Cynthia Stewart, April 23, 2018 Trial Tr., at 36:9-44:4.

Billy Thornton's medical records also indicate that he did not receive mental health follow-ups. His records indicate that he was only seen by mental health one time between being released from Mental Health Observation on January 3, 2018 and returning to a crisis cell at Fountain on February 22. *See generally* Pls. Ex. 1489,

Billy Thornton Medical Records; Cynthia Stewart, April 23, 2018 Trial Tr., at 50:1-52:19. There is no indication of a mental health follow up between his release from crisis on February 23 and his suicide on February 26. *Id.* at 56:17-57:8.

Excluding his two stays on Mental Health Observation, Billy Thornton was in segregation from November 21, 2017 until his hanging on February 26, or roughly 87 days in addition to his time on Mental Health Observation.[5] Mr. Thornton was on the mental health caseload and identified by mental health staff as being MH-2, the mental health code indicating a Serious Mental Illness. Pls. Ex. 1489, Billy Thornton Medical Records at ADOC0420757. He was variously diagnosed with unspecified depression with paranoid symptoms and auditory hallucinations. *Id.* at ADOC0420742, ADOC0420748. He was prescribed Remeron, an antidepressant medication, and had been given injections of Haldol, an anti-psychotic medication. *Id* at ADOC0420766.

B. Paul Ford[6]

Paul Ford committed suicide by hanging in a segregation cell at Kilby Correctional Facility on January 16, 2019. Ex. 16 (Jan. 17, 2019 ADOC News Release). During her April 23, 2018 testimony at the remedial trial on segregation, Warden of Holman Correctional Facility Cynthia Stewart testified to her knowledge of Mr. Ford's prior suicide attempt at Holman in segregation in early April. Cynthia

[5] There were 97 days between November 21, 2017 and February 26, 2018. Subtracting 8 days from December 27, 2017 to January 3, 2018, and the two days from February 22 to February 23, 2018, Billy Thornton spent approximately 87 days in segregation prior to his death.

[6] Mr. Ford testified before this Court in the hearing on the Motion to Unseal the Correctional Staffing Numbers by facility on October 24, 2018. Paul Ford, Oct. 24, 2018 R.D. Trial Tr.

Stewart, April 23, 2018 Trial Transcript at 30:7-34:2. For the entire period between his April 3, 2018 suicide attempt and his completed suicide on January 16, 2019, Mr. Ford was housed either in restrictive housing or on some form of crisis watch. Ex. 12. His medical records indicate that he had a Mental Health Code of 2, indicating a serious mental illness. Pls. Ex. 1653 at ADOC0425877.

First Suicide Attempt

On April 3, 2018, Paul Ford attempted suicide in his segregation cell at Holman by setting the contents of the cell on fire and hanging himself. Pls. Ex. 1654 (Paul Ford Medical Records) at ADOC0435097-ADOC0435098, ADOC0435069. The noose broke, and Mr. Ford fell to the ground, hitting his head and losing consciousness. Ex. 17 (May 23 Declaration of Paul Ford). Mr. Ford was removed from his cell and taken to a local hospital where he was treated for smoke inhalation. Pls. Ex. 1654 at ADOC0435070. He returned to Holman and spent two days on suicide watch in one of the P-cells on death row. Pls. Ex. 1593 (April 2018 Suicide Watch Report) at PDF pg. 6; Ex. 17 (May 23, 2018 Declaration of Paul Ford). He was then returned to the same segregation cell where he had attempted suicide. Upon return to the cell, he noticed that it had not been cleaned, and that the noose was still hanging where he had tied it. *Id* at 2. Between his release from suicide watch on April 5 and the time he wrote a declaration on May 23, he was not seen out of his cell for any mental health contacts such as a suicide watch follow-up. *See generally* Pls. Ex. 1654 (Paul Ford Medical Records); Ex. 17 (May 23, 2018 Declaration of Paul Ford) at 2.

