United States Virgin Islands

# GOLDEN GROVE
# ADULT CORRECTIONAL FACILITY

## *TENTH COMPLIANCE MONITORING REPORT*
**AMDENDED 03/07/2016**

**2013 Federal Court Settlement Agreement**
**In re: United States of America v. The Territory of the Virgin Islands (86/265)**

**Submitted February 21, 2016**

**Kenneth A. Ray, M.Ed., Monitor**
**Ronald M. Shansky, MD Medical Expert**
**Manual D. Romero, Operations Expert**
**Richard G. Dudley, Jr. MD, Mental Health Expert**

Kenneth A. Ray
JUSTICE SERVICES
*"Assess, Analyze, Actualize"*
PO Box 1481 Ashland, KY 41105-1481 Phone: 606-694-3031

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## PURPOSE

The Monitor intends this report to serve three primary goals: 1) assess, measure, and determine progress toward partial and substantial compliance with all provisions of the Settlement Agreement; 2) assess compliance progress relative to previous assessments; and 3) assist U.S. Virgin Island officials in developing action plans to systematically develop, prioritize, implement, and evaluate policies, procedures, and administrative and operational changes and improvements that ensure consistent substantial compliance with the Agreement and the provision of constitutional care and custody of prisoners incarcerated at the Golden Grove Adult Correctional Facility & Detention Center, St. Croix, Virgin Islands.

## EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

The this onsite compliance monitoring assessment was conducted December 14-17, 2015 and included a focused and productive Court status conference was held on Wednesday, December 16, 2015. Prior to this site visit, the Monitor coordinated communication between the parties and monitoring team in preparation for the onsite assessment.

This Settlement Agreement contains six (6) Sections. Each section contains a number of specific and measureable compliance requirements (Provisions). Combined, these six sections contain 130 provisions; 120 of these represent five (5) primary substantive sections while ten (10) provisions are contained within only one section, Section X. Implementation.

Each provision of this Agreement was evaluated using defined standards stated in Section G. Compliance Assessments. This assessment followed the required protocols and evaluated each provision according to the three standards stated below from the Agreement:

> *"In his or her reports, the Monitor will evaluate the status of compliance for each relevant provision of the Agreement using the following standards: (1) Substantial Compliance; (2) partial compliance, and (3) noncompliance. In order to assess compliance, the Monitor will review a sufficient number of pertinent documents to accurately assess current conditions; interview all necessary staff; and interview a sufficient number of prisoners to accurately assess current conditions. The Monitor will be responsible for independently verifying representations from Defendants regarding progress toward compliance and for examining supporting documentation, where applicable. Each Monitor's report will describe the steps taken to analyze conditions and assess compliance, including documents reviewed, individuals interviewed, and the factual basis for each of the Monitor's findings."*

Each provision was evaluated and rated with regard to 1) policy and procedure formulation and 2) implementation. The Monitor and monitoring experts provided recommendations for each provision found not in compliance with the Agreement. A draft assessment report was provided to the Parties for review and comment as required, and reasonable consideration was given to those comments in completing this final report.

The Monitor advances each Provision once substantive progress is clearly demonstrated by the Territory:

1. policies, procedures, protocols, and/or plans required of a provision are properly approved in accordance with this Agreement;
2. the above documents are promulgated and staff are adequately trained on those documents and related performance expectations; and,
3. those documents are adequately and effectively implemented. Implementation includes evaluation demonstrating that implemented policies, procedures, and training are measurably performing within the outcome expectations of this Agreement.

A Provision advances from noncompliance to partial compliance when 1) required policies and procedures for the Provision are approved by the Monitor, United States, and the Territory, 2) when 95% of staff required to be trained on the policies and procedures have done so with a minimum passing score of 80%, 3) the policies and procedures are fully implemented, and 4) the Territory objectively and measurably demonstrates implementation effectiveness. A Provision advances from partial to substantial compliance when continued valid and reliable evaluation of implemented policies, procedures, protocols, plans, etc. clearly justifies advancement. Justification is based on quantitatively and/or qualitatively evidence: 1) that implementation efforts are producing measurable outcomes intended in the Agreement, and 2) that outcome performance is valid and reliable (performance evaluations are likely to produce consistent and sustainable compliance.). The entire Agreement is eligible for termination once all provisions have reached and maintained substantial compliance for a minimum of 12 consecutive months. Although this Monitor will not withhold substantial compliance rating where advancement is adequately demonstrated using appropriate compliance evaluation methods and measures, this Monitor will and has reversed a compliance rating when the evidence supports doing so.

Some Provisions overlap. For example, many medical, mental health, and suicide prevention Provisions involve independent compliance assessment and scoring by both of the Monitor's medical and mental health experts. Such Provisions are advanced to the next level when both experts advance the Provision. The Provision, however, remains at the lowest compliance score when the experts' scores differ.

During the December site visit, the Monitor spent a significant amount of time with the Territory and United States revising the Territory's draft security policies. Accordingly, some areas below were not assessed during the December site visit, but will be assessed during the March site visit.

**ASSESSMENT FINDINGS OVERVIEW:**

Ten (10 / 28%) of 36 Medical/Mental Health Provisions advanced from NONCOMPLIANCE to PARTIAL COMPLIANCE. This assessment determined the Territory has accomplished

requisite completion of policies and procedures, staff training, and implementation of these Provisions:

| | |
|---|---|
| V | 1. a. Adequate intake screenings for serious medical and mental health conditions, to be conducted by qualified medical and mental health staff; |
| V | 1. b. Comprehensive initial and/or follow-up assessments, conducted by qualified medical and mental health professionals within three days of admission |
| V | 1. e. Maintenance of adequate medical and mental health records, including records, results, and orders received from off-site consultations and treatment conducted while the prisoner or detainee is in Golden Grove custody; |
| V | 1. f. (i) adequate sick call procedures with timely medical triage and physician review along with the logging, tracking and timely responses to requests by qualified medical and mental health professionals |
| V | 1. f. (ii) an adequate means to track, care for and monitor prisoners identified with medical and mental health needs; |
| V | 1. f. (v) adequate and timely referral to specialty care |
| V | f. (vi) adequate follow-up care and treatment after return from referral for outside diagnosis or treatment |
| V | 1. (iii) timely suicide risk assessment instrument by a qualified mental-health professional within an appropriate time not to exceed 24 hours of prisoner being placed on suicide precautions |
| V | 1.s. (i) Mental health care and treatment, including: timely, current, and adequate treatment plan develop and implementation |
| V | 1.s. (iii) adequate psychotropic medication practices, including monitoring for side effects and informed consent |

Additionally, the Territory, United States, and Monitor continued to actively collaborate on final approval of all security and safety-related policies and procedures as directed by the Court. Some of these documents remain in various stages of final approval except for twelve that were approved on December 16, 2015 while onsite during this compliance assessment. The following policies and procedures required under this Agreement have been approved by the United States and the Monitor:

1. IV. A.1.c.-d., C.1.a-d: Supervision of Inmates/Detainees
2. IV.B.1.a., IV.B.1.b, IV.B.1.e.:Visitation
3. IV. B.1. a.-e.: Mail Policy
4. IV.D.1-2: Security Staffing Policies (not including Staffing Plan)
5. IV.E.1: PREA
6. IV.K.1: Administrative Investigations & Staff Discipline
7. VI.1.a-j: Fire & Life Safety Plan
8. VII.1.a-c, e, f, k: EHS Maintenance
9. VII.1.d: Pest Control
10. VII. 1.g. & i: Inmate Bedding & Clothing

11. VII.1.h: Chemical Control
12. VII. 1.j Food Service

The value of the collaborative process cannot be understated. Despite numerous deviations from the compliance Schedule, active collaboration has consistently demonstrated its utility in the completion and approval of several high-quality and contemporary medical, mental health, suicide prevention, safety and security policies and procedures. The process has proven instrumentally beneficial in achieving measurable progress with certain training requirements, resolving disputes, and reaching mutually amical clarification of performance expectations when appropriate.

There are now 19 Provisions in Partial Compliance, 101 in Non-Compliance, and none in Substantial Compliance. Except for the ten (10) health care Provisions that advanced to Partial Compliance, all Provisions retain compliance ratings reporting in the 9th Compliance Report. The updated scorecard below quantifies compliance as of this assessment:

**GGACF 10th Compliance Scorecard**

| Areas of Compliance Per Agreement | Total Provisions | Non Compliance | Partial Compliance | Substantial Compliance |
|---|---|---|---|---|
| IV. Safety and Security | 59 | 56 | 3 | 0 |
| V. Medical, Mental Health Suicide Prevention | 36 | 26 | 10 | 0 |
| VI. Fire and Life Safety | 10 | 10 | 0 | 0 |
| VII. Environmental Health and Safety | 11 | 5 | 6 | 0 |
| VIII. Training | 4 | 4 | 0 | 0 |
| Total Substantive Provisions | 120 | 101 | 19 | 0 |
| Percent Compliance | 100% | 84% | 16% | 0% |

Provisions that failed to advance do so for the following reasons:

- All security and safety-related policies, procedures, and Staffing Plan are not approved;
- Security supervisor and officer staffing levels remain inadequate to reliably protect prisoners and staff from real and potential violence and harm.
- Security supervisor levels are insufficient to ensure consistent and routine oversight and supervision of staff and housing unit operations.
- Dangerous and nuisance contraband levels remain very high throughout housing units enabling prisoners the ability to violently and seriously harm others.
- Prisoner disciplinary practices are inconsistent and continue to impose disparate and excessive punishments.
- Prisoners with serious mental illness continue to remain in solitary confinement statuses with little or no out-of-cell time. Segregation review documentation remains unable to adequately demonstrate the existence of a meaningful and consistent review process.
- The prisoner classification system has not been validated.
- The fire safety/suppression system remains inoperable.

- A qualified training program does not exist to adequately train staff in the full implementation of this Agreement.
- The incident reporting system, as well as most documentation process, continues to lack a quality management process to reliably record and track incidents.
- The inmate complaint system (grievance process) remains untimely, disorganized, and inadequately documented to clearly demonstrate prisoners have reliable access to a meaningful compliant resolution mechanism.
- The administrative investigation process remains under-development but has not yet demonstrated requisite progress to advance.
- Reported PREA-related complaints by prisoners are not investigated consistently and resolved in a timely manner according to PREA requirements.
- Food services program capital improvements have not been completed.
- Facility hygiene and sanitation conditions remain deficient.

**Serious Security Breaches Evidencing Continued Noncompliance, Real and Potential Harm to GGACF Staff, Civilians, and the Community**

Serious security breaches within GGACF continue to occur and seem unfettered by management efforts to improve security practices. Both of the incidents discussed here strongly support justification that several Provisions of this Agreement are not showing compliance progress. The incidents highlight the chronic risks and dangers of inadequate staffing, excessive use of overtime, lax security practices, and staff noncompliance with standard security policies, inmate classification, and contraband control. Additionally, the lack of timeliness in administrative investigations following an incident is troubling. Both of these incidents were easily preventable if basic security practices were followed consistently and proper staff supervision and training maintained.

Incident 1: On 10/20/15 at approximately 0200 hours, an inmate being held in unit 9C escaped from the facility and was captured in the community at approximately 1000 hours the same day. The escape was discovered at approximately 0745 hours and confirmed at approximately 0819 hours. The inmate had not been noticed missing from his cell for approximately six (6) hours. The investigation report completed by VIBOC on December 24, 2015 states that the escape resulted from several security management breakdowns, before and during the actual incident. The second incident described hereafter evidences continued security management failures involving the same inmate, even after this incident.

According to the investigation report and my review of Shift Rosters for 10/18-20/15, the officer assigned to 9C had worked approximately 12 hours preceding the incident and another 8 hours from 1351 to 2201 hours on 10/18. It is quite likely that this officer was mentally fatigued before starting the second consecutive 8-hr. shift on 10/19/15.

The investigation report states that the inmate opened his unsecured cell door at approximately 0200 hours on 10/20/15. The cell door was reportedly previously opened at approximately 2000 hours on 10/19/15 to provide water to inmates. The report states the inmate exited his cell at about 0200, walked down the upper tier stairway, crawled past the enclosed officer's station, untied the fence and slid through the inner security door. The inmate was able exit the outer security door at housing unit 9D, the adjacent housing unit. The inmate then climbed thru an internal fence opening and climbed onto the fenced walkway, and eventually escaped from the facility. The report states the inmate was wearing civilian clothing, which was also a contributing factor to the previous escape involving the alleged sexual assault of a community member.

According to the report, the inmates in 9C were secured in their respective cells (locked down) at approximately 1800 hours by the housing unit officer. At 2000 hours, the same officer unlocked cell doors to provide water to inmates and reportedly re-secured all of the doors. At approximately 2210, the officer involved was authorized to leave the housing unit for a break to return at 2300 hours. The officer reports making cell checks thereafter until 0545. However, during the officer's break, no cell checks were made.

The 10/20/15 escape investigation report states this prisoner escaped from 9C around 0200. However, the November monthly classification housing record, provided by the Territory, documents he was placed in disciplinary segregation (9A-11) on 06/20/15 with an 11/24/15 classification review that recommended no housing status change. The December 2015 classification housing record documents the same 9A housing location and placement date with a 12/23/15 review date and no status change. These records don't seem to comport with him being in 9C on 10/20/15, which is after his 6/20/15 placement in 9A and before both segregation reviews indicating he remained there until at least 12/23/15. An examination of classification housing records did not show this inmate on any segregation records for June through October 2015. The December 17, 2015 count sheet shows him in 9A lockdown, which seems consistent with the December 23 classification review record. However, his 12/23/15 review is a Segregation Review form, not a Classification Review. This record shows he was placed in 9A-13 on 10/20/15, following his escape, which is inconsistent with previous records showing a 06/20/15 placement. The January classification housing record does not show this inmate in a disciplinary or administrative segregation status. I is also possible the 10/20/15 segregation placement date was incorrectly recorded.

In brief, this incident demonstrates a collapse of physical and operational security management for the following reasons:

1. The prisoner was able to exit his secured cell door in plain sight and exit the 9C building and campus without begin detected. It is more likely than not that the inmate's cell door was not properly secured either due to 1) a faulty locking mechanism, 2) manipulation of the lock by the inmate, or 3) the officer failed to properly check the door during each welfare check of the inmates in 9C.

2. A basic welfare check involves actual visual observation and accounting of each prisoner each time the check is made. Proper welfare checks are intended to detect escape attempts and missing inmates. The inmate was not found missing until several hours following his escape.

3. Security gates and doors were easily opened and closed by the inmate without detection.

4. The inmate topped the fence and covered walkway and exited the facility campus without detection.

5. No provisions were required by supervisors during the officer's break to ensure welfare checks were conducted.

6. Inmates continue to be allowed to wear civilian clothing.

7. Housing unit security doors and gates continue to be left unlocked despite written directives by management to keep doors and gates secured.

8. Inadequate staffing levels force the use of excessive amounts of overtime while leaving housing units not staffed by officers.

9. All of the issues listed above have been reported in this Monitor's previous reports, but not adequately corrected.

10. Classification and housing records do not appear to be consistent based on an examination of several documents recording this inmate's housing placements.

Incident 2: On 12/15/15, during the Monitoring visit, the inmate in the above case was involved in another serious security management breakdown in the GGCF medical building. This inmate was left unsecured and unattended by a security officer to allegedly use the bathroom. However, the inmate entered an office, accosted and made physical contact with one of the United States DOJ attorneys. Fortunately, Dr. Dudley was in the same office and the inmate stopped. The attorney involved was very shaken by the incident.

In brief, this incident demonstrates a collapse of physical and operational security management for the following reasons:

1. An inmate with a recent history of escape was not properly secured with restraints while in the medical building.

2. A lack of adequate physical security barriers and locked doors facilitated the inmate's undetected access to inner officer areas.

3. Lax security practices allowed a high-risk inmate to move freely about the medical building without proper security escort and constant supervision.

4. A lone security officer assigned to the medical building is deleteriously insufficient to provide adequate control and supervision when prisoners are in the building for medical services.

**TENTH MONITORING REPORT**
**GOLDEN GROVE ADULT CORRECTIONAL FACILITY**
**UNDER DEPARTMENT OF JUSTICE AGREEMENT**

## IV. SAFETY AND SUPERVISION

As required by the Constitution, Defendants will take reasonable steps to protect prisoners from harm, including violence by other prisoners. While some danger is inherent in a jail setting, Defendants will implement appropriate measures to minimize these risks including development and implementation of facility-specific security and control-related policies, procedures, and practices that will provide a reasonably safe and secure environment for all prisoners and staff.

### A. Supervision

**1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies regarding supervision of prisoners. These policies will include measures necessary to prevent prisoners from being exposed to an unreasonable risk of harm by other prisoners or staff and must include the following:**

**a. Development of housing units of security levels appropriately stratified for the classification of the prisoners in the institution, see also Section IV.F. re: Classification and Housing of Prisoners;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Draft Classification policies and procedures that include housing unit stratification have not yet been approved. However, approval and implementation of required policies and procedures will improve the Territory's ability to ensure institutional, staff and inmate safety and security in the interim. This problem is caused in part from inadequate security staffing levels needed to operate housing units that were recently closed. Ironically, these facilities were closed to improve security staffing levels in housing units that remained occupied by prisoners. Several prisoners were transferred to the mainland under housing contracts with other correctional facilities. This allowed the Territory to redeploy security staff assigned to the closed housing units to prisoner-occupied facilities. This action does seem to have generally improved housing unit security staffing levels but concomitantly eliminated the Territory's ability to fully comply with the intended outcomes of this Provision.

Examination of housing unit count sheets and onsite housing unit tours demonstrate continued ineffectiveness of prisoner classification and stratification practices. General population housing units are forced to operate as segregation units. Some prisoners are required to remain in lockdown status only for lack of adequate housing capacity to keep separate certain prisoner classifications i.e. gangs, under-protection, etc. The Monitor understands the conundrum the

Territory faces to resolve this aspect of noncompliance. However, this problem, like inadequate staffing levels, will instrumentally impair gaining compliance with this Agreement until fully resolved. Adequate housing capacity is a basic function of effective and compliant prisoner classification and stratification practices. Adequate security staffing levels are necessary to ensure adequate housing capacity is properly staffing, prisoners monitored and supervised.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Attain approval for required policies and procedures.

2. Train staff on approved policies and procedures.

3. Implement policies and procedures.

4. Identify appropriate alternatives to implement and maintain compliant classification and housing stratification practices.

5. Increase staffing

6. Ensure adequate and routine monitoring of housing units by shift supervisors.

**b. Post orders and first-line supervision of corrections officers in each housing unit (at least one officer per unit) based on an assessment of staffing needs;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This draft policy has not been approved. Final Post Orders have not been disseminated for this Provision. Examination of Supervisor Logs, Housing Unit Logs and Shift Rosters continue to evidence continued non-compliance.

The daily shift rosters is the primary record used by this Monitor to assess compliance with this Provision. Rosters are to be submitted to the Monitor on a monthly basis. Officers' work assignments are recorded on these rosters. Submission rates are improving but remain noncompliant.

This Monitor studied these records for 1) completeness, 2) legibility, 3) consistency, and 4) accuracy to determine document reliability for assessing compliance. The Territory submitted shift roster sets to this Monitor for November thru December, 2015. Approximately 97% of shift rosters were submitted for November and December. Records are audited for each of the three 24/7 shifts to determine validity and reliability of compliance assessment determinations. The table below shows record submission compliance rates for November and December:

| Monthly Shift Rosters Sets Audit |
|---|

| Year / Month | 2015 | | |
|---|---|---|---|
| Shift Rosters | Nov | Dec | Score |
| 1st Shift ( 10p-6a) | 93% | 100% | 97% |
| 2nd Shift (6a-2p) | 97% | 100% | 98% |
| 3rd Shift ( 2p-10p) | 100% | 100% | 100% |
| Score | 97% | 100% | 98% |
| Over- Time Report | | | |
| 1st Shift ( 10p-6a) | 90% | 100% | 95% |
| 2nd Shift (6a-2p) | 97% | 100% | 98% |
| 3rd Shift ( 2p-10p) | 100% | 90% | 95% |
| Score | 96% | 97% | 96% |
| Supervisor Inspection Report | | | |
| 1st Shift ( 10p-6a) | 93% | 100% | 97% |
| 2nd Shift (6a-2p) | 97% | 97% | 97% |
| 3rd Shift ( 2p-10p) | 100% | 97% | 98% |
| Score | 97% | 98% | 97% |
| GGACF Score | 96% | 98% | 97% |

180 shift roster records were studied to measure compliance with this provision. Hand-count of officer housing unit assignments indicates one (1) officer was assigned to housing units at least 95% of all shifts for the 61 days (183 shifts) examined. These documents did record some shifts where two housing units were staffed with one (1) officer. Additional, officer duty times (on to off duty time) showed times when officers were late to work but this analysis was unable to determine whether other officers were held over to remain in the housing unit until their relief arrived.

Supervisor and housing log entries continue to evidence staff shortages and absence of supervision. Examples of staffing and housing unit supervision problems documented in the log books include:

1. 10/9/15, 0630hrs: Officer on duty documents that he/she is the only office on duty in 9A which is on lockdown and will not be entering the unit, but will continue to observe from the office. Another officer did not show until 0815 to assist with breakfast (9A Log Book pg. 84).

2. 10/15/15, 0620hrs: Officer documents that he/she is the only officer on duty in 9A when he/she arrived to work on the unit, and will monitor the Unit through the window and will not travel the Unit alone (9A Log Book, pg. 105).

3. 10/16/15, 0730hrs: officer documents that there is only one officer on duty in the lockdown unit. A second CO was present during breakfast but left after breakfast was served (9A Log Book, pg. 111).

4. 10/21/15, 0750hrs: An officer once again documents only one officer on duty in 9A, and will not be conducting ay floor movement until another officer reports to help (9A Log Book, pg. 129).
5. 10/21/15, 1052hrs: An officer documents that he/she did not have contact with SGT Graham who reported that a check was made on the dorm and all appeared to be normal (9A Log Book, pg. 129).

6. 10/30/15, 0840hrs: An officer documents that only one officer on duty, and therefore, will not be conducting showers or recreation until another CO arrives to assist. At 0922 GIST officers enter to perform dormitory check (9A Log Book, pg. 166).

This is totally unacceptable for both inmate and officer safety. Another example was noted in the log book for housing unit 9C whereby on October 25, 2015 an officer makes an entry indicating that due to shortage of staff the Lieutenant conducted a unit check via telephone. This is also an unacceptable method of supervision.

**NOTE ADDED 03/07/2016: One January 31, 2016, this Monitor requested in writing clarification about a November 11, 2015 Shift Overtime Report; the Monitor's emailed request to the Territory stating the following:**

> ***"Hi, Shari – this is request clarification about shift staff and request contract housing records***
>
> ***First, the November 11, 2015 2p-10p Overtime Verification Document has 23 names suggesting overtime was used for most posts virtually the entire shift. Can you clarify why so many regular shift staff didn't show up for work. Second, I am requesting copies of all current contracts for housing GGACF prisoners and monthly invoices since transferring prisoners off-island. Thank you. Ken"***

**The Territory responded to this request of the Monitor on 02/22/16 as follows:**

> ***"Good Day Mr. Ray,***
>
> ***In response to your February 4, 2016 inquiry about the 23 officers working overtime.***
>
> ***I spoke to Warden Trotter and she provided the below response to your inquiry.***
>
> ***Good Afternoon Bonnie,***

> ***Lt. Francis was the supervisor on November 11, 2015. Instead of noting the officers working overtime on shift, she annotated special assignments officers and their normal post if they were at the facility past their normal work hours. The ones highlighted on the Overtime Verification Sheet are the officers on special assignments who worked over on their post. On the roster itself, I noted in pink (the time) the officers who are assigned to 1400/2200 that worked on November 11, 2015. There were a total of 11 personnel working overtime for the 1400/2200 shift not 23. Two of them were supervisors, OIC Sheppard and Lt. Francis.***
>
> ***Note: I forgot to highlight Detention R&D and ACF as special assignments, but both officers were working overtime. I hope this helps. Please see the attachment below."***

**The Monitor's request above was made in good faith and with the specific intention of ensuring the accuracy of 10th Monitor Report. Overtime-use calculations in the first filing of the 10th Report were based on documents from the Territory representing shift staffing levels and use of overtime to supplement staffing shortages. This Monitor relied on the face value of the 11/11/2015 2pm-10pm Shift Overtime Verification document for these calculations. This official record clearly records that 23 officers worked overtime, primarily due to staffing shortages at specific GGACF locations. However, the Territory's 02/22/2016 response to the Monitor's 01/31/16 request was after the filing of the 10th Report. As a result, the overtime calculations below are inaccurate in so much as there were reportedly 11, not 23, officers working overtime on 11/11/2015 2pm-10pm shift. Although this difference of 12 officers does not change the Monitor's repeated concerns about facility safety and security relative to excessive overtime use, it does call into question the veracity the Monitor's interpretations of any record provided by the Territory for monitoring purposes. This, combined with the Territory's history of delayed and incomplete submission of requested documents, continues to significantly hamper the monitoring process and the effective management of the monitoring budget.**

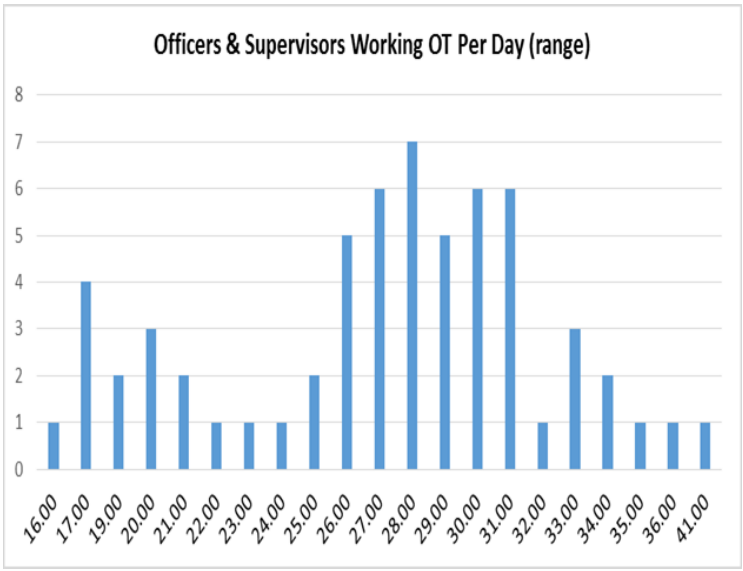
**Overtime calculations below have not been amended as a result of the Territory's clarification of overtime used on 11/1/15. To do so would require significant and costly data work and recalculation by this Monitor. Therefore, there is no change to this section of the report as shown below.**

Shift rosters, Overtime Verification records, and Supervisor Shift logs continue to document enormous amounts of overtime required to operate the facility and housing units. It is typical to see shift supervisors note that shifts are "extremely short staffed" on shift rosters and log entries. Entire shifts are sometime held over to cover the next shift because of inadequate staffing levels. Examination of daily overtime records show that overtime was required for each of the 61 day reporting period. The number of officers and supervisors working overtime per day averaged over 27 and ranged from 16 to 41. The tables below shows these statistics.

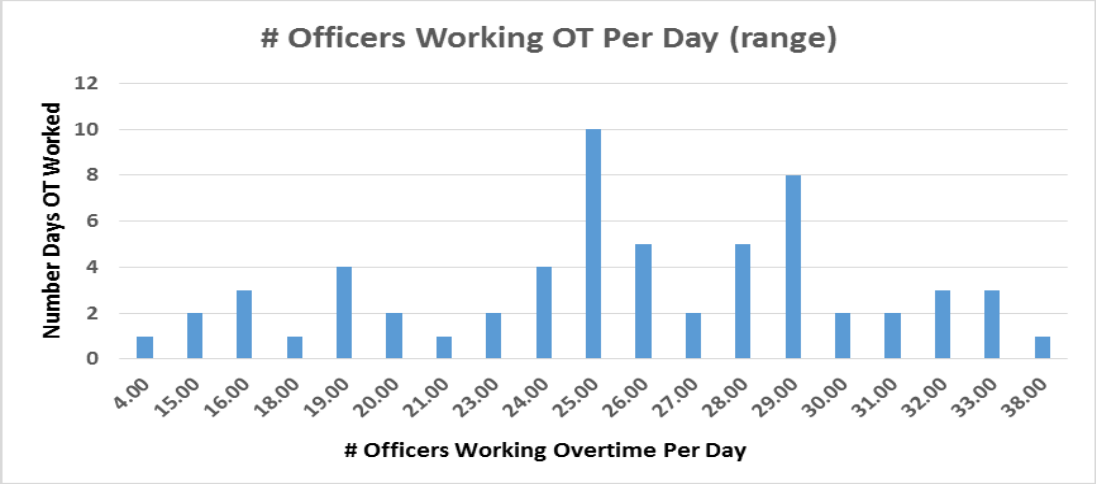
| Officers & Supervisors working OT Per Day | | |
|---|---|---|
| Days | 61 | |
| Mean | | 27.0984 |
| Median | | 28.0000 |
| Mode | | 28.00 |
| Minimum | | 16.00 |
| Maximum | | 41.00 |

The chart and graph below illustrates how often (# of Days) 16 to 41 officers and supervisors worked overtime.

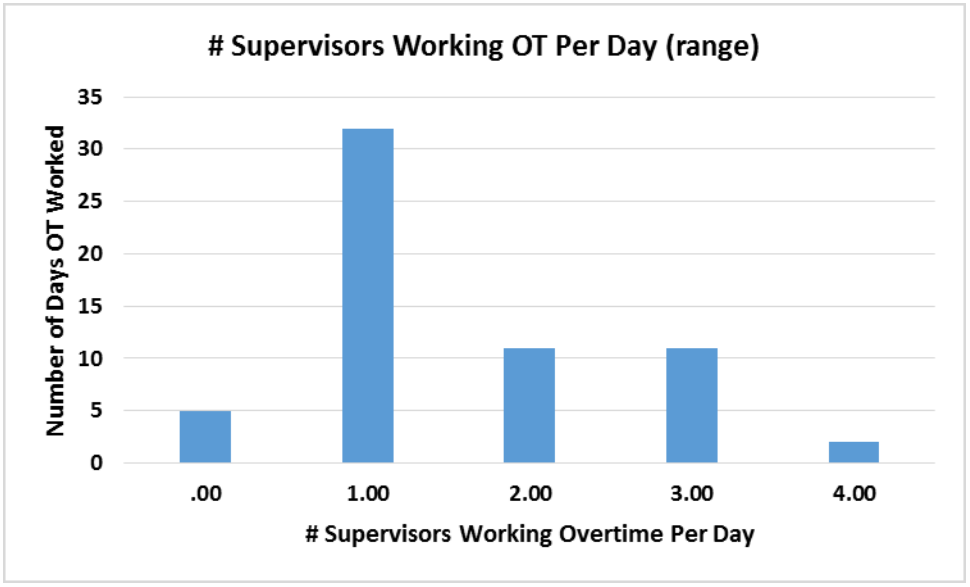
| Range of # of Officers and Supervisors working OT Per Day | # of Days | Percent of Days | Cumulative Percent |
|---|---|---|---|
| 16 - Officers & Supervisors | 1 | 1.6 | 1.6 |
| 17.00 | 4 | 6.6 | 8.2 |
| 19.00 | 2 | 3.3 | 11.5 |
| 20.00 | 3 | 4.9 | 16.4 |
| 21.00 | 2 | 3.3 | 19.7 |
| 22.00 | 1 | 1.6 | 21.3 |
| 23.00 | 1 | 1.6 | 23.0 |
| 24.00 | 1 | 1.6 | 24.6 |
| 25.00 | 2 | 3.3 | 27.9 |
| 26.00 | 5 | 8.2 | 36.1 |
| 27.00 | 6 | 9.8 | 45.9 |
| 28.00 | 7 | 11.5 | 57.4 |
| 29.00 | 5 | 8.2 | 65.6 |
| 30.00 | 6 | 9.8 | 75.4 |
| 31.00 | 6 | 9.8 | 85.2 |
| 32.00 | 1 | 1.6 | 86.9 |
| 33.00 | 3 | 4.9 | 91.8 |
| 34.00 | 2 | 3.3 | 95.1 |
| 35.00 | 1 | 1.6 | 96.7 |
| 36.00 | 1 | 1.6 | 98.4 |
| 41.00 | 1 | 1.6 | 100.0 |
| Total | 61 | 100.0 | |



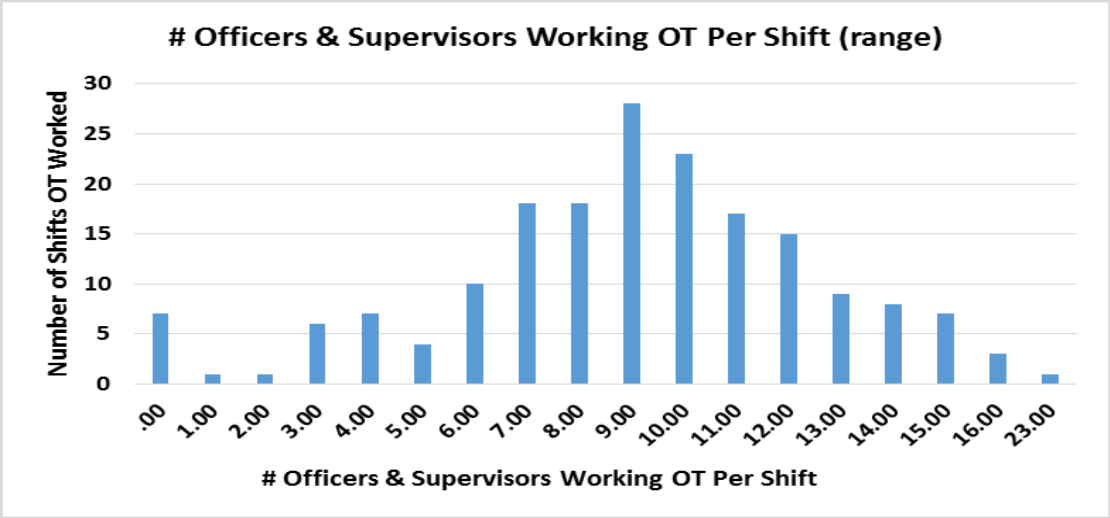

An average of 25 officers, range 4 to 38, worked overtime per day. The graph below shows how often (Number of Days OT Worked) the range of 4 to 38 officers per day worked overtime. For example, one (1) day required four (4) officers to work overtime up to ten (10) days requiring 25 officers to work overtime and so on.



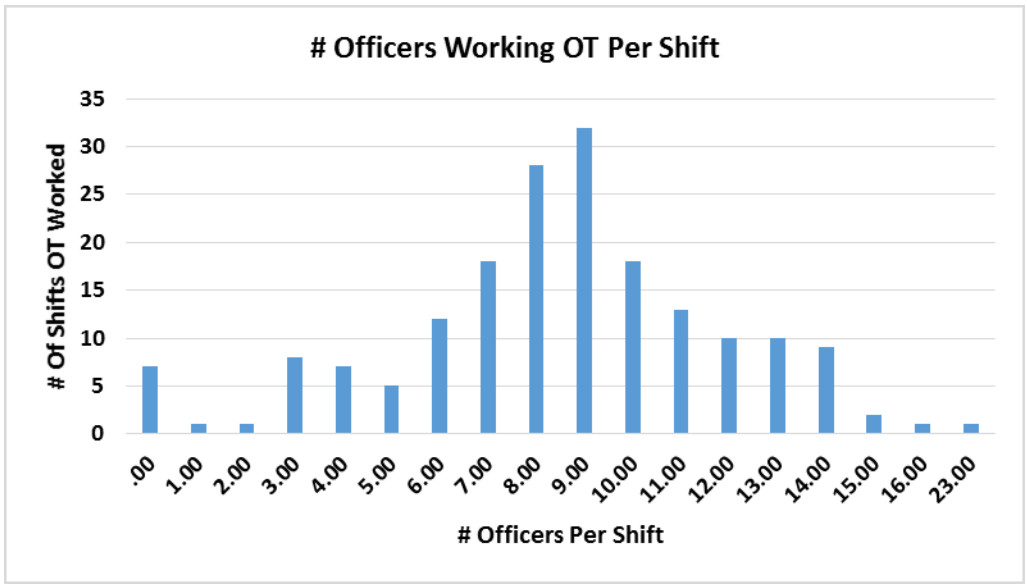

Only five (5 / 8.2%) of the 61 days did not require overtime for shift supervision. For the 56 days involving use of overtime for shift supervision, the number of supervisors working overtime ranged from 1 to 4 per day. The graph below shows how often (Number of Days OT Worked) the range of 1 to 4 supervisors per day worked overtime.