Transfer to Donaldson and Kilby, time in O-Dorm

On July 30, 2018, Mr. Ford was placed on acute suicide watch at Holman after being found with a noose hanging in his cell and his head bleeding. Pls. Ex. 1654 at ADOC0435082. The same day, he was given injections of Haldol and Benadryl and transferred to Donaldson Correctional Facility, where his status was reduced to Non-Acute Suicide Watch. *Id* at ADOC0435081, Pls. Ex. 1596, July 2018 Suicide Watch Report at 4, 7. He was eventually transferred to Kilby, where he was placed in segregation on August 9, 2018. Ex. 18 (Aug. 14, 2018 Restrictive Housing Report) at ADOC0423737. Restrictive Housing Reports from August 14 indicate that his Mental Health Code was 2, indicating a serious mental illness. *Id.*

On or about August 23, Plaintiffs' counsel was informed that Mr. Ford was on Mental Health Observation status in O-dorm (a unit typically used for crisis placement) and could not, therefore, attend a legal visit. Ex. 4 (ADOC Emails re: Paul Ford) at 2-3. ADOC counsel later confirmed in an email to Plaintiffs that Mr. Ford was under Mental Health Observation and thus unavailable for a visit. *Id* at 1. However, Plaintiffs' counsel later learned that while Mr. Ford had been in O-dorm during the period in question, he was not under Mental Health Observation or any other form of crisis placement. *Id.* Mr. Ford returned to segregation on September 20, 2018. Ex. 19 (9.25.18 Restrictive Housing Report) at ADOC0439738. The Restrictive Housing Report produced by Defendants for September 25, 2018 indicates that his Mental Health Code was changed to 1. *Id.*

Mr. Ford does not appear in the crisis cell utilization logs from Kilby for August or for September. Ex. 20 (Aug. 2018 Crisis Cell Utilization Logs) at SPA_0156-SPA_0167; Ex. 21 (Sept. 2018 Crisis Cell Utilization Logs) at SPA_0473-

SPA_0481.

Motion to Unseal Hearing Testimony and Subsequent Suicide Watch Placement

On October 24, 2018, Mr. Ford testified in a hearing on Plaintiffs' Motion to Unseal the Correctional Staffing Reports. Mr. Ford testified to his knowledge of staffing levels and patterns at the facilities where he had been housed. In particular, he testified that while in segregation at Holman, the facility was so understaffed that officers would frequently offer persons in segregation a cigarette if they would agree not to take a shower. Paul Ford, Oct. 24, 2018 R.D. Trial Tr., 23:24-24:18.

Mr. Ford remained in segregation at Kilby until December 12, 2018. On December 12, Mr. Ford engaged in self-harm, which required medical treatment, and ended up back on suicide watch. Ex. 25, Dec. 1-15 Kilby Suicide Watch Logs, at PDF 31. He stayed on crisis watch in O-dorm until December 21, when he was returned to segregation. Ex. 11 (12.25.18 Restrictive Housing Roster). Mr. Ford remained in segregation until his death on January 16, 2019. Ex. 12 (1.15.19 Restrictive Housing Roster) at ADOC0462432; Ex. 17 (Jan. 17, 2019 ADOC News Release).

In sum, Mr. Ford was in some form of restrictive housing from December 5, 2017 until his death on January 16, 2019, notwithstanding the three periods of time he spent on suicide watch and the period of approximately one month between August and September when he was housed in O-dorm. Ex. 23 (4.2.18 Restrictive Housing Roster) at ADOC0420499; Ex. 12 (1.15.19 Restrictive Housing Roster) at ADOC0462432.