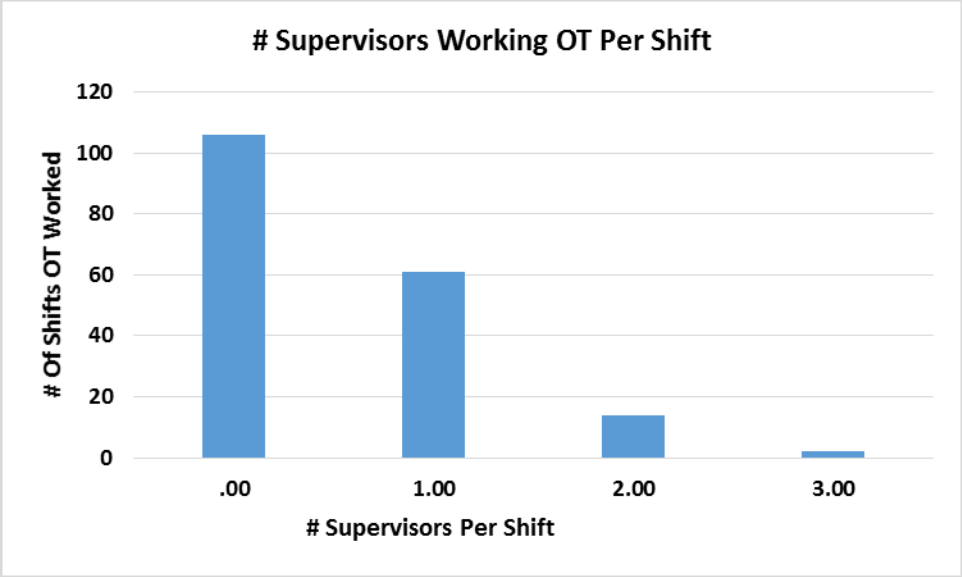

This assessment period involved 183 shifts (3 shifts per day x 61 days). Examination of overtime use per shift found similarly troubling use of overtime. Only seven (7 / 3.8%) of the 183 shifts did not require use of overtime for officers or supervisors. The number of officers and supervisors working overtime ranged from 1 to 23 per shift, approximate average of nine (9). 176 (96%) of the 183 shifts required correctional officer overtime. The graph below shows the number of shifts requiring officers and supervisors to work overtime. For example, one (1) shift required one (1) officer or supervisor working overtime up to 28 shifts requiring overtime from nine (9) officers and supervisors.




The number of correctional officers working overtime ranged from 1 to 23 per shift, averaging approximately nine (9).




However, overtime requirements per shift were much less for supervisors. 106 (60%) of the 183 shifts did not report overtime for supervisors. When overtime was reported, the number of supervisors working overtime ranged from 1 to 3 per shift, approximately 1.5 per shift.




These findings cannot be interpreted that overtime usage ensured adequate staff coverage during the period assessed. To the contrary, overtime usage has not demonstrated compliance with staffing levels required in the Staffing Analysis Report. Additionally, GGACF reported overtime levels continue to expose staff and inmates to real and potential harm.

**Excessive Overtime must be curtailed!**

Excessive overtime is contraindicated for ensuring an alert and health correctional workforce. Extant scientific literature on this subject reports serious and detrimental effects of excessive overtime on safety and employee health. Excessive overtime can reduce employee alertness, significantly contribute to work safety errors, and cause and/or exacerbate employee medical problems. Such detrimental performance outcomes place staff and inmates at greater risk of harm while contributing to excessive use off-days by employees, which can be inferred by facility records. Excessive overtime is self-perpetuating. Employees are forced to work excessive overtime, they become exhausted and are less effective on the job and/or are absent. Reduced employee effectiveness increases performance error rates and facility risks. Work absences require use of overtime to staff the facility. GGACF correctional officers and supervisors are the backbone of the facility's security program. However, that backbone is being weakened by excessive use of overtime. This weakening of the security program will likely not be repaired until sufficient security staff are employed. The most effective policy implementation or training program will never improve compliance substantially without sufficient staffing levels.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Immediately correct documentation problems shown above.

2. Use a standardize Shift Roster form that includes **ALL** locations and designate "CLOSED" for all locations that are out of service.

3. Rapidly implement the NIC Staffing Analysis recommendations.

4. Complete the draft staffing, as required under the Agreement that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff.

5. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff working overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.

6. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.

7. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.

8. Subsequent to policy and procedure development and revisions, conduct a complete review of existing specific and general post orders to ensure they are:
   a. post specific;
   b. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   c. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   d. maintained at each post, kept current, and easily accessible;
   e. regularly reviewed, revised, updated;
   f. consistently enforced;
   g. known to staff through pre-service, in-service, and ongoing training.

9. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues are detected and resolved in a timely manner.

10. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.

11. GGACF upper management must monitor compliance with any written instructions to subordinate supervisors if compliance with such orders are expected to be followed.

12. Create and implement one, standardized, shift staffing form for supervisors to accurately record shift staffing levels.

**c. Communication to and from corrections officers assigned to housing units (i.e. functional radios); and**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Policies and procedures required for this Provision have been approved. All officers (including recruits) require functional radios in their possession at all times while assigned duties within the security perimeter. Compliance with this requirement helps to ensure safety of staff and prisoners. However, prisoners and staff are exposed to extreme danger when all on duty staff are not assigned radios.

During this inspection, with some exceptions, we observed that officers assigned to housing units and other areas of the facility had functional hand-held radios. When the monitoring team visited A Dorm, the officer on duty informed the monitor that he does not wear his radio at all times, but instead keeps it at the desk, even when he is in the housing unit. This practice should stop.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement the approved policies and procedures.

2. Timely repair and replace nonfunctioning radio and telephone communications equipment throughout the facility, and add additional communications equipment where indicated.

3. The Monitor will continue to review radio equipment inventories and functionality during each onsite assessment.

4. Ensure adequate supply of radio batteries to enable officers to carry radios on their person at all times. **The GGACF Warden did issue written directives to all staff requiring compliance with this recommendation.**

5. Ensure all persons carrying radios are fully trained to understand and operate all radio functions proficiently.

**d. Supervision by corrections officers assigned to cellblocks, including any special management housing units (e.g., administrative or disciplinary segregation) and cells to which prisoners on suicide watch are assigned, including:**

**(i) conducting of adequate rounds by corrections officers and security supervisors in all cellblocks; and**
**(ii) conducting of adequate rounds by corrections officers and security supervisors in areas of the prison other than cellblocks.**

**ASSESSMENT: NONCOMPLIANCE** - No substantive improvement from previous assessment.

**FINDINGS:** Officer and supervisor staffing levels remain detrimentally insufficient to meet this requirement. It is impossible for current staffing levels to adequately perform these compliance requirements. Officers and supervisors are daily tasked with a plethora of duties and responsibilities. Officers are ill prepared and unable to perform safe and security rounds when they are the only person assigned to a housing unit. Although officers do so to the limited extend possible, doing so places the officer and prisoners at extreme personal risk. An officer should never be required to conduct housing unit rounds without a back-up officer observing them and able to quickly provide assistance when needed. Incident reports have demonstrated serious assaults on officers working alone in housing units, housing unit keys being taken from an officer by and inmate, and very slow officer response to inmate-on-inmate assaults due to inadequate staffing levels. Contraband control efforts are severely impaired because inadequate staffing levels impair regular cell searches by insufficient numbers of on-duty housing officers.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to recommendations regarding Post Orders.

2. Ensure housing units and cell blocks are consistently staffed at levels required to ensure staff and inmate safety and security, and according to inmate risks and needs.

3. Create a schedule for regular rounds by medical and mental health care staff for each shift to ensure that special needs inmates (suicidal, mentally ill, medically infirm, vulnerable, etc.) are monitored more frequently and by qualified health care staff.

4. Create a schedule for supervisory rounds, by shift, to ensure that supervisors routinely inspect general and special housing units to ensure compliance staffing requirements, policy and procedures, and to interview inmates presenting problem conditions. Supervisors should also ensure that all safety and security equipment is present and functional during these inspections and immediately replace any nonfunctional equipment. **The supervisory rounds forms should be filled out at the end of each round and collected in a central location and submitted to the Monitor and USDOJ on a monthly basis.**

5. Repair all broken lights in housing units and cells, issue flashlights to staff for cell inspections, keep all housing unit doors locked, repair broken control panels to improve unit security.

**B. Contraband**

1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility specific policies regarding contraband that are designed to limit the presence of dangerous material in the facility. Such policies will include the following:

**a. Clear definitions of what items constitute contraband;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Drafted policies include definition of what items constitute contraband but additional revisions are required before approval by the United States and this Monitor is attained.

The movement and presence of nuisance and dangerous contraband continues to remain rampant within GGACF based on examination of somewhat reliable contraband log documents. Contraband confiscation records examined document continued presence of weapons, drugs, cell-phones, money, and nuisance items. Complete assessment of contraband control progress was impaired by records provided by the Territory to the Monitor on 01/15/2016. The Evidence Room (contraband) Log contains 19 contraband confiscation entries. Entries include weapons, drugs, cell phones, and money. Date entries for confiscated items were not recorded in the appropriate column and the dates seem out of sequence with other log records. The 2015 dates recorded begin with March, then April, then June, October, December, then January 2016. However, similar entry dates are recorded on other records. The Monitor is unable to reliably interpret this record but can conclude that contraband remains very problematic. The document in question also evidences GGACF management has yet to engage effective document quality control or assurance practices. The Monitor will return to include descriptive analysis of contraband activity once valid and reliable documents are consistently provided by the Territory.

The parties have held several conference calls to discuss the draft Contraband Policy, as well as the list of allowable property. Although the Territory has agreed, after discussion with the United States, to allow newspapers and books at the facility, the Territory apparently has banned local newspapers from the facility. The parties are continuing to discuss this policy.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement the new policy according to the terms of this Agreement once approved.

2. Ensure supervisors comply with supervision rounds requirements.

3. Ensure corrections officers comply with contraband control and related security policies and protocol.

**b. Prevention of the introduction of contraband from anyone entering or leaving Golden Grove, through processes including prisoner mail and package inspection and searches of all individuals and vehicles entering the prison;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Refer to B.a. above.

It should be noted that GGACF lobby entrance security included a more comprehensive and somewhat more consistent search process during our previous inspection than this one. During this inspection we noted that the walk-through metal detector was not operable and searches were inconsistently conducted. The Mail policy has been fully approved.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement the new policy and procedures.

2. Ensure supervisors comply with supervision rounds requirements.

3. Ensure corrections officers comply with contraband control and related security policies and protocol.

4. Continue positive efforts in searching people before entering the facility.

5. A "stop and check" protocol for inspecting staff packages after initial entry into the facility must be developed and implemented.

6. Provide handheld metal detectors for contraband inspections at facility entry points and as needed for on-campus inspection.

7. Be prepared to thoroughly discuss current vehicle, mail, and package inspection methods and process during the 11th onsite tour and assessment.

8. Train supervisors to provide on-the-job-training (OJT) and staff mentoring in the areas of adequate searches, contraband prevention and control, and basic inmate supervision and security.

**c. Detection of contraband within Golden Grove, through processes including:**

**(i) supervision of prisoners in common areas, the kitchen, shops, laundry, clinical, and other ar Golden Grove to which prisoners may have access;**
**(ii) pat-down search, metal detector, and other appropriate searches of prisons coming from are where they may have had access to contraband, such as intake, returning from visitation or retu from the kitchen, shops, laundry, or clinic;**
**(iii) regular and random search of physical areas in which contraband may be hidden or placed, as cells and common areas where prisoners have access (e.g.**
**clinic, kitchen, dayrooms, storage areas, showers);**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Also refer to above contraband findings and discussion.

GGACF remains unable to provide necessary levels of prisoner supervision in any area of the campus with existing staffing levels. This is evidenced by the previously discussed examination of Evidence Collection logs, Supervisor Logs, and Shift Rosters. The Monitoring team again observed during this visit no pat down searching of ANY prisoner entering or leaving housing units. None of the housing units are equipped with metal detectors as previously recommended and required in paragraph ii above. GIST staff confirmed again during this visit that regular and random searches are very infrequent but sorely needed. Official GGACF documents evidence that dangerous weapons, drugs and alcohol, cell phones, and nuisance contraband remains accessible to prisoners.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to above, expand application of recommendation to provision c (i-iii) above.

2. See recommendations regarding staffing levels.

3. Ensure inmates are systematically and consistently searched each time they enter and exit maintenance shop areas, kitchen areas, and any area and/or building containing items that can be used as contraband.

4. Always search prisoners each time they enter and exit housing units.

5. Always search all containers entering and exiting the facility, buildings, and housing units.

**d. Confiscation and preservation as evidence/destruction of contraband; and**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** No change was found since previous reports. Above Contraband Provision findings and discussion adequately support no change in this assessment rating.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Review and implement relevant recommendations for Contraband above, specifically B1b.

2. Implement a continuous quality improvement program (CQI) for the Evidence Log to ensure the record is valid, reliable, and supports effective compliance monitoring.

**e. Admission procedures and escorts for visitors to the facility.**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** The Visitation policy has been approved.

Front desk admission security checks were inadequate and inconsistent. The walk-through metal detector that was in place during our previous inspection was now inoperable.
Monitoring team briefcases were searched before each daily visit, but we were not required to consistently empty our pockets. The monitoring team was consistently provided identification for each day of this visit.

First, very low staffing levels logically suggest GGACF is forced to prioritize duty assignments to where security protection needs are greatest – the housing units and prisoner locations. Second, none of the different Shift Roster forms show "Visitation" as a post for recording staffing levels.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Continue to ensure timely and consistent escorts for the monitoring team and USDOJ officials during all onsite visits.

2. Continue to maintain adequate supplies of visitor identification cards and ensure that all visitors conspicuously wear badges at all times while inside the security perimeter.

3. Implement document quality improvement protocols to improve reliability of the two supervisor reporting systems used for this assessment to aid in demonstrating compliance.

## C. General Security

| |
|---|
| 1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility specific policies designed to promote the safety and security of prisoners and that include the following: |

**a. Clothing that prisoners and staff are required or permitted to wear and/or possess;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The Inmate Clothing policy has been approved.

Prisoners continue to be allowed to wear personal "street" clothes in and out of the housing units. Several prisoners were again observed wearing non-correctional attire in day rooms, their cells, and in the yard.

We continue to observe that some on-duty security staff were wearing unmarked clothing and some wore unmarked lightweight jackets that covered their uniforms. Security staff reported having to purchase their uniforms (including shirts, pants, and shoes) themselves. Security staff also reported not receiving expected yearly allowances for clothing maintenance.

Unlike specialized law enforcement staff, there is no value or understandable purpose in allowing uniformed security staff to wear unmarked clothing or to wear personal attire that covers portions of their uniforms. The security officer uniform is specifically marked to provide clear and obvious awareness of the presence of a security officer. As such, a marked security officer uniform should never be obscured. This problem continues to be documented in the GGACF Security Administrator's monthly reports for at least 90 days.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Require inmates to wear issued institutional clothing ONLY.

2. Take timely and appropriate corrective action with staff who fail to enforce inmate uniform policies and inmates who refuse to comply with those policies.

3. Ensure that all staff wear their required GGACF uniform at all times, and take timely and appropriate corrective action with staff who refuse to do so.

4. Consider acquiring correctional apparel that provides obvious recognition of the inmates' classification/status.

5. Ensure there is a consistently sufficient supply of uniforms for regular laundry exchanges and changes in an inmate's classification and/or status.

6. Consider developing a correctional industry for making uniforms onsite.

7. Select/make uniforms specifically designed to reduce/eliminate places to hide contraband and weapons.

8. Mark all uniforms with highly visible letters/numbers.

**b. Identification that prisoners, staff, and visitors are required to carry and/or display;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Refer to previous findings and discussions pertaining to B.a, C.1.a. In addition, some prisoners were again observed either not wearing identification or not properly displaying their identification if it was being worn. During the onsite visit, the monitoring team and the USDOJ were given and required to wear visitor badges.

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

1. Ensure staff compliance with this provision.

2. Ensure adequate supplies for making identification cards.

3. Regularly audit identification card inventory and maintain proper controls to prevent inappropriate acquisition of cards. Conduct regular "identification card counts" using methods similar to key control inventories.

4. Consistently enforce identification card policies and procedures.

**c. Requirements for locking and unlocking of exterior and interior gates and doors, including doors to cells consistent with security, classification and fire safety needs;**

**ASSESSMENT: NONCOMPLIANCE** - Noted some improvement from previous assessment.

**FINDINGS: Previously requested training documents demonstrating completion of staff training on this subject matter have not been provided to this Monitor**. Additionally, some of the Shift Supervisor Rounds reports and Housing Unit Logs, as well as direct observation during our visit show several inoperable locking mechanisms in various areas of the facility. However, it should be noted that on a positive note, doors that had been previously identified

as inoperable in the sally port area, detention housing and R&D have been repaired. The slider grills/gates in the L and K units remain inoperable.

Inconsistent and incomplete use of these reports makes it very difficult to use these documents as a credible sources to advancing this provision, and it is logical that compliance with this provision is frustrated by inadequate maintenance staffing levels. The Director reported that the locksmith position is now a permanent position, but they still need to resolve an insurance issue.

However, even with an adequate locking system maintenance program, prisoners will continue to gain dangerous access to each other until security staff consistently practice good key control. A log book entry, for example, reported that the Alpha Unit officer station was left open and unsecured (Supervisor Log Book, 09/15/15, pg. 225.

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

1. Provide Monitor requested training records showing a 95 percent minimum successful completion rate.

2. Repair/replace all broken locks and keys.

3. Develop, revise, implement, audit lock/key inventory.

4. Regularly inspect keys, locks, and electronic locking systems to ensure reliable functionality, detection of tampering, and timely repair/replacement.

5. Continue to ensure staff are adequately trained in the proper use of mechanical and/or electronic locking systems according to their post assignments.

6. Consistently sanction inmates for attempting to manipulate or manipulating any security locking system or device.

7. Secure access to keys and electronic locking control panels.
8. Keep security doors locked.

9. Replace or upgrade existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.

10. Improve video surveillance of internal areas by placing cameras in all housing units and inmate locations, and add additional cameras to monitor external access points to ensure rapid detection of attempts to disable or damage locking devices/systems.

11. Increase perimeter and internal lighting to improve detection of sabotage to locking devices and mechanisms.

12. Supervisor should inspect all locking systems during each shift and report for investigation and/or repair any signs of lock disrepair, malfunctioning, or manipulations.

**d. Procedures for the inspection and maintenance of operational cell and other locks in Golden Grove to ensure locks are operational and not compromised by tampering; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The policies and procedures that address this provision have been finalized and now staff need to be training on them and they need to be implemented. However, these policies and procedures alone cannot ultimately demonstrate compliance until GGACF has sufficient staffing levels to ensure compliance. This is because these policies and procedures require a much higher level of routine attention to all housing unit locking mechanisms by housing unit officers and supervisors.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Employ and maintain adequate Maintenance staffing levels.

2. As requested in the previous two reports, **develop an "all-locks" maintenance plan for review by the Monitor and incorporation into policies and procedures**. The plan should include a complete inventory of all locks, locking mechanisms, date lock found non-functional, date of repair /replacement was completed, and a list of all locks and locking systems taken offline. The plan should include, at a minimum, the following elements and should use an Excel spreadsheet: Where the lock is specifically located – (Perimeter gate, housing unit 9A, cell #, emergency door, etc.), and lock number, lock type, condition, etc.

3. Establish a deadline for developing and implementing the lock plan to include policies, procedures, training, and continuous quality assurance.

**e. Pre-employment background checks and required self-reporting of arrests and convictions for all facility staff, with centralized tracking and periodic supervisory review of this information for early staff intervention,**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This assessment did not review whether corrective action had been take regarding problems found in GGACF personnel folders . GGACF hired a new Human Resources Manager who is responsible for the organization of personnel records. These issues

will be reviewed during the March 2016 site visit. The problems identified during the previous visit included:

- Missing verification of training documentation
- No application and/or background investigation record
- Missing criminal background-check documentation
- No uniformity of folder content, disorganization
- Incomplete documentation regarding disciplinary action (i.e. notification of policy violation with no other information regarding disciplinary process or case disposition)
- Employer/reference background forms missing or not completed
- Missing Personal History statements
- Pre-service psychological assessments found in some folders but not others
- Missing fingerprint records
- Incomplete military status questionnaire

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. The employee folder/record system should be standardized and well organized.

2. All folders should contain completed Applicant Personal History Statements, criminal history check verification documents.

3. Medical records should be kept separately from the general personnel folder.

4. Training records should be kept in a staff training folder and separate from the training folder. These records should be reviewed periodically for quality assurance purposes and remedial instruction and/or training provide to records staff where indicated.

**D. Security Staffing**

1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies and a staffing plan that provides for adequate staff to implement this Agreement, as well as policies, procedures, and practices regarding staffing necessary to comply with the Constitution that include the following:

**a. A security staffing analysis, incorporating a realistic shift factor for all levels of security staff at Golden Grove;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Contents of the proposed Staffing Plan remain in dispute. The plan lacks specific detail to provide complete direction and guidance for its implementation. The parties and Monitor are continuing to discuss these issues. Among other things, the Monitor and United States are troubled by the requirement in the Staffing Plan that incoming officers sign a contract mandating that they remain with the BOC for at least three years or they will not receive a favorable recommendation for future employers.

The correctional culture is coercive enough not to add a sour flavor to the job just to attain employment. And such language is negative versus a positive measure for recruitment and maintaining the workforce. Better pay and less overtime in the aggregate will do much more to reduce staff stress, error, and performance. Recruiting employees from the mainland will likely not attract much interest simply do to pay, compared to cost of living. For example, this Monitor provided very brief research to Territory officials that compared mainland and VI salaries for correctional officers. The data were adjusted for cost of living difference. These comparisons showed conservable differences in salaries that were well above the Territory's current and proposed correctional officer salaries. Again, this research was very brief to simply encourage Territory officials to include a variety of options for recruiting staff.

The plan also lacks provisions related to officer pay. This matter has been referred to the court for resolution and is pending final disposition. Extant subject matter literature seems to suggest that salary increases combined with other improvements with job satisfaction could help to stabilize the Territory's job force. A reasonable raise combined with prescriptive positive administrative/operational (i.e., better training) changes could promote better recruitment and retention outcomes.

The Monitor conducted a limited and brief salary survey comparing St. Croix's reported cost of living with the starting and top salaries for several mainland agencies. Based on the provisional results, the Monitor concluded that the Territory could have a very difficult time recruiting from the mainland.

The staffing analysis remains a provisional document for verifying actually staffing requirements. This is because the Territory did not provide the NIC analysis requested data to estimate actual net annual work hours. This estimate requires quantifying actual staff work hours required to operate all GGACF posts and all hours staff were off duty for various reasons i.e. sick, days off, vacation, etc. In the absence of these data points the analyst used national net annual work hour estimates to determine staffing levels. A staffing reanalysis may be required should full implementation of the staffing plan fail to yield adequate staffing levels to safety operate the facility.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement the approved policy

2. Attain approval for and implement the required Staffing Plan

**b. A security staffing plan, with timetables, to implement the results of the security staffing analysis; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As stated in D.1.a above.

**RECOMMENDATIONS:** As stated above

**c. Policies and procedures for periodic reviews of, and necessary amendments to, Golden Grove's staffing analysis and security staffing plan.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The staffing policy and procedure has been approved by the United States and this Monitor, but not the Staffing Plan.

**RECOMMENDATIONS:** As stated above

**1. Defendants will implement the staffing plan developed pursuant to D.1 .**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Refer to previous findings related to staffing analysis and planning.

**RECOMMENDATIONS:** Finalize, fund, and implement staffing plan.

**E. Sexual Abuse of Prisoners.**

**1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies that incorporate the definitions and substantive requirements of the Prison Rape Elimination Act (PREA) and any implementing regulations.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: As noted in the previous reports, the Territory has not completed the required PREA self-audit. PREA policies and procedures have been submitted to USDOJ and this Monitor and they have been finalized and approved. The Territory has resolved the 24/7 hotline. The Territory has initiated a Memorandum of Understanding (MOU) with the USVI

Police Department to conduct criminal investigations of sexual misconduct at GGACF. It was unclear, however whether or not this MOU has been signed by both entities.

Mr. James Warren is charged with the duty to conduct administrative investigations of sexual misconduct at GGACF. Mr. Warren reported that he is working on a PREA related investigation that was reported in November 2015. We were unable to examine three (3) PREA-related allegations because as of January 14, 2016 we had not yet been provided with all information or administrative investigations regarding these alleged incidents. However, on January 15, 2016, Counsel for Defendant's provided us with copies of two (2) PREA related investigations. One of those investigations was responsive to a request made by the Monitor to Defendant's on January 6, 2016. The second investigation appears to have the same date regarding one (1) of the requested investigations, but it does not appear to that it was the one requested by the Monitor. Nevertheless, we reviewed the two (2) provided investigations. One of the investigations involved an allegation of sexual harassment made by an inmate against an officer in May 2015. The Investigator found this allegation to be "unfounded". Although it is commendable that BOC staff commenced the process of conducting investigations with the appointment of the Chief Inspector, this investigation exemplifies the past inattention by GGACF to act upon allegations of sexual misconduct. The second investigation does not appear to the one the Monitor requested, but nevertheless we also reviewed this investigation. This investigation involved an inmate-on-inmate allegation of alleged sexual advances. In this investigation, the Chief Inspector found the allegation to be sustained. However, there is no indication in the investigation as to what the recommended corrective action will be or any referral to other GGACF staff or the Director of Corrections for corrective action. The Chief Inspector conducted timely investigations of both of these cases from the time he was assigned to investigate them as requested by the Director of Corrections. However, it appears that the investigations were assigned to the Chief Inspector only after repeated requests for the investigation reports by the Monitor. For example, one PREA-related incident allegedly occurred on September 9, 2015, but was not received by the Chief Inspector for investigation until January 8, 2016. The PREA investigation regarding the May 2015 incident also was not referred to the Chief Inspector for investigation until January 8, 2016. The Monitor requested both investigation reports during the December 2015 site visit, and again by email on January 6, 2016.

It should also be noted that during our previous site visit we requested that an investigation be undertaken regarding the alleged allegation by an inmate of excessive force by a GIST officer on July 29, 2015. It does not appear that such investigation has been launched.

Facility staff reported that following our last inspection WTS Consultant Services provided general training to staff and inmates on PREA. Staff training was conducted on 9/29 & 10/2/15 according to training rosters provided. However, these rosters are difficult to interpret due to slopping entries. Additionally, these records do not document that 95% of staff required to complete this training did so with a passing score of 80% or better. We reviewed the course presentation by WTS and found it to be adequate. This is a good start and the process should continue as GGACF officials implement their PREA policies and procedures. Additionally,

Mr. Warren reported that he took an on-line PREA Investigations Course. This initiative will also benefit the process for conducting sexual misconduct related investigations.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. GGACF should take advantage of the National PREA Resource Center at http://www.prearesourcecenter.org/, and the National Institute of Corrections at http://nicic.gov/ for qualified information about PREA compliance, training, and other related resources.

2. Review PREA and develop an action plan for the implementation of PREA requirements.
3. Appoint a PREA Compliance Coordinator as soon as possible.

4. BOC officials are encouraged to send at least one qualified staff person to USDOJ's PREA auditor certification training. All costs are covered by USDOJ.

5. Complete the PREA Self-Audit.

6. Fill additional investigator position slated for a 6/16 hire date, according to the Territory.

## F. Classification and Housing of Prisoners

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|---|
| 1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility specific policies that will appropriately classify, house, and maintain separation of prisoners based on a validated risk assessment instrument in order to prevent an unreasonable risk of harm. Such policies will include the following: |

**a. The development and implementation of an objective and annually validated system that classifies detainees and sentenced prisoners as quickly after intake as security-needs and available information permit, and no later than 24-48 hours after intake, considering the prisoner's charge, prior commitments, age, suicide risk, history of escape, history of violence, gang affiliations, history of victimization, and special needs such as mental, physical, or developmental disability;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The Territory is still in the process of validating the current classification system. Apparently James Austin, Classification Expert is continuing to work with the Territory on the process. Draft classification policies and procedures have been submitted to this Monitor and USDOJ for review and comment according to the revised Schedule.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Complete an empirical validation of the current classification instrument(s).

2. Review, revise, develop, train, implement, and evaluate policies and procedures that provide more accurate and complete guidance for a valid and reliable classification system for non-convicted and convicted inmate populations.

3. Consider requesting assistance from the National Institute of Corrections for assistance in this process and the development of an objective classification system.

4. Contact USDOJ / NIC for Objective Classification Technical Assistance.

5. Ensure classification staff are well-trained in classification protocols and routinely monitor classification documents for accuracy.

**b. Housing and separation of prisoners in accordance with their classification;**

**ASSESSMENT: NONCOMPLIANCE** - No substantive improvement from previous assessment.

**FINDINGS:** As stated in F.1.a above. Additionally, we continue to note the housing of mixed classifications of prisoners in housing units. During this review we did not examine whether or not this mixing also includes the housing of maximum security inmates in the same cell as minimum security inmates. During our next review we will examine this phenomena in more detail as classification policies and procedures are implemented and staff trained on them. This practice significantly deviates from industry standards and violates the Agreement and related legal requirements.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Inmates should be housed and separated according to reliable classification process as previously discussed.

2. Pending completion of a reliable classification process, GGACF officials should use the Incident Log Report and other reliable information sources to target population cohorts for housing and separation that is more consistent with behavioral risks and needs.

3. Comply with the Settlement Agreement prohibiting housing seriously mentally ill inmates in isolation cells or locked-down housing units. Mental health staff must continue to conduct a serious, comprehensive assessment of all prisoners on both the detention and sentenced side lock down units to determine mental health needs and direct mental health staff to determine if a different, less punitive housing placement is available.

**c. Systems for preventing prisoners from obtaining unauthorized access to prisoners in other units;**

**ASSESSMENT: NONCOMPLIANCE** – Minor improvement noted, but not yet substantive or sustained

**FINDINGS:** Same findings as noted in the above Classification section. During the December 2015 compliance tour, we observed some housing unit doors being left open and/or unlocked, and prisoner movement outside of assigned housing units with little or no supervision.

**RECOMMENDATIONS:**

1. Refer to previously discussed security-related findings and recommendations.

2. Refer to previously discussed classification-related findings and recommendations.

**d. The development and implementation of a system to re-classify prisoners, as appropriate, following incidents that may affect prisoner classification, such as prisoner assaults and sustained disciplinary charges/charges dismissed for due process violations;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** See previously discussed classification findings.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to recommendations related to grievance and disciplinary policies and procedures.

2. Ensure accuracy of monthly disciplinary committee reports.

3. The Territory must correct problems reported in the monthly disciplinary committee reports.

4. Train classification staff to accurately and consistently complete initial and re-classifications accordingly.

**e. The collection and periodic evaluation of data concerning prisoner-on-prisoner assaults, prisoners who report gang affiliation, the most serious offense leading to incarceration, prisoners placed in protective custody, and reports of serious prisoner misconduct;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The current incident reporting system remains inadequate for complying with this provision. As previously noted in this report, the quality of incident reports remains problematic and the incident reporting log system does not consistently capture all reported incidents. Additionally, Disciplinary Committee monthly reports continue to report problems with missing and late submission of incident reports. Interviews with the sergeant responsible for the prisoner discipline program continues to state the same problems with incident reporting practices and quality oversight.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Timely approve and implement policies and procedures for the accurate and complete use of the Incident Tracking System.

2. Develop and implement a continuous quality assurance policy and program to ensure that incident reports and logs are consistently accurate and complete.
3. Revise incident report forms to include all essential elements to track incident data in a systematic and unified manner.

4. Establish an incident tracking database to produce and regularly review valid and reliable incident information and data.

5. Revise use of the incident reporting system as discussed above 6. Assign additional staff to GIST as described above.

**f. Regular review of prisoners in segregation to minimize time in segregation, and provision of adequate opportunities for out-of-cell time for prisoners in segregation.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Segregation-related (Special Housing) policies and procedures remain working products and yet approved. The new segregation review form was implemented during the December 2015 onsite assessment, but review documentation remains deficient.

Assessment of this Provision involves examination and cross-referencing of these primary records. December 2015 records were examined for this assessment:

1. Segregation review records
2. Housing unit count sheets to determine prisoners assigned segregation/lockdown status requiring regular reviews.
3. Chronic care records to identify medical/mental health needs of prisoners in segregation/lockdown living conditions.

Document quality examination found marginal improvement but important problems continue. For example, some of segregation review records failed to record date the prisoner was placed into segregation or reason (discipline, administrative, etc.). Some records failed record that an inmate was seriously mentally ill. Some documents failed to meaningfully complete certain sections of the form. For example, writing "valid" to item 1 (VIII) does not meaningfully respond to the question, which asks "Are there reasons for circumstances for placement in Segregation still valid?" The question asks for "reasons" and a narrative explanation should be provided. Similarly, VII 2 asks for a description of what alternatives [to segregation] were discussed and considered for placement. "N/A" is not an appropriate response. This section should describe alternatives discussed and how those alternatives were ruled out or not accepted. Another review document (BOC101160, 12/23/15) states the prisoner was not present during the review. This record fails to record the prisoner's current segregation status, if the prisoner had been seen by an RN in the past two weeks or mental health professional in the past week (items I, III, IV). Additionally, none of the ten prisoner needs and wellness questions (item V) were answered. However, the segregation committee remarks about the prisoner there is "no apparent distress", "Spoke with detainee appears in good health but didn't say much", and "refused to be interviewed". All of these sections should have been completed whether or not the prisoner participated in the interview. This can be accomplished by reviewing records maintained in the officers' station. All segregation review records must answer all questions regardless of whether or not a prisoner participants in the process. These documents are important and valuable quality assurance records used to demonstrate compliance with this Provision, policies and procedures.

GGACF housing unit count sheets recorded that 227 prisoners were in custody on 12/17/15; 35 (15%) were in a segregation/lock down status on 12/17/15. These 35 prisoners were housed in units 9A (13), 9C (9), 9D (4), and Lima (9). A 15% daily segregation rate seems extraordinarily and dangerously high compared to local, state, and federal rates. On an average day, up to 4.4% of state and federal inmates and 2.7% of jail (detention) inmates were held in segregation. The GGACF daily segregation rate, therefore, ranges from approximately 3.5 to almost 7 times higher than compared rates. Similarly, the amount of time GGACF prisoners are held in a segregation status seems extremely high. Fifty percent (50%) of these prisoners have remained in segregation for more than nine months. Approximately a third for more than 18 months. Four prisoners, including a seriously ill prisoner, has remained segregated from two to over four years. The table below shows prisoner lengths of stay for the in segregation.

The table that follows shows descriptive statistics for GGACF segregation.

| GGACF Prisoners in Segregation/Lock Down on 12/17/15 | | | | | | | |
|---|---|---|---|---|---|---|---|
| Prisoner | Reason | Days | Months | Years | Months in Segregation | | |
| 1 | Administrative | 1617 | 53.9 | 4.4 | Time Spent | Prisoners | % |
| 2 | Discipline | 1422 | 47.4 | 3.9 | 1-3 Months | 5.00 | 26.32% |
| 3 | Administrative | 927 | 30.9 | 2.5 | 4-6 | 3.00 | 15.79% |
| 4 | Discipline | 765 | 25.5 | 2.1 | 7-9 | 3.00 | 15.79% |
| 5 | Not Recorded | 589 | 19.6 | 1.6 | 10-18 | 3.00 | 15.79% |
| 6 | Discipline | 541 | 18.0 | 1.5 | 19-25 | 2.00 | 10.53% |
| 7 | Administrative | 485 | 16.2 | 1.3 | 26-30 | 1.00 | 5.26% |
| 8 | Administrative | 312 | 10.4 | 0.9 | > 30 | 2.00 | 10.53% |
| 9 | Administrative | 276 | 9.2 | 0.8 | | | |
| 10 | Discipline | 261 | 8.7 | 0.7 | | | |
| 11 | Administrative | 236 | 7.9 | 0.6 | | | |
| 12 | Discipline | 203 | 6.8 | 0.6 | | | |
| 13 | Discipline | 143 | 4.8 | 0.4 | | | |
| 14 | Discipline | 120 | 4.0 | 0.3 | | | |
| 15 | Discipline | 93 | 3.1 | 0.3 | | | |
| 16 | Discipline | 87 | 2.9 | 0.2 | | | |
| 17 | Discipline | 76 | 2.5 | 0.2 | | | |
| 18 | Discipline | 64 | 2.1 | 0.2 | | | |
| 19 | Discipline | 41 | 1.4 | 0.1 | | | |

Segregation review forms were provided for 20 (57%) of the 35 segregated prisoners. Records provided could not verify that segregation reviews were performed for all segregation prisoners as shown in the table below:

| 12/17/15 Count Sheets | Lock Down Count | December Seg Reviews Provided | % Seg Reviews |
|---|---|---|---|
| 9A | 13 | 11 | 85% |
| 9C | 9 | 4 | 44% |
| 9D | 4 | 0 | 0% |
| Lima | 9 | 5 | 56% |
| Totals | 35 | 20 | 57% |

Although review forms record important information about prisoner health and hygiene status, the form does not provide information from which to determine whether opportunities for out-of-cell time were adequate. Form section V question 5 asks if the prisoner received at one hour of recreation each day. Section V was completed for 17 of the 20 records; all 17 review documents recorded the prisoners stated they had received one hour of recreation daily. Provision of adequate out-of-cell time cannot be determine by the current segregation review form. This form should be revised specifically determine opportunities to out-of-cell time between reviews was adequate.