Mental Health Decompensation

Mr. Ford was not on the mental health caseload at the time of his first suicide attempt in April 2018. Pls. Ex. 1654 (Paul Ford Medical Records) at ADOC0435104. After that attempt, he was discharged from suicide watch directly back to segregation. By the time of his second suicide attempt, in late July 2018, he had been in segregation for 234 days.[7] He was prescribed Remeron, an antidepressant, Risperdal, an anti-psychotic, and was given injections of Haldol, another anti-psychotic. *Id.* at ADOC0435081. He was put on the mental health caseload with a mental health code indicating a serious mental illness. *Id.* He was diagnosed with a mood disorder, and a psychiatrist considered the possibility that he had Major Depressive Disorder, a categorical serious mental illness. *Id.* at ADOC0435025, ADOC0435075. Nevertheless, during his initial segregation placement screening at Kilby, a licensed Mental Health Practitioner indicated that he did not have an SMI flag; that he had no history of suicide attempts or behavior; and that he required no mental health referral or removal from segregation. Pls. Ex. 1653(Paul Ford Medical Records) at ADOC0425884-ADOC0425885. He remained in a restrictive housing setting from August 9, 2018, until his death on January 16, 2019, a period of 160 days.[8] The tragic trajectory of Mr. Ford's final months underscores the dire threat of serious harm that isolation poses even to people not previously identified as being mentally ill.

LEGAL STANDARD

[7] Ex. 23, (4.2.18 Restrictive Housing Roster) notes that he was placed in segregation on December 5, 2017. There are 237 days between December 5, 2017 and July 30, 2018. He was on suicide watch for three days in April.

[8] This includes his time in O-dorm, which has been acknowledged by the court to be a segregation-like setting.

To obtain a temporary restraining order or preliminary injunction, the moving party must show: (1) a substantial likelihood of success on the merits; (2) that it will suffer irreparable injury unless the injunction is issued; (3) that the threatened injury outweighs possible harm that the injunction may cause the opposing party; and (4) that the injunction would not disserve the public interest. *GeorgiaCarry.Org, Inc. v. U.S. Army Corps of Engineers*, 788 F.3d 1318, 1322 (11th Cir. 2015). If a temporary restraining order is sought, the moving party must also show that immediate and irreparable injury will result before the adverse party can be heard in opposition. *See* Fed. R. Civ. P. 65(b)(1)(A).

ARGUMENT

I. PLAINTIFFS HAVE ALREADY PREVAILED ON THE MERITS OF THEIR CLAIM THAT DEFENDANTS ARE DELIBERATELY INDIFFERENT TO SERIOUS RISKS CREATED BY THEIR SEGREGATION PRACTICES AND WILL SHOW THAT DEFENDANTS REMAIN DELIBERATELY INDIFFERENT AND IMMEDIATE RELIEF IS NECESSARY

The Eighth Amendment requires that prison officials adequately meet the serious mental health needs of prisoners. *See Rogers v. Evans*, 792 F.2d 1052, 1058 (11th Cir. 1986). It also requires that officials "take reasonable measures to guarantee the safety of the inmates." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (internal quotations omitted). Officials violate the Eighth Amendment when they are deliberately indifferent to prisoners' risk of self-inflicted injuries, including suicide. *Waldrop v. Evans*, 871 F.2d 1030, 1036 (11th Cir. 1989); *Edwards v. Gilbert*, 867 F.2d 1271, 1274–75 (11th Cir. 1989). Prison officials violate the

Eighth Amendment when they are deliberately indifferent to a substantial risk to prisoner safety. *Farmer*, 511 U.S. at 834.

Deliberate indifference "entails something more than mere negligence," but "the cases are also clear that it is satisfied by something less than acts or omissions for the very purpose of causing harm or with knowledge that harm will result." *Id.* at 835. Where officials have actual knowledge that prisoners are at substantial risk of serious harm, but "disregard[] that known risk by failing to respond to it in an (objectively) reasonable manner," they violate the Eighth Amendment. *Rodriguez v. Sec'y for Dep't of Corr.*, 508 F.3d 611, 617 (11th Cir. 2007); *see also Farmer*, 511 U.S. at 836 ("It is, indeed, fair to say that acting or failing to act with deliberate indifference to a substantial risk of serious harm to a prisoner is the equivalent of recklessly disregarding that risk.").