Examination of completed segregation of for this assessment period found several documentation problems. Some of the documents were not accurately completed, some failed

to adequately document inmate needs and alternatives to segregation, some documentation contained important inconsistencies. The following records reviewed illustrate these problems:

Overall, the segregation review process and documentation has improved marginally compared to previous assessments. Particular attention should be devoted to ensuring all documents are accurately completed. The Warden should approved and sign only segregation review documents (or any record for that matter) that are complete and accurate.

The number of prisoners being held in segregation and the length of time prisoners spend so confined is very troubling. The scientific literature regarding segregation continues to document the seriously harmful effects of prisoner solitary confinement on their medical, psychological, and social wellbeing. Research has also demonstrated that some prisoners held in segregation for long periods of time are more likely to recidivate after release and commit violence in the community as products of segregation. GGACF officials must develop constitutionally-sound and healthy alternatives to current segregation practices.

**RECOMMENDATIONS:** Review, revise, develop, train, implement, and evaluate segregation housing policies to:

1. Minimize time in segregation.

2. Provide adequate opportunities for out-of-cell time for inmates.

3. Ensure regular and consistent monitoring by medical and mental health staff.
4. Ensure inmate hygiene is maintained while housed in segregation.

5. Track and document (log) segregation housing conditions of confinement and inmate status.

6. Continue to ensure inmates with special needs are monitored frequently as indicated by a security and health risk/needs assessment. A routine schedule for conducting these rounds must be continuously monitored for compliance.

7. Develop and implement a monthly segregation housing unit log that tracks lengths of stay and compliance with this provision.

8. Defendants are reminded that segregation should never be used to punish or serve as a treatment for inmates who are mentally ill, and may never be used for inmates with serious mental illness.

9. Improve the quality and completeness of segregation review documentation.

## G. Incidents and Referrals

**1. Defendants will develop and submit to USDOJ for review and approval facility-specific policies to alert facility management of serious incidents at Golden Grove so they can take corrective, preventive, individual, and systemic action. Such policies will include the following:**

**a. Reporting by staff of serious incidents, including:**
**(i) fights;**
**(ii) serious rule violations;**
**(iii) serious injuries to prisoners;**
**(iv) suicide attempts;**
**(v) cell extractions;**
**(vi) medical emergencies;**
**(vii) contraband;**
**(viii) serious vandalism;**
**(ix) fires; and**
**(x) deaths of prisoners;**

**ASSESSMENT: NONCOMPLIANCE -**

**FINDINGS:** Examination of incident logs and reports for October through December 2015 continue to warrant management implementation of better documentation quality control and accountability methods. Incident reporting deficiencies discussed in previous compliance reports remain unresolved by GGACF management:

1. Inconsistent incident report numbers
2. Incomplete reports
3. Page numbers and other basic information missing
4. Reports not being recorded on the incident log
5. Using different incident numbers for each inmate involved in the same incident
6. Using different incident numbers for different officers reporting the same incident
7. Illegibility
8. Missing signatures
9. Duplicate records
10. Inconsistent recording of incident type
11. No recording of incident type
12. Incident, Evidence, and Disciplinary logs don't cross-reference each other
13. Blanks (e.g., date, incident numbers, reason for submitting report, etc.)

As stated in previous monitoring reports, the existing incident reporting system must be completely overhauled if it is to provide valid and reliable information from which to meaningfully evaluate serious events in order to comply with this Provision or any provision

requiring accurate and complete incident reporting to assess compliance levels. A simple document quality assurance and compliance accountability process should be implemented and minimally include the following steps:

1. Officer completes an incident report
2. First-line shift supervisor reviews the report for completeness, accuracy, and legibility
3. First-line approves, signs, and forwards reports that meeting requirements above, deficient reports are immediately returned to the author with specific written and/or verbal instructions for correction
4. Shift commanders should review and approve only reports meeting the requirements in step two
5. Shift commanders should return to reports first-line shift supervisors that fail to meet the above requirements with verbal and/or verbal instructions for correction
6. The chiefs, Security Administrator, Asst. Warden and Warden should review all reports for quality assurance and operational management purposes.

**RECOMMENDATIONS:** Previous recommendations remain appropriate

1. Develop protocols for current tracking system to improve data validity and reliability; the Incident Log document is replete with duplication and misleading entries.

2. Develop a unified incident coding system for valid and reliable information and data collection, reporting, and analysis.

3. Establish regular monthly quality assurance meeting process involving all major department team leaders to review serious incident reports and recommend evidence-based remedial measures for eliminating/mitigating incident frequency and severity.

4. Train staff in applying adopted policies and use of forms, implement a continuous quality assurance protocol.

5. Require supervisors to carefully review all incident reports for completeness, accuracy, and consistency.

**b. Review by senior management of reports regarding the above incidents to determine whether to refer the incident for administrative or criminal investigation and to ascertain and address incident trends (e.g., particular individuals, shifts, units, etc.);**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Records were not provided by GGACF management staff to demonstrate compliance that this process exists. A regular administrative process required under this provision has not yet been formalized. Such a process first requires wholesale improvements in incident reporting systems and reporting review process. Furthermore, valid and meaningful incident data for tracking and management purposes relies completely on the quality of the incident reporting system, quality compliance monitoring, and timely data management. It is imperative that GGACF management staff implement a measurable document quality assurance and management process for the incident reporting system.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to recommendations in G.1.a above.

**c. Requirements for preservation of evidence; and.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As stated in previous monitoring reports, the Evidence Log should include incident report numbers to cross-reference incident reports and evidence (i.e., contraband). This revision to the Evidence Log will help to provide efficient and timely matching of incident reports to evidence, and make the Evidence Log a very useful tool for tracking and managing facility incidents for planning, implementation, and evaluation strategic contraband control policies.

**RECOMMENDATIONS:** Previous recommendations remain appropriate

1. Refer to similar recommendations regarding contraband.

**d. Central tracking of the above incidents.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Findings described in G.1.a adequately articulate continued problems found with the incident central tracking and logging system.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to previous recommendations regarding incident reporting and tracking.

2. Consider implementation of an electronic jail management system for centralization of incident reporting and data analysis.

3. Implement a quality assurance process that consistently ensures incident log accuracy and completeness.

**2. The policy will provide that reports, reviews, and corrective action be made promptly and within a specified period.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Prompt event reporting, investigation, and resolution remains problematic. Deficiencies in the current incident reporting and management process must be improved before other measures intended to gain compliance with this Provision will matter.

Examination of various records evidence problems in compliance. For example, the required management review of a use of force incident occurring on 10/29/15 was not completed until 11/13/15. Despite this incident involving relatively low-level force and without injury to any person, the management review and final disposition should have been much timelier. This problem is also demonstrated in the inmate complaints (grievance log). Times from inmate complaint to final resolution of the complaint are often unreasonably lengthy, if recorded at all. Administrative investigation reports also demonstrate lack of promptness. For example, this Monitor requested investigative documents for several serious complaints and events occurring over the past six months. Responses to this request included investigation documents dated weeks following the events.

Related draft policies and procedures include specified timelines for incident reviews and resolution. This problem can be easily corrected by GGACF management implementing those timeframes before these policies receive final approval.

**RECOMMENDATIONS: Previous recommendations remain appropriate.**

1. Include this element in the required policy and procedure.

2. Establish reasonable timeframes as indicated.

3. Develop and implement corrective action protocols to address staff noncompliance with adopted policies and procedures.

4. Initiate corrective action against supervisors and staff who continually fail to submit and/or approve deficient, late, or no incident reports as required by policy and this Agreement.

**H. Use of Force by Staff on Prisoners**

**1. Defendants will develop and submit to USDOJ and the Monitor for review and approval of facility-specific policies that prohibit the use of unnecessary or excessive force on prisoners and provide adequate staff training, systems for use of force supervisory review and investigation, and discipline and/or re-training of staff found to engage in unnecessary or excessive force. Such policies, training, and systems will include the following:**

**a. Permissible forms of physical force along a use of force continuum;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The required policies and procedures remain in final draft form pending further review before being approved by the United States and this Monitor. These documents contain the elements required in this Provision.

Examination of incident reports and monthly management reports provided found three use of force (UOF) events, one each for October, November, and December 2015. Required supervisory review records were provided for the October and November incidents. The October management record was not provided to this Monitor as previously requested and the December management report recorded there were no UOF incidents, which differs from the review of December incident reports. The November management report documents the one incident reported that month.

October 29, 2015 UOF incident report involved officers using only physical force to control a prisoner while confiscating contraband from him. The incident report indicates officers "grabbed, shoved, and punched" the prisoner to overcome passive resistance and to prevent the prisoner for getting too close to officers and leaving his cell. The incident report does not state whether the prisoner was injured but a nurse was summoned to assess for medical needs. The prisoner denied need for medical care. The incident report appears to have been accurately completed. However, the required supervisor review was not completed until 11/13/15, two weeks post incident. Examination of this review form indicates necessary revisions. The form does not include "punching" as a force option but should. The reviewer also referred this incident for administrative investigation due to the prisoner's allegation of excessive force. These investigative records will be requested and examined. This incident, at present, seems to involve justified use of force.

November 18, 2015 UOF incident report involved the use of an electronic control weapon (ECW), Taser, to gain compliance of a prisoner to confiscate contraband from his person. Related incident reports document the prisoner failed to fully comply with officers' instructions to place his hands on his bunk while they were attempting to search him. Officers report the prisoner put his hands in his waistband and he was stunned once with the Taser to gain his compliance. The "Primary" officer's report of this incident is incomplete and inaccurate. Boxes on the report form for recording force was involved were not completed. On its face, the report would not be noticed as an incident involving force. This speaks further about document quality improvement concerns discussed in the Incident Reporting section of this report. A review of the Incident Commander's Review/Critique report shows additional problems with this incident and document accuracy issues. For UOF clarification purposes, this Monitor reviewed the medical departments Chronic Care Log to determine whether use of ECW may be contraindicated for this prisoner; the prisoner involved was not on the log.

December 29, 2015 UOF incident report involved and officer "tussling" with a prisoner while attempting to confiscate contraband from him. The report is very short and fails to clearly articulate what type of force was used by the officer. This would not be considered a UOF incident if the officer simply grabbed the contraband away from the prisoner. However, this is a reportable force incident if tussling involved any physical force against the prisoner to gain control of the contraband or control of the prisoner. Again, this incident report demonstrates incident reporting quality assurance deficiencies; incident reports should be clearly written so as to leave no question about incident facts.

The commander review of this incident concludes that this incident complied with GGACF policy, procedure, and training. However, the incident report fails to adequately document justification for ECW force. It is also very troubling that this review reports there were no medical staff on duty when the decision was made to use ECW. The incident report fails to articulate this situation requiring emergent UOF. The safety literature on Taser has empirically determined that this weapon can contribute to serious injury and death under certain circumstances. Use of Taser (or an ECW) is discouraged when medical staff are not readily available, except in circumstances when its use is absolutely necessary to prevent the real, present, and imminent danger of physical harm to others or escape. Additionally, this reviewer cannot accurately conclude this incident complied with policies and procedures when the incident report was not accurately completed. This Monitor has requested for review video recordings and Taser data for this incident.

The use of force reporting, review process, and program remains noncompliant. These findings also provide a pertinent object lesson with regard to gaining Partial Compliance even after required policies and procedures are properly implemented according to the Agreement. These findings would prevent a Partial Compliance rating or would result in a Partial Compliance rating being returned to Noncompliance. Effective quality assurance management practice can help prevent this from happening.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Finalize, approve, and implement draft use of force policies and procedures upon approval and once the revised implementation schedule is approved.

2. Ensure all force incidents are properly reported and document complete supervisory reviews of all reported force incidents.

3. Implement a continuous quality improvement protocol to ensure all incident reports and supervisory review of document are 1) complete, 2) accurate, and 3) comprehensive.

4. All planned uses of force must be monitored and controlled by an onsite supervisor.

5. GGACF must promptly and thoroughly investigate all inmate complaints of excessive force and take necessary corrective action to protect inmates and staff.

6. Strictly prohibit ECD use except to for emergency situations requiring that level of force to prevent imminent physical harm to staff, the inmate, or other inmates.

**b. Circumstances under which the permissible forms of physical force may be used;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As noted above, the draft policy has not yet been approved and implemented.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement policy and procedures once approved.

**c. Impermissible uses of force, including force against a restrained prisoner, force as a response to verbal threats, and other unnecessary or excessive force;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** See above findings.

**RECOMMENDATIONS:** Implement policy and procedures once approved.

**d. Pre-service training and annual competency-based and scenario-based training on permitted/unauthorized uses of force and de-escalation tactics;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The training program cannot be revised to meet this requirement until the new policy is approved. This Monitor and USDOJ also must first receive, review, and approve preservice and annual training curricula.

**RECOMMENDATIONS:**

1. Implement new policy once approved.

2. Provide this Monitor and DOJ with all current training curricula.

**e. Training and certification required before being permitted to carry and use an authorized weapon;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above.

**f. Comprehensive and timely reporting of use of force by those who use or witness it;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Reliability in the incident reporting system is inadequate to determine whether reports are completed and submitted on a timely basis. Some of the reports examined lack requisite comprehensiveness to comply with this Provision.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement supervisory quality improvement review for all reports to ensure accuracy and completeness before approval.

2. As requested in the previous report, the Territory must develop a use of force tracking log that includes elements to verify that reports are submitted complete and timely.

3. Comply with Monitor's request for documents.

**g. Supervision and videotaping of planned uses of force;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No planned uses of force were reported during this assessment period. However, the Territory did not provide proof that GGACF staff had access to video equipment if needed.

**RECOMMENDATIONS:** Implement policy once approved.

**h. Appropriate oversight and processes for the selection and assignment of staff to armory operations and to posts permitting the use of deadly force such as the perimeter towers;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No change.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Provide the Monitor documentation of Compliance for this Provision.

**i. Prompt medical evaluation and treatment after uses of force and photographic documentation of whether there are injuries;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The November 2015 incident reports medical staff were not available during the use of the Taser. However, qualified medical staff should have been available, as previously stated. Under the circumstances reported, medical staff should have performed a post-incident assessment for Taser burns and latent injuries. The prisoner denied medical need in the October 2015 incident. No injuries were reporting during the December 2015 "tussling" event. None of the records report photographic documentation of whether there were injuries.

**RECOMMENDATIONS:**

1. Provide Monitor documentation of Compliance with this Provision.

**j. Prompt administrative review of use of force reports for accuracy;**

**ASSESSMENT: NON COMPLIANCE**

**FINDINGS:** The November UOF incident previously described demonstrates noncompliance with this Provision. A two week interval between a UOF incident and review does not meet this requirement. Additionally, the reviews examined demonstrates deficiencies in review accuracy as discussed.

**RECOMMENDATIONS: Previous recommendations remain appropriate.**

1. Ensure that supervisor/administrative reviews of incidents involving use of force resolve problems related to reporting accuracy, completeness, and consistency.

2. Provide the Monitor documentation of Compliance with this Provision for ALL previous use of force incidents as requested.

**k. Timely referral for criminal and/or administrative investigation based on review of clear criteria, including prisoner injuries, report inconsistencies, and prisoner complaints;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as discussed above in this set of Provisions.

**RECOMMENDATIONS:** Implement policy once approved

**l. Administrative investigation of uses of force;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Implement policy once approved.

**m. Central tracking of all uses of force that records: staff involved, prisoner injuries, prisoner complaints/grievances regarding use of force, and disciplinary actions regarding use of force, with periodic evaluation for early staff intervention;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above. No central tracking system has been developed by GGACF officials; this system will not be of much value unless and until quality assurance managements measures, as previously discussed, are in place and determined to be effective.

**RECOMMENDATIONS:**

1. Develop and implement Central Tracking system to include all required elements.

**n. Supervisory review of uses of force to determine whether corrective action, discipline, policy review or training changes are required; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This policy draft remains under review.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Immediately issue directives to supervisors to complete reviews for all incidents involving use of force. Monitor compliance, correct deficiencies, and document compliance with this provision.

**o. Re-training and sanctions against staff for improper uses of force.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Noncompliance with this provision is a cumulative result of noncompliance with the Use of Force section of the Agreement. Re-training and sanctions against staff for improper use of force cannot be appropriately determined without routine and adequate administrative review of force events. Compliance with this provision is contingent upon compliance with the administrative review provision.

**RECOMMENDATIONS:**

1. Comply with Administrative Review provisions of this Agreement.

2. Develop and prepare to implement remedial use of force training.

**I. Use of Physical Restraints on Prisoners**

**1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies to protect against unnecessary or excessive use of physical force/restraints and provide reasonable safety to prisoners who are restrained. Such policies will address the following:**

**a. Permissible and unauthorized types of use of restraints**;

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement this policy once approved according to the new schedule.

**b. Circumstances under which various types of restraint can be used;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above

**RECOMMENDATIONS:**

1. Same as above.

**c. Duration of the use of permitted forms of restraints;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: Same as above.

**RECOMMENDATIONS:** Same as above.

**d. Required observation of prisoners placed in restraints;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.
**RECOMMENDATIONS:** Same as above.

**e. Limitations on use of restraints on mentally ill prisoners, including appropriate consultation with mental health staff; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above.

**f. Required termination of the use of restraints .**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above

**J. Prisoner Complaints**

1. Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies so that prisoners can report, and facility management can timely address, prisoners' complaints in an individual and systemic fashion. Such policies will include the following:

**a. A prisoner complaint system with confidential access and reporting, including assistance to prisoners with cognitive difficulties;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The parties and this Monitor remain engaged in the final review and approval process for these policies and procedures. The draft documents include language to provide prisoners confidential access and reporting of complaints, and assistance for prisoners of communication and cognitive disabilities and/or impairments.

The existing prisoner complaint (grievance) system remains problematic for ensuring meaningful, timely, and consistent response and resolution of prisoner complaints. This is determined by examination of the current GGACF Grievance Log for October – December 2015. This log demonstrates marginal but insufficient improvement compared to previously reported findings.

The log records 49 prisoner complaints for the period assessed. Prisoner complaints involving an array of issues, including: food service (11), prisoner work issues (5), complaints about staff conduct (9), medical concerns (1), housing conditions (1), and "other" (22). The table below quantifies prisoner complaints assessed:

| GGACF Prisoner Grievances Recorded - October - December 2015 | | | | | |
|---|---|---|---|---|---|
| Issue / Month | Oct | Nov | Dec | N | % |
| Food Service | 3 | 2 | 6 | 11 | 22% |
| Work Issues | 3 | 1 | 1 | 5 | 10% |
| Staff Conduct | 9 | 0 | 0 | 9 | 18% |
| Medical | 0 | 1 | 0 | 1 | 2% |
| Housing Conditions | 0 | 0 | 1 | 1 | 2% |
| Other | 6 | 8 | 8 | 22 | 45% |
| Totals | 21 | 12 | 16 | 49 | 100% |
| & | 43% | 24% | 33% | | |

Log document quality remains deficient for effectively managing and tracking prisoner complaints. Accurate and complete recording of prisoner complaints requires consistent entry of specific information about a complaint on the log. Accurate and complete entry of this information in the log allows GGACF management the ability to track complaints by prisoner and ensure whether complaint resolution is meaningful and timely.

Examination of the 49 logged complaints found 38 of the required entries were missing. Information missing on the log included the prisoner BOC# (1), date complaint was received (1), time complaint was received (6), response to complaint date (10), the date the response was returned to the prisoner-complainant (10), and descriptive response to the complaint (10). There were 38 missing information elements for the 49 complaints logged for this review period. The table below quantifies missing information for the complaints logged:

| GGACF Prisoner Grievance Log - October - December, 2015 | | | | | |
|---|---|---|---|---|---|
| **Compliance Information Omitted** | **Oct** | **Nov** | **Dec** | **Ttl** | **%** |
| **BOC#** | 1 | 0 | 0 | 1 | 2.6% |
| Date Received | 0 | 0 | 1 | 1 | 2.6% |
| Time Received | 0 | 3 | 3 | 6 | 15.8% |
| Classification | 0 | 0 | 0 | 0 | 0.0% |
| Type | 0 | 0 | 0 | 0 | 0.0% |
| Date Forwarded | 0 | 0 | 0 | 0 | 0.0% |
| Response DueDate | 0 | 0 | 0 | 0 | 0.0% |
| Response Date | 2 | 3 | 5 | 10 | 26.3% |
| Date Returned to Inmate | 2 | 3 | 5 | 10 | 26.3% |
| Summary | 0 | 0 | 0 | 0 | 0.0% |
| Response | 2 | 3 | 5 | 10 | 26.3% |
| **Totals** | 7 | 12 | 19 | 38 | 100.0% |
| **Missing Information / Complaint Ratio** | 0.33 | 1.00 | 1.19 | 0.78 | |

This document quality problem appears to have increased from October to December 2015. The ratio of missing information to recorded complaints grew from .33 (1 error in 3 complaints) to 1.19 (more than 1 error per complaint recorded). These document quality problems have been repeatedly reported and discussed with GGACF management staff. These findings echo document and process quality assurance and accountability problems described elsewhere in this and previous compliance reports.

The grievance log seems to demonstrate a decrease in the time interval from receipt of a prisoner complaint to the date when a response is returned to the prisoner. However, document quality problems do not allow for a definitive conclusion.

GGACF appears to use a seven (7) day interval from receipt of a complaint to when a response is to the prisoner. These time intervals were analyzed by subtracting dates logged for when complaints were received from when response were due. Thirty-eight (39/80%) of the 49 complaints logged included dates required for this analysis.

Response-time compliance analysis findings:

- 39 (80%) of the 49 prisoner complaint records were usable for this analysis
- 15 (38%) of the usable records recorded responses beyond required due dates
- Usable records decreased from October to December, 90% to 69% respectively
- Late responses decreased from October from 63% late response to zero (0) in December

The table below describes analysis findings:

| GGACF Prisioner Complaint Response Timeliness Analysis | | | | |
|---|---|---|---|---|
| Response Lateness | Oct | Nov | Dec | Total |
| Total Records | 21 | 12 | 16 | 49 |
| Usable Records | 19 | 9 | 11 | 39 |
| % Usable Records | 90% | 75% | 69% | 80% |
| Late Responses | 12 | 3 | 0 | 15 |
| % Late Responses | 63% | 33% | 0% | 38% |
| Late Days 1-3 | 9 | 2 | 0 | 11 |
| 4 - 7 | 0 | 0 | 0 | 0 |
| 8 - 10 | 1 | 0 | 0 | 1 |
| 11 - 15 | 0 | 0 | 0 | 0 |
| > 15 | 2 | 1 | 0 | 3 |
| Total | 12 | 3 | 0 | 15 |

The grievance log requires entering a narrative response to prisoner complaints; no responses were recorded for 10 of the 49 records. Narratives recorded are very brief and seem to describe what the responder will do or did about the complaint. Many of the response descriptions do not consistently or clearly describe the response that was actually provided to a prisoner who filed a complaint. The log does not adequately record or describe whether or how a complaint is finally resolved but should. Below are some specific examples of this observation:

| Logged Prisoner Complaint Summary | Logged Response to Prisoner Complaint |
|---|---|
| 10/1/5 - Inmate stated he was suspended from work in the kitchen without a copy of complaint & a proper investigation filed against him due to complaint made against him by cook. | 10/26/15 - Response: Inmate case reference his termination from the kitchen was forward to the chief Investigator for further review. |
| 10/1/15 - request Officer not be allowed to be present around his meals because officer have spit and masturbated in his food. On August 23, 2015 stated that he was going to urinate in his tea. This is an ongoing problem and he will file a law suit for violation of detainee rights. | 10/13/15 - Chief stated inmate Complaint was forward to the Chief Investigator for further investigation |
| 10/30/15 - Inmate said he was charged and placed in lockdown but charges were dismissed. He wanted to know where he was deem a threat to the facility. | 11/4/15 - Chief will make an inquiry as to the reasons inmate was deemed a threat to the institution and will let him know by 11/6/15 |

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and correction action.

2. Ensure tracking log is consistently completed and accurate.

3. Assign reliable and timely oversight of the inmate complaint process and logs to a staff person who will provide the process consistent, dedicated, and comprehensive attention.

4. Develop a valid and reliable tracking a quality management statistical report for monitoring inmate and facility needs and problems.

5. Ensure staff are available during onsite visits to allow this Monitor to adequately assess this Provision.

**b. Timely investigation of prisoners' complaints, prioritizing those relating to safety, medical and/or mental health care;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Notwithstanding previously described omissions in required log information, there have been significant delays in investigating serious prisoner complaints. This is partly due to the delays in filling the Investigator vacancy. It is also the result of GGACF not prioritizing such complaints to ensure timely complaint resolution. This problem appears to be improving with the hiring of a qualified investigator.

1. The "Type" column is intended to prioritize a complaint as "emergency" or "normal". However, this column is often blank.
2. Response to "emergency" complaints can range from zero (0) to nine (9) days.
3. Descriptions of prisoner complaints often do not support designating the complaint as an emergency.
4. Response often does not articulate what, if any, emergency (or even urgent) actions were taken to resolve the complaint.

The inmate complaint system remains problematic and unreliable. The grievance log is inconsistently maintained and confusing on its face. **This issue has been discussed with GGACF management officials at each site visit with little or no substantive improvement accomplished to date. The Monitor and USDOJ were assured by GGACF management this matter would be corrected but records consistently demonstrate otherwise.**

**RECOMMENDATIONS:** Same as above

**c. Corrective action taken in response to complaints leading to the identification of violations any departmental policy or regulation, including the imposition of appropriate discipline against staff whose misconduct is established by the investigation of a complaint;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Documentation provided is inadequate for assessing compliance with this provision. The description of the prisoner complaint system discussed above is also suggestive of noncompliance with this provision.

**RECOMMENDATIONS:**

1. Develop quality assurance process to ensure the completeness and accuracy of the Grievance Log documents and processes.

**d. Centralized tracking of records of prisoner complaints, as well as their disposition; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: Same as above.

**RECOMMENDATIONS**: Same as above, and:

1. Develop and implement a formal and reliable centralized tracking system of inmate complaints and grievances that includes necessary complaint information and facts and complaint disposition.

2. Monitor the current tracking system to ensure timely, consistent, and complete administration.

**e. Periodic management review of prisoner complaints for trends and individual and systemic issues.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Similar to administrative investigations, use of force and incident reviews, this process remains essentially nonexistent.

**RECOMMENDATIONS:** Same as above.

1. Conduct monthly administrative reviews of the inmate complaint/grievance tracking reports. Use data from those reviews to identify patterns of individual staff and inmate problems, as well as systemic problems in need of correction.

**K. Administrative Investigations**

**1. Defendants will develop and submit to USDOJ for review and approval facility-specific policies so that serious incidents are timely and thoroughly investigated and that systemic issues and staff misconduct revealed by the investigations are addressed in an individual and systemic fashion. Such policies will address the timely, adequate investigations of alleged staff misconduct; violations of policies, practices, or procedures; and incidents involving assaults, sexual abuse, contraband, and excessive use of force. Such policies will provide for:**

**1. Timely, documented interviews of all staff and prisoners involved in incidents;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The Investigator (Chief Inspector) position was filled prior to our last inspection. The Chief Inspector reported that two (2) additional positions have been created for investigators. Both of those investigators will be interchangeable between GGACF and the St. Thomas Facility. Furthermore, the Territory informed the Monitor that one of these two investigator positions has been hire and begins work on 3/16. However, it will take some time for the Office of the Chief Inspector to be fully developed and fully functional. These are certainly steps in the right directions. Also, please refer to the discussion/findings noted in paragraph E-1 of this report.

**RECOMMENDATIONS**: Same as previous report

1. Fill the vacant investigator positions.

2. Supervisory/management staff must be consistently held appropriately accountable for adherence to agency rules, regulations, policies, and procedures.

3. The November 2014 housing unit riot must be thoroughly investigated and reviewed to prevent similar future events and to improve organizational planning, response, and management of these types of major incidents.

**2. Adequate investigatory reports that consider all relevant evidence (physical evidence, interviews, recordings, documents, etc.) and attempt to resolve inconsistencies between witness statements;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:**

1. Same as above.

2. Develop, as part of these, methods for adequate collection, recording, handling, labeling, preserving, and maintaining administrative investigation evidence, information, data, etc.

3. **Centralized tracking and supervisory review of administrative investigations to determine whether individual or systemic corrective action, discipline, policy review, or training modifications are required;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No substantive change since previous visit, but with the creation of the Chief Inspector's Office and with the ultimate addition of investigators, it is expected that this area of the Settlement Agreement will advance in compliance ratings in future inspections. We are encouraged that the Territory is taking steps to develop and implement a credible investigatory component as previously noted in this report.

**RECOMMENDATIONS:**

1. Refer to previous findings regarding information tracking systems and methods.

2. Ensure tracking system maintains salient facts and information to support systematic administrative decision-making for initiating remedial/corrective actions, staff/inmate discipline where indicated, efficacy of policy, procedure, and/or training and, that supports valid and reliable changes and/or revisions to the process.

**4. Pre-service and in-service training of investigators regarding policies (including the use of force policy) and interviewing/investigatory techniques; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Examination of the CV provided by the Territory of the Investigator infers this person is well qualified, but specific documentation of pre-service and in-service training is still not apparent. Additionally, training on the new Use of Force policy will be essential to the investigative process and expectations regarding the use of force.

**RECOMMENDATIONS:**

1. Fill the currently vacant Investigator positions as soon as possible.

2. Finalize, approve, and implement relevant policies and procedures.

3. Create a formal pre- and in-service training program to train staff who are involved in initial and/or administrative investigation.

4. Provide adequate training of investigative staff on topics in areas of incident scene investigation and appropriate administrative investigation methods, processes, techniques, legal and ethical issues, etc.

5. Provide training for administration/leadership staff in the areas of administrative investigation oversight, coordination, and management.

6. Develop and implement, as an adjunct to these policies and procedures, an "Investigators Manual" that provides guidance to staff responsible for oversight and investigative activities.

7. Provide the Monitor qualification documents for the newly appointed Chief Investigator for review upon his/her appointment**.**

**5. Disciplinary action of anyone determined to have engaged in misconduct at Golden Grove.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No change from previous Report.

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

1. Finalize, approve, and implement relevant policies and procedures.

2. Review and revise current regulations on staff disciplinary actions and penalties to ensure completeness and efficacy.

3. Integrate the information in the above into the administrative policies and procedures previously discussed.

4. Record and maintain onsite records of staff misconduct investigative reports and determinations.

5. Protect the integrity and confidentiality of these staff records, control access to records, provide a process for authorizing legitimate access and review of these records for general reporting purposes, monitoring, and supervision of staff.

6. Provide training to supervision staff in the appropriate use of this information for purposes of staff supervision, counseling, discipline, promotion, etc.

7. As with all training, especially training required for and that supports the monitoring of the Agreement, ensure complete training records are maintained onsite.

## V. MEDICAL AND MENTAL HEALTH CARE

Defendants shall provide constitutionally adequate medical and mental health care, including screening, assessment, treatment, and monitoring of prisoners' medical and mental health needs. Defendants also shall protect the safety of prisoners at risk for self-injurious behavior or suicide, including giving priority access to care to individuals most at risk of harm and who otherwise meet the criteria for inclusion in the target population for being at high risk for suicide.

**1. Accordingly, Defendants will develop and submit to USDOJ and the Monitor for review and approval, facility-specific policies regarding the following:**

**a. Adequate intake screenings for serious medical and mental health conditions, to be conducted by qualified medical and mental health staff;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS:** With regard to the policies and procedures, all of the medical policies have been approved and training has been provided to more than 95% of the staff, and those staff have scored better than 80% on a post-training exam. It is interesting to note that as we reviewed records we did find some issues in each of those three areas, although overall, there has been significant progress since our September visit. This is the first visit to find a stable onsite Medical Director who is committed and invested in the outcomes of her patients.

With regard to the intake policy and procedure, the staffing does not yet allow 24/7 coverage by registered nurses. At best, nurses are onsite until usually between 8:00 a.m. and midnight, thus leaving a minimum of eight hours and sometimes longer without the presence of a registered nurse. We also continued to find delays in the completion of the nurse screen for up to 20 or more hours from the time of entry to the facility. All of the records we reviewed of patients entering the facility since our last monitoring visit did have nurse screens completed by a registered nurse within the first 24 hours. However, it was more common than not that patients waited between 12 and 20 hours for that screen to be completed. We also reviewed a record of a patient who had their nurse screen on Day 1 and had their practitioner exam on Day 2, but the inmate's booking information was not entered into the computer system until Day 3. We addressed this with the Director of the Bureau of Corrections. We were told that this delay occurred as a result of classification staff not being onsite on weekends. In my experience, since the booking process is in fact a 24/7 process, there should always be staff onsite who can enter newly booked inmates or detainees into the offender tracking system. The Director indicated he would look into the reasons why this delay was occurring.

Although the timeliness requirement includes no later than 24 hours after booking, the expectation is that the process will be completed within four hours of the booking the inmate. It is a liability for both the patient and the Territory to have a person sitting onsite in the intake area

while the program has no understanding of his medical issues. The nurse intake screen should be viewed as analogous to the fingerprinting for custody. Thus, the nurse intake screen is the medical fingerprint for each inmate, allowing the jurisdiction to know not only the inmate's criminal background but also their medical needs.

We also reviewed a record of a patient who, when entering, appeared to be receiving methadone maintenance and yet this was not addressed. We discussed this case with the Medical Director. Since the facility is not licensed to provide methadone maintenance, there are two options to consider. One option would be to have the program in which the patient was enrolled to provide methadone on a daily basis by bringing the methadone to the facility. A more likely option is for the methadone program to recommend a detoxification regimen to be provided at the facility until the patient is released.

We also reviewed the tuberculosis screening program and generally found it satisfactory. However, in patients identified as having a positive skin test at the time of reading by the nurse, she/he should re-query questions with the patient with regard to acute TB symptoms and then document this in the record, for example, "The patient denies cough, weight loss, night sweats or coughing up blood." Overall, there has been improvement in the quality and completion of nurse intake screening. Enabling registered nurses onsite around the clock should, along with review and feedback by the head nurse, result in improved performance.

**Patient #1**
This patient is a 23-year-old who arrived at the facility on 11/14/15, which was a Saturday. The patient had insomnia, bipolar disorder, claustrophobia and asthma. He was listed as a priority 1 due to mental health issues. He was seen by Ms. Murray (the mental health coordinator) on 11/17 for a complete mental health screen.

**Patient #2**
This patient is a 49-year-old who arrived at the facility on 11/18/15, and his screen was on 11/19. He arrived on a Thursday at 3:50 p.m., but his intake screen was not done until the following day. He was also seen by a physician on 11/19.

**Patient #3**
This patient is a 55-year-old female who arrived at the facility on 11/12/15 at 6:08 p.m. She had her screen on 11/13 at 3:10 p.m. The patient was identified as having PTSD and depression and was classified as a priority 1 because of mental health issues. She was seen by mental health staff within the first week.

**RECOMMENDATIONS:**

1. Fill the registered nurse positions so that there is 24/7 registered nurse-staffing onsite.

2. When nurses identify a patient with a positive TB skin test, they should re-query the patient regarding acute TB symptoms.

3. The Medical Director should discuss with the methadone maintenance program a regimen that allows satisfactory detoxification from methadone while the patient is incarcerated.
4. The Director must arrange for booking to be entered into the computer at the beginning of the intake process.

5. The goal for completion of the nurse intake screen must be within four hours of the entry into the offender tracking system of the booking information.

6. Complete the training and post-test examinations for relevant medical staff with regard to the infection control policy, the intoxication and detoxification policy as well as the discharge planning policy.

**MENTAL HEALTH FINDINGS:** See above noted medical findings as they relate to the timeliness of the intake screenings and plans to now perform these screenings in the intake facility.

As noted in the last report, it appears that there is a subset of new admissions who are either unwilling or unable to reveal a history of serious mental health difficulties and/or current mental health difficulties at intake, but who then do reveal such during the initial mental health assessment, which is currently being performed on all new admissions. Although there are likely various reasons why this occurs, there is concern that the perceived lack of privacy afforded by performing intake screenings in the intake facility (vs. a private room in the medical facility) might make it even more difficult for some new admissions to reveal any significant mental health difficulties during the intake screening process. Therefore, we will continue to carefully monitor for this.

**RECOMMENDATIONS:**

1. Track data to support evidence of successful implementation of the policy and demonstrate adequacy of the quality of the screening process.

2. Continue to examine cases where an inmate with a negative mental health screen is later identified as an inmate in need of mental health services, and then explore options for altering the mental health screening process (be it the content and/or the conditions under which it is performed) so as to minimize the number of such false negative mental health screenings.

3. Assure that the mental health training that will eventually be provided to corrections officers helps them to appreciate the importance of their use of the ‘behavioral checklist’ and

enhances their ability to use the 'behavioral checklist', given that the 'behavioral checklist' is one of the ways to identify inmates who are suffering from mental health problems that were not identified at intake.

4. Continue the practice of completing mental health assessments on all new admissions.

**b. Comprehensive initial and/or follow-up assessments, conducted by qualified medical and mental health professionals within three days of admission.**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS**: As we understand it, Dr. Callwood, the Medical Director, is onsite Monday through Wednesday and Dr. Park has filled in when he has been available. Our understanding is that another physician has been identified who is very interested in working Thursdays and Fridays, which would provide sufficient coverage for more timely intake history and physicals. We understand this position has been filled as an employee v. a contractor.