The Court has already found Defendants to be deliberately indifferent to serious risks of prisoner suicide and self-harm, in part through its segregation and suicide prevention practices. *Braggs*, 257 F. Supp. 3d at 1218-31, 1244-67. In the Liability Opinion, the Court found, "The skyrocketing number of suicides within ADOC, the majority of which occurred in segregation, reflects the combined effect of the lack of screening, monitoring, and treatment in segregation units and the dangerous conditions in segregation cells." *Id.* at 1245. The Court, relying on both Plaintiffs' and Defendants' security experts, found that correctional officers do not conduct the necessary 30-minute rounds in segregation. *Id.* at 1244-45. This problem that is made even more dangerous by the fact that segregation cells in ADOC are not suicide-resistant. *Id.*

The Court found that prisoners with serious mental-health needs are overrepresented in ADOC segregation. *Id.* at 1242. The Court concluded "that it is categorically inappropriate to place prisoners with serious mental illness in segregation absent extenuating circumstances." *Id.* at 1247.

The Court also found that the "follow-up care provided to many prisoners upon their release form suicide watch at ADOC is woefully inadequate." *Id.* at 1231. The Court noted that Plaintiffs' experts Drs. Haney and Burns had "identified a pattern of cycling between crisis cells and segregation with little follow-up treatment after crisis-cell release." *Id.*

Plaintiffs will show that Defendants remain deliberately indifferent to the risk of suicide and self-harm posed by segregation. Segregation cells in ADOC still have tie-off points, and correctional officers are not adequately monitoring the units. Nine people in ADOC have committed suicide in segregation or segregation-like settings in the last year. *See* Ex. 12 (Suicides in ADOC from Dec. 2017 to Jan. 2019). Plaintiffs have been able to confirm that at least eight of those individuals hanged themselves in their segregation cells.[9] *Id.*

Moreover, prisoners with serious mental-health needs remain overrepresented in ADOC segregation. *See* Ex. 13 (Prisoners with Mental Illness in Segregation 2012-2018). And, though the Court declared it to be categorically inappropriate, Defendants continue to place people with serious mental illness in segregation. *See* Ex. 6 (9.18.18 Restrictive Housing Roster); Ex. 7 (11.20.18 Restrictive Housing Roster); Ex. 11 (12.21.18 Segregation List); Ex. 22 (1.15.19

[9] Plaintiffs have received no documentation from ADOC indicating the method by which Mark Araujo committed suicide.

Restrictive Housing Roster); Ex. 12 (Suicides in ADOC from Dec. 2017 to Jan. 2019); *see also* Ex. 14 (Repeated Crisis Placements and Discharges to Segregation).

Many prisoners with serious mental-health needs cycle back and forth between crisis placements and segregation. *See* Ex. 12 (Suicides in ADOC from Dec. 2017 to Jan. 2019); Ex. 14 (Repeated Crisis Placements and Discharges to Segregation). And Defendants still are not providing the necessary follow-up treatment to individuals discharged from crisis placements. *See* Ex. 12 (Suicides in ADOC from Dec. 2017 to Jan. 2019); Ex. 14 (Repeated Crisis Placements and Discharges to Segregation); Dr. Kathryn Burns, Dec. 6, 2018 Trial Tr., at 135:4-16, 140:8-9, 141:11-12, 145:10-12, 147:8-10, 156:10-12 (identifying instances in which prisoners did not receive the follow-up appointments required by the Court's Interim Suicide Prevention Order); Pls. Dem. Ex. 200 (Status of Current Remedial Order Compliance as Shown by 50 Mental Health Records from July 1, 2018 through end of October 2018).

Plaintiffs will show that Defendants remain deliberately indifferent and that immediate relief is necessary to prevent serious harm or death to prisoners with serious mental-health needs.