**Patient #1**
This patient is a 34-year-old who arrived at the facility on 11/3/15 with a history of seizure disorder. He had his intake screen that day and he was assessed as acuity 2, but he did not receive his physical exam until six days later. At the time of the exam, he complained of chest pain and the history obtained was insufficient.

**Patient #2**
This patient is a 25-year-old who arrived at the facility on 10/22/15 and was screened on 10/23 at 11:00 a.m. He had a history of asthma and his peak flow was 400. He was an acuity 1 and was seen by the physician that day, but there was no mention of the asthma and no follow-up chronic care visit.

**RECOMMENDATIONS:**

1. Pursue a contract for additional physician hours so that the history and physical can be provided timely.

2. The Medical Director should provide feedback to the Head Nurse with regard to the appropriateness of the acuity level assignment from the nurse screen.

3. The Medical Director should develop a procedure that insures a timely initial chronic care visit based on disease control. If the patient meets disease control criteria of good control, the initial chronic care visit must be no later than 3-4 weeks; if the patient meets the criteria of fair control, no more than 2 weeks, and if the patient meets the disease control criteria of poor control, no more than 1 week for the scheduled initial chronic disease visit.

**MENTAL HEALTH FINDINGS:** As was noted in the prior report, the 'psychosocial assessment intake log' indicates that initial mental health assessments are being performed on *all* new admissions the day of or the day after the mental health unit received the intake screening. Therefore, comprehensive mental health assessments are being performed well within three days of admission, except in cases where there was a delay in performing the intake screening, or a delay in sending the results of the intake screening to mental health staff.

Psychosocial assessments are now also being performed on inmates who entered the facility prior to the time when such assessments were being performed on all new admissions, with the initial focus being on completing assessments on inmates who are currently on the mental health caseload.

As recommended, the 'initial mental health assessment form' has been expanded to include a more rigorous assessment of any history of serious trauma, especially violent trauma, and the presence of any resultant clinically significant trauma-related symptoms and/or developmental difficulties, especially those that might render the inmate subject to deterioration and/or behavioral difficulties while incarcerated.

Also as recommended, the 'psychosocial assessment intake log' has been modified to include the date when inmates who are referred to see the psychiatrist actually see the psychiatrist. A review of this modified log reveals that those inmates who are referred to the psychiatrist generally see her in a timely manner. However, as previously noted, a timely face-to-face evaluation by the psychiatrist is not always possible due to the fact that the psychiatrist, who is part-time, is not always at the facility; when the psychiatrist is not at the facility, she is contacted by telephone for a consultation. However, the availability of video conferencing would allow her to actually perform an evaluation when she is offsite, which would be particularly helpful in cases where the inmates' status is noted as urgent. We understand the Territory has begun the process of installing Tele-psychiatry (VSEE). It has been installed on one of the exam room computers. The Territory is in the process of installing the system on other computers, including Dr. Callwood and Dr. Sang's personal computers.

**RECOMMENDATIONS:**

1. Continue to track inmates entering the facility and monitor time from admission to screening to initial psychosocial assessment, and to initial psychiatric assessment for those referred for an initial psychiatric assessment.

2. Continue performing initial mental health assessments on all new inmates, and continue efforts to perform such assessments on those who entered the facility prior to the time the current initial mental health assessments were being performed.

3. Develop a video conferencing mechanism that would allow the psychiatrist to perform psychiatric evaluations from an offsite location.

4. To the extent that the initial psychosocial assessment fails to identify any inmates with serious mental health difficulties (later picked up as a result of a referral to mental health by

way of a 'behavioral check list'), explore for factors that might have contributed to the failure of the initial assessment process to identify that inmate's mental health needs.

5. Develop a protocol or procedure for responding to inmates who refuse to engage in an initial mental health assessment.

**c. Prisoners' timely access to and provision of adequate medical and mental health care for serious chronic and acute conditions, including prenatal care for pregnant prisoners;**

**ASSESSMENT: NONCOMPLIANCE (Partial Compliance for Medical, Non Compliance for Mental Health)**

**MEDICAL FINDINGS:** We have used this section to address medical sick call, focusing on the acute part of the section. A separate section deals with chronic care needs.

The sick call log was consistently utilized and again we are able to report that a nurse generally saw the patients timely; most patients were seen by a nurse on the same day as receipt of the request. The exam rooms in the housing areas, according to staff and our own tour, have been completed and are available for appropriate use. In some records, we found insufficient subjective data obtained and in other records insufficient objective data obtained.

**Patient #1**
This patient is a 21-year-old who arrived at the facility on 9/3/13. On 11/19/15, he complained of painful urination. His vital signs were normal and no urinalysis was done, we were told, because the appropriate equipment was not available. This patient was seen by a physician and appropriate treatment was provided.

**Patient #2**
This patient is a 35-year-old with a history of hypertension, bipolar disorder and seizure disorder along with hypertriglyceridemia. On 11/23/15, he complained of chest pain. Among the elements that are considered necessary for a history with regard to chest pain are things that make the chest pain worse or things that make the chest pain better, and these were absent from the history.

**Patient #3**
This patient is a 25-year-old who arrived at the facility on 12/2/14. The patient presented with a history of asthma. On 11/9/15, he complained of shortness of breath and a chest cold for two days. He also complained of wheezing at night. His peak flow rate was 350. The patient was provided nebulization treatment; however, there was no post-treatment peak expiratory flow rate documented in the record. The peak flow is appropriate in order to objectively quantify the improvement after treatment.

**RECOMMENDATIONS:**

1. The head nurse should provide feedback with regard to the nursing professional performance with regard to sick call.

2. Implement a procedure such that nurses by protocol always obtain a pre and post nebulization treatment peak expiratory flow rate.

3. Most of the nurse sick call should be completed within the housing unit exam rooms. This will require transporting the medical records to the housing unit exam rooms.

**MENTAL HEALTH FINDINGS**: As noted in the last report, the 'mental health follow-up log' lists all detainees and inmates who are on the mental health caseload, their psychiatric diagnosis, whether they have been on a suicide watch, placed in restraints or placed in seclusion, the date of their last psychiatric evaluation and any prescribed psychotropic medications, and the scheduled date for a follow-up psychiatric evaluation. Given the exciting development of non-psychopharmacologic therapeutic interventions, these will also be noted on the follow-up log.

As recommended, the frequency of psychiatric follow-up visits has been reviewed, with a focus on whether or not at least some inmates were being seen frequently enough. As a result, the time between psychiatric follow-up visits has been reduced to a time period that is well within the standard.

Much thought has been given to the development of a clear protocol for inmates with major Axis I psychiatric disorders, for which treatment with psychopharmacologic agents is indicated but who either totally refuse to take medication or are not fully compliant with medication. With further exploration of the problem, examples of various types of situations were identified. For example, Patient #1 suffers from schizophrenia and is on lots of medication. He periodically refuses to take his medication, but usually when asked the next day he will take his medication. If such a patient refuses oral medication too frequently, IM medication would be considered. Patient #2 also suffers from schizophrenia. He has consistently refused to take medication and gets extremely angry when it is suggested that he take medication. Otherwise, he isn't a threat to himself or others and does not present a management problem, and so he has not been forced to take medication. In contrast, Patient #3, who also totally refuses to take medication, threatens staff and is otherwise a major management problem. Therefore, steps need to be taken to go to court to force treatment. Patient #4 represents a subset of those who refuse to take psychotropic medication in that he also refuses to take medication for other chronic and potentially life-threatening medical conditions. Going to court to force treatment should be an effort made by both the mental health unit and the medical unit. Therefore, a clear protocol for those who are not fully compliant with medication and those who totally refuse to take medication must recognize these different patient types.

As previously noted, the 'behavioral checklist/sick call log' lists all inmates for which a 'behavioral checklist' or a 'sick call request' was completed, the nature of the complaint, the date the form was received, the date the social work assessment was performed, if/when a referral to the psychiatrist was made, the date of any requested psychiatric evaluation, and the date for any

required follow-up. In addition to tracking all of this information, the information contained in this log also helps in efforts to monitor the efficacy of the initial assessment process (to the extent that it identifies inmates who were not previously found to have clinically significant mental health needs), and helps to monitor the efficacy of the treatment provided (to the extent the it identifies inmates who are already on the mental health case load who are continuing to have significant difficulty despite receiving treatment – for example, as noted above, this information helped to identify the fact that some patients needed to be seen more frequently than they were being seen).

The non-psychopharmacologic treatment options continue to be an extremely helpful and very popular service provided by the mental health unit, especially the group therapy program. As was recommended, the possible addition of a 'psychoeducational group', focused on helping those with major mental health disorders learn about their disorders and how to best participate in the management of their disorder; a 'dual-diagnosis group', focused on those with a substance abuse disorder and another major mental health disorder; and a 'support group for those with a history of exposure to severe trauma(s)' is being explored.

It is important to again note that the fuller implementation of non-psychopharmacologic treatment options requires filling the remaining mental health staff positions, completing the renovation of space where group therapy, etc. will be done, and the timely availability of corrections staff to transport inmates to and from group therapy sessions, etc.

In addition, it appears that the mental health staff is unaware of the work that has been done to develop PREA policies and procedures, and they are therefore unclear about their role in the implementation of PREA policy and procedures. Although this monitor initiated discussion with the mental health staff about all of this, it became clear that a more complete review of PREA and PREA policies and procedures must be provided to mental health staff before staff can become clear about their expected roles and responsibilities and prepare to assume those roles and responsibilities. We understand The Territory has begun the process of getting the staff acquainted with the policy ahead of any training. It has been provided to the staff and portions of the policy relevant to mental health have been highlighted for ease of reference.

**RECOMMENDATIONS:**

1. Moving forward, a variety of quality indicators regarding services should be developed and maintained to aid the staff in ongoing quality improvement reviews as well as provide proof of practice for the monitoring team and any other Bureau, independent agency or accrediting body.

2. Continue to expand non-psychopharmacologic treatment options, which will include addressing some of the impediments to such an expansion noted above.

3. Formalize the protocol or procedure for responding to inmates for whom psychopharmacologic intervention is indicated but yet refuse to take medication. This is especially important for those inmates who are being held in seclusion because they are not receiving treatment despite the fact that they are so severely mentally ill.

4. Take the above noted necessary steps to help mental health staff understand their expected roles and responsibilities with regard to PREA and prepare to assume those roles and responsibilities.

**d. Continuity, administration, and management of medications that address**

**(i) timely responses to orders for medications and laboratory tests;**
**(ii) timely and routine physician review of medications and clinical practices**
**(iii) review for known side effects of medications; and,**
**(iv) sufficient supplies of medication upon discharge for prisoners with serious medical and mental health needs;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** There is a Medical Director on-site three days a week. We were told that from the time of ordering to the time of receipt by the patient, the process is working timely. However, there have been no quality improvement studies that document such timeliness. In addition, the Medical Director has not yet begun to review the use of medications, particularly by practitioners other than herself. Finally, we came across a patient with both medical and mental health issues who was released from court, returned to the jail and was released from the jail without ever receiving any of the regimen for medical and mental health problems. We were told that this occurred because when patients are released from court, custody does not notify the medical department so it can review the record, obtain any necessary medications and, if possible, arrange for post-release appointments. Two of the elements that could be studied and documented have not yet begun to be implemented and therefore the current assessment of noncompliance.

The new Medical Director has arranged for a different pharmacy and has reworked the contract with the pharmacist so that the pharmacist is predominantly monitoring the medication program and ensuring that the program minimizes the possibility of errors and complies with Territorial law.

During this visit, we observed the medication administration during the morning medication pass in several of the housing units. The officer who accompanied the nurse did an excellent job of ensuring that patients identified themselves. They brought water to the medication administration, the patients swallowed the medication with water and they cooperated in the post-ingestion mouth check. However, there was still one patient who did not swallow water either during the ingestion or immediately after, and did not cooperate with the mouth check. This behavior violates the rules of receiving medication, rules that have been provided to the inmates. The inmate has a right to refuse any and all medication, but they do not have a right to determine the rules under which the

administration occurs. Therefore, we indicated that the particular inmate in question needs to be counseled such that he will not receive medication if he does not comply with the rules. He must ingest water at the time of administration or immediately thereafter and participate in a mouth check. Also, the nurse performing the medication administration brought all the patient medications together for each housing unit and they were not easily separated by patient. We indicated that the carrying container should include a vehicle to better organize the patient medications so that she can be certain that each patient appropriately receives the correct and complete regimen. We understand the GGACF Warden issued on or about 12/8/15 a directive to all security staff and management a directive mandating specific procedures for complying with the pill call process. This directive was re-issued on 2/21/16. This process will be assessed again during the 11th onsite visit.

**RECOMMENDATIONS:**

1. The medical program should work with custody so that there is a procedure that arranges for a timely notification of patients soon to be released by the courts. This is necessary so that the medical department, once notified, can review the medical record and arrange for the patient to receive any medications and appointments necessary for successful reentry before they depart the facility.

2. The QI program should, with the Medical Director and Head Nurse, perform a study of a sample of orders provided by clinicians and track the time of the order along with the time of receipt. For the overwhelming majority of orders, the requirement is that receipt should occur within 24 hours.

3. The inmate who refused to follow the medication rules needs to be counseled that he will no longer be provided medication if he does not comply with the rules.

4. The nurses should be provided a carrying container that allows segregation of each patient's regimen within a particular cluster, e.g., housing unit. The Head Nurse should work with the nursing staff and the administrator to create such a methodology.

5. An electronic medication administration record will facilitate more accurate completion of the process and can be provided with several electronic records.

**MENTAL HEALTH FINDINGS:** See the discussion under medical findings with regard to medication administration.

As noted above, with more frequent visits, the timely and routine physician review of medications and clinical practices is much improved. The review for known side effects of medications is documented, and now with more frequent visits, such reviews are also timelier.

See also above discussion about medication noncompliance and the formalization of a protocol to address such.

During this monitoring visit, there was a much more detailed discussion about and review of discharge planning, especially with regard to providing inmates with a sufficient supply of medication upon discharge. This review revealed that there are inmates with very serious mental health difficulties who were being treated while incarcerated, but who were released without any medication. It at least appears that, for the most part, such inmates went to court and were released, then returned to the facility for their belongings but mental health wasn't notified that they were leaving the facility. Therefore, there was no chance to give them a supply of medication to use until they could begin treatment on the outside. This was particularly troubling, given that at least 3 of those released during the last monitoring period had previously evidenced symptoms such as auditory hallucinations and/or dramatic swings in their mood, at times accompanied by suicidal ideation. In at least one case, the psychiatrist had recommended long-term psychiatric placement upon release, a plan that could also not be implemented given that the mental health unit was not notified of his release.

This impediment to discharge planning and providing those being released with an adequate supply of medication was discussed with the administration, and options for addressing those impediments were explored. Whether or not any of those options are selected and implemented, and whether or not such implementation results in improved discharge planning will have to be determined at the time of the next site visit.

**RECOMMENDATIONS:**

1. The use of the medication refusal forms to allow nursing staff to notify clinicians of any significant pattern of medication refusal and the review of such forms by prescribing clinicians should be tracked. It may also be helpful to have a place on the form where the prescribing clinician can sign, indicating that the form has been seen and reviewed.

2. GGACF should develop a heat risk policy and ensure that all inmates have access to plentiful supplies of water and ventilation methods at all times. A list of inmates on medications that have heat-related risks should be maintained, and these inmates should have access to ice and water when the heat index indicates an elevated risk of heat-related illnesses.

3. GGACF should develop a heat risk policy and ensure that all inmates have access to plentiful supplies of water and ventilation methods at all times. A list of inmates on medications that have heat-related risks should be maintained, and these inmates should have access to ice and water when the heat index indicates an elevated risk of heat-related illnesses.

4. Regular assessment for medication adverse effects is well-documented, but through training such efforts should be expanded to involve all mental health staff in the identification of medication adverse effects.

5. The above noted impediments to the implementation of a discharge plan must be addressed so that inmates who are released receive an adequate supply of medication and a thoughtful referral to an appropriate treatment program/facility.

**e. Maintenance of adequate medical and mental health records, including records, results, and orders received from off-site consultations and treatment conducted while the prisoner or detainee is in Golden Grove custody;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS:** The medical record policy has been approved and the training and post-test and post-training examinations have been provided to the monitor. The filing errors have been substantially reduced. We have talked about the value of an electronic record so that records do not have to be carried to the housing units and multiple people can access completely legible records simultaneously.

**RECOMMENDATIONS:**

1. Continue to improve the organization of the medical records, including the timeliness and appropriateness of medical document filing.

2. Continue to explore the implementation of an electronic record.

**MENTAL HEALTH FINDINGS:** While doing chart reviews, it became clear that the organization of the mental health section of the medical records is much improved. As recommended, these records now also include all of the various therapeutic interventions that each inmate is receiving, including non-pharmacologic interventions.

As recommended, revisions to the 'treatment plan' reflect a multi-disciplinary approach to treatment planning, with a clearer indication of which interventions are focused on addressing which problems. What remains to be added to the treatment plan is a planned approach to addressing those who have refused treatment.

**RECOMMENDATIONS:**

1. Now that mental health records are appropriately organized and filed, a quality improvement tool needs to be developed to track compliance with this provision.

2. The mental health records should be organized chronologically.

3. The approved 'treatment plan' form needs further development, and should be expanded to describe planned interventions for those who have refused medication or other important therapeutic interventions.

**f. Prisoners' timely access to and the provision of constitutional medical and mental health care to prisoners including but not limited to:**

**(i) adequate sick call procedures with timely medical triage and physician review along with the logging, tracking and timely responses to requests by qualified medical and mental health professionals**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS:** This item was dealt with under letter (c), including recommendations for this provision. It must be emphasized that not only have the policies and procedures been approved, training provided and the exams passed by the staff, but also there is now stability in onsite coverage by the Medical Director.

**RECOMMENDATIONS:** See letter (c) findings and recommendations.

**MENTAL HEALTH FINDINGS:** The 'sick call log' and sick call procedures have already been discussed above, and a review of the log indicates that the response to sick call requests is consistently timely and complete.