II. DEFENDANTS' FAILURE TO ADEQUATELY ADDRESS THE RISKS RESULTING FROM THEIR SEGREGATION PRACTICES CREATES A SUBSTANTIAL THREAT OF IRREPARABLE INJURY

The injury at issue in this Motion – suicide – is patently imminent and irreparable. It happened before, notably in Plaintiff Jamie Wallace's case. It has continued to happen – twelve times since December 30, 2017 – and will likely

happen again soon unless this Court intervenes. Defendants' failure to adequately address the risks relating to segregation practices in ADOC puts prisoners at immediate and substantial risk of suicide and serious self-harm.

As set forth above, Defendants' conduct and knowing failure to act constitutes an ongoing violation of their constitutional duty to adequately protect the safety of the men and women in their custody. An ongoing constitutional violation also constitutes irreparable harm in and of itself. *See Laube v. Haley*, 234 F. Supp. 2d 1227, 1251 (M.D. Ala. 2002) ("The existence of a continuing constitutional violation constitutes proof of an irreparable harm . . . .") (quoting *Preston v. Thompson*, 589 F.2d 300, 303 n. 3 (7th Cir.1978)).

III. THE THREATENED INJURY TO VULNERABLE PRISONERS SIGNIFICANTLY OUTWEIGHS THE HARM OF ISSUING AN INJUNCTION AGAINST DEFENDANTS

The Court has already found that the practices discussed herein create a substantial risk that prisoners will decompensate and that some will commit suicide. In the last 13 months, twelve people have died by suicide. In the last two months alone, five people have killed themselves in ADOC custody. Weighed against any administrative difficulties Defendants may incur, this actual and threatened harm to prisoners necessitates injunctive relief. *Laube*, 234 F. Supp. at 1252 (finding that the defendants would "suffer no harm from providing sufficient staff and adequate facilities to reduce the risk of assault and harm to women prisoners"); *see also Ancata v. Prison Health Servs., Inc.*, 769 F.2d 700, 705 (11th Cir. 1985) ("Lack of funds for facilities cannot justify an unconstitutional lack of competent medical care and treatment for inmates."). Leading up to the liability

trial, and in the year and a half since the Court issued the Liability Opinion, Defendants have failed their constitutional duty to adequately address the risks arising from their segregation practices. The Court must not allow Defendants' unconstitutional practices to continue any longer.

IV. A RESTRAINING ORDER OR PRELIMINARY INJUNCTION WOULD BE IN THE PUBLIC INTEREST

The public has a substantial interest in preventing the preventable deaths of prisoners and safeguarding the rights afforded under the Constitution. *Laube*, 234 F. Supp. at 1252 ("[T]here is a strong public interest in requiring that plaintiffs' constitutional rights no longer be violated, as well as in prevention of the foreseeable violence that will occur if present conditions persist."). Defendants have disregarded their constitutional obligation to address the risks of their segregation practices and protect suicidal prisoners. The public would be served by an injunction requiring them to adhere to their constitutional duty.

V. PLAINTIFFS SHOULD NOT BE REQUIRED TO POST BOND UNDER FED. R. CIV. P. 65(C)

The Court should require no security or nominal security under Fed. R. Civ. P. 65(c), as Plaintiffs and class members are prisoners seeking compliance with their basic civil rights and injunctive relief to prevent further death and serious injury. *See BellSouth Telecomm., Inc. v. MCIMetro Access Transmission Servs., LLC*, 425 F.3d 964, 971 (11th Cir. 2005) ("[I]t is well-established that the amount of security required by the rule is a matter within the discretion of the trial court, and the court may elect to require no security at all.") (quotations and ellipses omitted); *Complete Angler, LLC v. City of Clearwater, Fla.*, 607 F. Supp. 2d 1326,

1335 (M.D. Fla. 2009) ("Waiving the bond requirement is particularly appropriate where a plaintiff alleges the infringement of a fundamental constitutional right."); *see also All States Humane Game Fowl Org., Inc. v. City of Jacksonville, Fla.*, No. 308-CV-312-J-33MCR, 2008 WL 2949442, at *13 (M.D. Fla. July 29, 2008) ("Plaintiffs bring a constitutional law complaint and allege infringement of fundamental rights. The action that they fear, permanent destruction of their roosters, is a considerable loss to face. The Court finds it appropriate to waive the bond requirement in this case.").

RELIEF REQUEST

Specifically, Plaintiffs seek an order restraining and enjoining Defendants Jefferson Dunn and Ruth Naglich, in their official capacities, and their officers, agents, servants, employees, attorneys, and persons who are in active concert or participation with them from failing and/or refusing to do the following:[10]

Until the Court has entered remedial orders regarding suicide prevention and segregation, and such orders are shown to have been fully implemented:

1) Defendants shall not house any individual who has had an SMI Flag in the last year in segregation;

2) For any person who meets any of the following criteria:

a) Has had a mental health code of MH-2 within the last year;

b) Has been on any kind of crisis placement (suicide watch or

[10] Plaintiffs have consulted with their psychiatric expert, Dr. Kathryn Burns, regarding the specific details of the immediate relief they seek. She is prepared to provide further testimony to the Court if necessary as to the appropriateness and necessity of the relief Plaintiffs seek.

mental health observation) for a total of ten days within the last month;

c) Has been on any kind of crisis placement (suicide watch or mental health observation) for at least two periods of five days within the last six months;

Defendants shall not house the person in segregation. Moreover, regardless of where such persons are housed, they shall have at least two hours out-of-cell unstructured time per day, every day, and one out-of-cell, confidential clinical encounter with their counselor every week during the duration of the period the person is in a restrictive, celled environment.

3) Defendants shall not release any person from any kind of crisis placement (suicide watch or mental health observation) to segregation. There shall be at least ten (10) calendar days between release from the crisis placement and placement in segregation.

4) Defendants shall conduct and document security rounds in every segregation unit and every unit in which persons are kept in cells 22.5 hours or more per day. Security rounds shall be done at least every 30 minutes, on a staggered basis.

CONCLUSION

For the foregoing reasons, Plaintiffs respectfully request that this Court enter a temporary restraining order or preliminary injunction as set forth in this Motion.

Dated: January 18, 2019 Respectfully Submitted,

/s/ Maria V. Morris

Maria V. Morris
One of the Attorneys for Plaintiffs
Southern Poverty Law Center
400 Washington Avenue
Montgomery, AL 36104

Rhonda Brownstein (ASB-3193-O64R)
Maria V. Morris (ASB-2198-R64M)
Grace Graham (ASB-3040-A64G)
Jonathan Blocker (ASB-6818-G19I)
Caitlin J. Sandley (ASB-5317-S48R)
David Clay Washington (ASB-6599-Y42I)
SOUTHERN POVERTY LAW CENTER
400 Washington Avenue
Montgomery, AL 36104
Telephone: (334) 956-8200
Facsimile: (334) 956-8481
rhonda.brownstein@splcenter.org
maria.morris@splcenter.org
grace.graham@splcenter.org
jonathan.blocker@splcenter.org
cj.sandley@splcenter.org
david.washington@splcenter.org

Lisa W. Borden (ASB-5673-D57L)
William G. Somerville, III (ASB-6185-E63W)
Andrew P. Walsh (ASB-3755-W77W)
Dennis Nabors
Patricia Clotfelter (ASB-0841-F43P)
BAKER, DONELSON, BEARMAN,
CALDWELL & BERKOWITZ PC
420 20th Street North, Suite 1400
Birmingham, AL 35203
lborden@bakerdonelson.com
wsomerville@bakerdonelson.com
awalsh@bakerdonelson.com
dnabors@bakerdonelson.com
pclotfelter@bakerdonelson.com

/s/ Anil A. Mujumdar
Anil A. Mujumdar (ASB-2004-L65M)
One of the Attorneys for Plaintiffs
Alabama Disabilities Advocacy Program
2332 2nd Avenue North
Birmingham, AL 35203

Gregory M. Zarzaur, Esq. (ASB-0759-E45Z)
Anil A. Mujumdar, Esq. (ASB-2004-L65M)
Diandra S. Debrosse, Esq. (ASB-2956-N76D)
Denise Wiginton, Esq. (ASB-5905-D27W)
ZARZAUR MUJUMDAR & DEBROSSE
2332 2nd Avenue North
Birmingham, AL 35203
Telephone: (205) 983-7985
Facsimile: (888) 505-0523
gregory@zarzaur.com
anil@zarzaur.com
fuli@zarzaur.com
denise@zarzaur.com

William Van Der Pol, Jr., Esq. (ASB-2112-114F)
Glenn N. Baxter, Esq. (ASB-3825-A41G)
Lonnie Williams, Esq.
Barbara A. Lawrence, Esq.
Andrea J. Mixson, Esq.
Ashley N. Austin, Esq. (ASB-1059-F69L)
ALABAMA DISABILITIES
ADVOCACY PROGRAM
Box 870395
Tuscaloosa, AL 35487
Telephone: (205) 348-4928
Facsimile: (205) 348-3909
wvanderpoljur@adap.ua.edu
gnbaxter@adap.ua.edu
lwilliams@aadap.ua.edu
blawrence@adap.ua.edu
amixson@adap.ua.edu
aaustin@adap.ua.edu

ATTORNEYS FOR THE PLAINTIFFS

CERTIFICATE OF SERVICE

I hereby certify that I have on this 18th day of January, 2019 electronically filed the foregoing with the clerk of court by using the CM/ECF system, which will send a notice of electronic filing to the following:

David R. Boyd, Esq.
John G. Smith, Esq.
John W. Naramore, Esq.
Balch & Bingham LLP
Post Office Box 78
Montgomery, AL 36101-0078
dboyd@balch.com
jgsmith@balch.com
jnaramore@balch.com

Steven C. Corhern, Esq.
Balch & Bingham LLP
Post Office Box 306
Birmingham, AL 35201-0306
scorhern@balch.com

Joseph G. Stewart, Jr., Esq.
Gary L. Willford, Jr., Esq.
Alabama Department
Of Corrections
Legal Division
301 South Ripley Street
Montgomery, AL 36104
joseph.stewart@doc.alabama.gov
gary.willford@doc.alabama.gov

Philip Piggott, Esq.
Starnes Davis Florie LLP
100 Brookwood Place – 7th Floor
Birmingham, AL 35209
ppiggott@starneslaw.com

William R. Lunsford, Esq.
Matthew Reeves, Esq.
Melissa K. Marler, Esq.
Stephen C. Rogers, Esq.
Alyson L. Smith, Esq.
Melissa C. Neri, Esq.
Maynard, Cooper & Gale, P.C.
655 Gallatin Street, SW
Huntsville, AL 35801
blunsford@maynardcooper.com
mreeves@maynardcooper.com
mmarler@maynardcooper.com
srogers@maynardcooper.com
asmith@maynardcooper.com
mneri@maynardcooper.com

Luther M. Dorr, Jr., Esq.
Maynard, Cooper & Gale, P.C.
1901 6th Avenue North, Suite 2400
Birmingham, AL 35203
rdorr@maynardcooper.com

Deana Johnson, Esq.
Brett T. Lane, Esq.
MHM Services, Inc.
1447 Peachtree Street, N.E., Suite 500
Atlanta, GA 30309
djohnson@mhm-services.com
btlane@mhm-services.com

/s/ Maria V. Morris
One of the Attorneys for Plaintiffs