**RECOMMENDATIONS:**

1. See section '1c' FINDINGS and RECOMMENDATIONS.

**f. (ii) an adequate means to track, care for and monitor prisoners identified with medical and mental health needs;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS:** We interpret this area as referring to a chronic care list and an ability to track the sequence of visits. Although the policies have been approved, training has occurred, and sufficient staff have passed the post-training tests, this area is clearly the farthest from substantial compliance. We reviewed five records of patients whose names were on the chronic care list. However, our review of all five records was sufficiently problematic such that we realized this program needs to be completely reworked. The medical monitor expects to spend some time with the new Medical Director providing technical assistance on how to best implement this area. Among the problems were records in which the problem list inside the medical record did not contain the problem for which the chronic disease program was following the patient. We also found a record in which, although the patient gave a history of a problem, was never confirmed by laboratory tests, although such confirmation should be easily available. We also found a significant number of records in which the initial chronic care visit was delayed, sometimes beyond 60 or 90 days. We also found records in which, after the initial chronic care visit, the patient was not seen in the appointed timeframe nor was there any explanation in the record. We also found records in which mandatory laboratory tests were not ordered as well as chronic care forms not appropriately completed. Some of the deficiencies in the documentation included inadequate subjective

information, inadequate objective information, lack of assessment of degree of control and sometimes inappropriate plans for the degree of control. We believe this program provides the biggest challenge for the new Medical Director.

**Patient #1**
This patient entered the facility with a history of lupus erythematosus; however, this diagnosis was not on the problem list. In addition, there were no laboratory tests to confirm that diagnosis.

**Patient #2**
This patient arrived at the facility in February 2004, with a history of hypertension, hyperlipidemia, glaucoma and bipolar disorder. His most recent visit was six months earlier, in June 2015. At that last visit, neither the hypertension nor the hyperlipidemia nor the glaucoma were addressed. Rather, the only documentation addressed a headache and cerumen in the ear canal. There was no mention of blood pressure control or hyperlipidemia control. There were no blood studies for hyperlipidemia.

**Patient #3**
This patient had a blank problem list despite his history of angina. He had an initial chronic disease visit in August 2015, but there was no assessment of degree of control and no lipid studies. This patient has not been seen since.

**Patient #4**
This is a 77-year-old patient with a history of prostate cancer, asthma and hypertension. He has been seen once a year on follow-up forms. He never had an initial chronic disease database completed. His last chronic disease visit was in September 2013, where it was ordered that the patient be seen again in two weeks. He has not been seen since.

**Patient #5**
This is a 44-year-old patient who arrived at the facility in December 2011 with type 2 diabetes, hypertension, hyperlipidemia and mental health issues. He had his initial chronic disease visit form completed in April 2014, but other than family history, everything else is blank. He was seen once in 2014 and twice in 2015. His most recent chronic disease visit was in October 2015. He was assessed as being in fair control for his diabetes and in good control for his hypertension. He was scheduled to be seen in November for his diabetes but this never occurred.

In summary, this program needs to be started anew, with an understanding of how to create and appropriately document chronic disease follow up.

**RECOMMENDATIONS:**

1. The Medical Director and the medical monitor should discuss the chronic disease program in its entirety with a plan evolving to rebuild the chronic disease program.

2. A chronic disease nurse should work closely with the Medical Director to insure that all patients have received the necessary diagnostic test per the required guidelines.

**MENTAL HEALTH FINDINGS:** As noted above, the 'mental health follow-up log' has been carefully maintained and is up-to-date. All patients on the mental health case load are consistently being seen and receiving treatment at appropriate intervals except those who have refused treatment; all modalities of treatment including group therapy sessions and other counseling services are logged; and the therapeutic interventions being employed appear to be appropriate.

**RECOMMENDATIONS:**

1. See section '1c' for recommendations regarding the 'mental health follow-up log'.
2. As the 'treatment plan' is expanded to include all services and the therapeutic goal(s) for each intervention, the development of an integrated treatment log for all interventions continues to be a recommendation.

**f. (iii) chronic and acute care with clinical practice guidelines and appropriate and timely follow-up care;**

**ASSESSMENT: NONCOMPLIANCE (Partial Compliance for Medical, Non Compliance for Mental Health)**

**MEDICAL FINDINGS:** See f (ii).

**RECOMMENDATIONS:** See f (ii).

**MENTAL HEALTH FINDINGS:** See sections '1b', '1c', '1d', and '1f' subsections i and ii

For clarity, it should be noted that the primary issue that is holding mental health back here is the development and implementation of a clear protocol for seriously mentally ill patients who refuse treatment. This will be a major focus during the next monitoring visit.

**RECOMMENDATIONS:** See sections '1b', '1c', '1d', and '1f' sub-sections i and ii

**f. (iv) adequate measures for providing emergency care, including training of staff: (1) to recognize serious injuries and life-threatening conditions; (2) to provide first-aid procedures for serious injuries and life-threatening conditions; (3) to recognize and timely respond to emergency medical and mental-health crises;**

**ASSESSMENT: NONCOMPLIANCE (Partial Compliance for Medical, Non Compliance for Mental Health).**

**MEDICAL FINDINGS:** We reviewed five records of patients who were listed in the unscheduled service log as needing unscheduled services, most of whom were ultimately sent offsite. The process for providing emergency care breaks down after hours when, we are told, that officers call the Head Nurse who then calls the Medical Director. She decides to send out the patients. We believe her ability to triage patients advanced once the Territory completes implementation of the tele-health system. We did find that both onsite and offsite unscheduled services were documented in the same log. We also toured the housing units and inspected the emergency bags. We were pleased to find that all bags were well-maintained and had been reviewed on a daily basis by medical staff. There has been an improvement in notification to the Medical Director of identified emergencies. Most patients had the offsite service documents filed in the record and initialed as having been reviewed and, in addition, most saw the doctor upon return within a few days. However, there can be improvement in the timeliness of retrieval of offsite service documents; we found a record in which the offsite service document was reviewed and initialed by a nurse only. We were informed that four days after the patient returned, the patient was released and the document was retrieved after release. We indicated to the Medical Director that the nurse should initial that document and explain that this was received post-release and that is why the physician had not reviewed it.

**Patient #1**
This patient is a 35-year-old with hypertension, bipolar disorder, seizure disorder and hypertriglyceridemia who arrived on 11/23/15. He was sent out due to chest pain and his offsite service report was available, but not until the patient was released, about four days later. The nurse initialed it without indicating on the report that it had been received after release.

**RECOMMENDATIONS:**

1. Continue to aggressively pursue offsite service documents so that they are retrieved as timely as possible for use by the Medical Director.

2. The Medical Director should utilize actual cases to review and discuss with the nursing staff with regard to what was performed well and what items could be improved.

**MENTAL HEALTH FINDINGS**: See medical findings and recommendations. Also, correctional staff have not been adequately trained to recognize and timely respond to emergency medical and mental-health crises. Partial Compliance can be achieved following requisite staff training and evidence-based demonstration of policy compliance.

**RECOMMENDATIONS:**

1. Develop video conference capability that would allow the psychiatrist to assess inmates who are in urgent need of an assessment even when she is off site.

2. The training of all staff in recognizing mental health emergencies has not yet occurred but should move forward as planned

**f. (v) adequate and timely referral to specialty care;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS:** We reviewed eight records of patients sent offsite for scheduled offsite services. We used the log to determine which records to select. All records we utilized had these services provided since our last monitoring visit. Of the eight records we reviewed, a few records did not have a follow-up visit with the primary care clinician after the offsite service. The offsite service documents were usually obtained, although some not timely. Overall, this service has improved since our last visit. However, it is still in partial compliance.

**Patient #1**
This is a 25-year-old with asthma. On 10/23/15, he was referred for a soft cystic mass on his left forearm. He was seen on 12/3 with a diagnosis of a fatty tumor to be excised at the hospital. He was then sent for surgery on 12/11, but that operative report is still pending. He was seen in chronic care clinic for his asthma on 12/15. He was not seen after the initial diagnostic visit with the surgeon.

**Patient #2**
This is a 24-year-old with asthma, who received an order for a dermatologist on 11/26/15. His appointment was on 12/10. However, the dermatology note by the dermatologist does not indicate what the regimen was for this patient. The Medical Director will have to contact the dermatologist and she will follow this patient.

**RECOMMENDATIONS:**

1. The Medical Director must ensure that following a scheduled offsite service there is a follow-up visit onsite with herself or another practitioner.

2. The offsite service coordinator should ensure that offsite service documents are accessed timely.

**f. (vi) adequate follow-up care and treatment after return from referral for outside diagnosis or treatment; See above**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MEDICAL FINDINGS:** The relevant policy is Hospital and Specialty Care, which is included with the Group 1 policies. Medical/Mental Health staff were trained on this in July 2015 and documentation provided to the US and monitor on 8/3/15. The Territory met the 95%/80% requirement. The master training list was provided to the Territory and the Monitor on 12/15/15. In addition, we identified a case of a patient who entered the facility on methadone maintenance but this was not provided, nor was the problem addressed. We discussed our recommendations encouraging the Medical Director to work with the local methadone maintenance program to, at a minimum, receive a recommended regimen that should be followed for detoxification.

**RECOMMENDATIONS:** This has been discussed under f (v).

**MENTAL HEALTH FINDINGS:** With regard to mental health, adequate follow-up care and treatment after return from referral for outside diagnosis and treatment is facilitated by the fact that the facility's psychiatrist is also the psychiatrist at the hospital. Notwithstanding this fact, care must be given to formally referencing emergency assessments performed and treatment given at the hospital, and the linking of that to follow-up care and treatment.

A somewhat related issue is the availability of up-to-date information for inmates being admitted upon a transfer from St. Thomas or the Federal Prison in Puerto Rico. Reportedly, there tends to be delays in entering such transfers into the 'smart jail' system, and as a result there is a period of time when mental health staff doesn't even know that they are at the facility. How much, if any, information mental health staff receives about such transfers (with regard to whether or not they suffer from mental health difficulties) requires further exploration.

**RECOMMENDATIONS:** Refer to medical findings and recommendations.

**g. Adequate care for intoxication and detoxification related to alcohol and/or drugs;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** The training with regard to this policy and procedure has not been completed. In addition, we identified a case of a patient who entered the facility on methadone maintenance but this was not provided, nor was the problem addressed. We discussed under recommendations encouraging the Medical Director to work with the local methadone maintenance program to, at a minimum, receive a recommended regimen that should be followed for detoxification.

**RECOMMENDATIONS:**

1. Complete the training and examinations on this area.

2. The Medical Director is to obtain recommendations from the methadone maintenance program on a regimen for detoxification.

**MENTAL HEALTH FINDINGS:** See medical findings and recommendations.

The monitor remains concerned about the management of the subset of individuals suffering from substance abuse difficulties who also suffer from some other major psychiatric difficulty, and whether that other major psychiatric difficulty is evident while the individual is intoxicated and/or becomes evident during detoxification. In either case, it is well recognized that with such patients, the management of substance abuse difficulties and such other mental difficulties must be done in an integrated and coordinated way if interventions are to be effective.

**RECOMMENDATIONS:**

1. Assure the integration of mental health staff into the assessment and treatment of intoxicated inmates and those undergoing detoxification when there is evidence that the inmate is also suffering from other major psychiatric difficulties.

**h. Infection Control, including guidelines and precautions and testing, monitoring and treatment programs.**

**ASSESSMENT: NONCOMPLIANCE.**

**MEDICAL FINDINGS:** This item still requires training of the nursing staff and oversight of the training of the officers, which should be accomplished by the Medical Director. We have previously discussed with regard to intake the recommendation to ensure that nurses re-query patients regarding active TB symptoms when they find a positive skin test. This should be documented in the record. We also strongly recommend a program regarding skin

infections and the control of MRSA. This has historically been problematic in correctional settings. It is important to track both culture-proven and presumptively treated MRSA infections. Accomplishing this must be done through notification to the designated infection control nurse who keeps track of and reports monthly the number of presumptively treated and the number of culture-proven cases each month.

**RECOMMENDATIONS:**

1. Train the nursing staff so that when they identify a positive TB skin test they are to re-query the patient regarding acute TB symptoms and document this in the record.

2. A program should be established to report monthly both presumptively treated as well as culture-proven skin infections.

**MENTAL HEALTH FINDINGS**: Defer to Dr. Shansky's report

**RECOMMENDATIONS**: None.

**i. Adequate suicide prevention, including:**
**(i) the immediate referral of any prisoner with suicide or serious mental health needs to an appropriate metal health professional;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As was noted in prior reports, reviews of 'behavioral checklists', sick call requests, and the 'behavioral checklist/sick call log' indicate that there continues to be clear corrections officer referrals and inmate self-referrals for suicide concerns and other serious mental health concerns. These documents and records also indicate an immediate response to these referrals by the mental health unit. However, what is difficult to determine is how quickly corrections officers identified serious mental health needs and then completed a 'behavioral checklist', which is the other key element in addressing this issue. Therefore, as training of corrections officers on suicide prevention and other mental health emergencies continues, such training should also focus on identifying problems as early as possible (i.e., if possible, when deterioration begins/before a full crisis occurs).

**RECOMMENDATIONS:**

1. Continue to monitor and review future behavioral health checklist referral tracking logs.

2. Because all staff have not yet been trained with an approved curriculum for suicide prevention, this provision remains noncompliant. It is recognized that despite not having been trained, the security staff does an excellent job completing these forms when behavioral problems are identified. However, there should also be an assessment of how early in the process of the emergence of suicidal ideation or other mental health emergency that such difficulties are identified by security staff.

**(ii) a protocol for constant observation of suicidal prisoners until supervision needs are assessed by a qualified mental health professional;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** During this monitoring period, six (6) suicide watch charts were reviewed but only one of those charts showed a monitoring log was initiation. There was one clear case where an inmate was placed on Level One suicide watch by the mental health unit, which includes monitoring every 15 minutes. The order was documented in the inmate's mental health record. It was also noted in the 'Unit Log', but another entry in the Unit Log seemed to indicate, at least initially, that the supervisor was unaware of the order and/or that other officers who should have been notified were not notified. Although the suicide watch was ordered for at least 6 days, and apparently even more than that, there was only one other mention of this in the Unit Log, and that mention did not include the level ordered or the required frequency of monitoring. It simply stated that the inmate was on suicide watch and needed to be monitored. There was no indication in the Unit Log that the inmate was monitored at all, and there has been no production of a separate observation form for this inmate for this monitor's review.

Given the above noted, this monitor can only conclude that at minimum, there is insufficient documentation or data to demonstrate any constant observation of inmates until they are evaluated by a qualified mental health professional and insufficient documentation or data to demonstrate any observation of inmates consistent with the level of suicide watch ordered after an inmate is evaluated. Of course, this lack of documentation or data raises the question of whether or not observation is occurring at all.

**RECOMMENDATIONS:**

1. The facility will need to develop a means of documenting whether or not an inmate is maintained on constant observation until the time of the evaluation in order to demonstrate compliance with this provision. Similarly, the facility will need to develop a means of documenting whether or not an inmate is being observed consistent with the level of suicide watch ordered following an evaluation by mental health.

2. Currently, documentation is scattered between an observation form and hit-or-miss notations in the officers' unit log. Implement approved Log of Suicide Watch (PCO) Rounds.

3. Once implemented, these should be reviewed by mental health staff regularly to ensure security's compliance with the policy.

**(iii) timely suicide risk assessment instrument by a qualified mental-health professional within an appropriate time not to exceed 24 hours of prisoner being placed on suicide precautions;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MENTAL HEALTH FINDINGS:** A well-developed suicide risk assessment instrument is in place and being utilized as indicated. Staff have been trained on the approved policy and procedure.

**RECOMMENDATIONS**:

1. Continue to utilize the suicide risk assessment tool and develop quality assurance data to demonstrate compliance with this provision. Ensure required annual training is completed as required.

**(iv) readily available, safely secured, suicide cut-down tools;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS**: Although suicide cut-down tools are in place and safely secured, it is not at all clear that they are readily available (i.e., can be quickly enough retrieved from their location to be useful in the event of a suicide attempt). It is also not clear that all security staff are familiar with their use. Additionally, all correctional staff have not been trained on the approved policy but training has commenced, according to the Territory.

**RECOMMENDATIONS:**

1. Assure that rapid access to cut-down tools is possible.

2. Complete training.

3. Demonstrate compliance with approved policy following completion of requisite training.

**(v) instruction and scenario-based training of all staff in responding to suicide attempts, including use of suicide cut-down tools;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** See above section on cut-down tools

**RECOMMENDATIONS:**

1. Complete training for all staff on suicide prevention, including training for security staff on the use of cut-down tools, followed by an assessment of competency to employ such suicide prevention efforts.

**(vi) instruction and competency-based training of all staff in suicide prevention, including the identification of suicide risk factors;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Training has commenced but has not been completed.

**RECOMMENDATIONS:**

1. The facility proposed to complete this training by July 31, 2016 for all staff.

2. Effectiveness of the training will need to be demonstrated by the use of competency measuring tools and follow-up quality improvement studies.

**(vii) availability of suicide resistant cells;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** The plan to create suicide resistant cells in the medical facility that was previously presented to this monitor has not been implemented. This monitor has now been told that a suicide resistant cell was being created in the intake area; it is the understanding of the monitor that the decision to move on that was at least in large part based on the fact that there was always a corrections officer there who could monitor an inmate on suicide watch. However, it is unclear to this monitor whether this is only a temporary measure until staffing levels increase or whether it has been decided to move the location of the suicide resistant cell, despite the fact that such a relocation complicates the ability of mental health staff (and medical staff) to provide evaluation, monitoring and treatment services to suicidal inmates.

**RECOMMENDATIONS:**

1. GGACF is encouraged to **urgently** complete renovations in order to provide appropriate and safe suicide and close observation cells. Ideally, such cells would be in the infirmary. As expressed in the last 3 reports, all measures should be taken to provide adequate space within the cell, suicide resistant sinks and commodes, and ensure the absence of any protruding objects within the cell that would facilitate the placement of a ligature. Please refer to all of the detailed recommendations in the Monitor's fifth assessment report regarding the configuration and structure of suicide-resistant housing.

2. Even when suicide-resistant cells are available, security staff will still need to be present in the suicide prevention housing area to monitor inmates on suicide prevention 24 hours per day. As noted above, appropriate logs for documenting security staff monitoring will need to be developed, maintained and then reviewed for compliance with policy and procedures.

3. Even when suicide-resistant cells are available, a nurse must be present in the suicide prevention housing area 24 hours a day to complete the required monitoring of the patient every shift. These records will also need to be reviewed for compliance with policy and procedures

4. Until such time that the proposed suicide prevention housing area has been fully renovated and operational, security staff must provide *constant* observation of inmates placed on the highest levels of suicide watch, and document that such constant observation is taking place. This documentation should be reviewed for compliance with policy and procedures.

**(viii) protocol for the constant supervision of actively suicidal prisoners and close supervision of other prisoners at risk of suicide;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** The medical/mental health records and a log maintained by the mental health coordinator clearly track and provide information obtained from ongoing evaluations regarding indications for the various levels of suicide watch ordered. A review of medical/mental health records and the tracking log indicated that the protocol for the mental health supervision of actively suicidal inmates is clear, consistent with current standards of medical practice, and carefully followed. However, as noted above (in section vii), it is impossible to document the extent to which security staff is providing the level of observation required to ensure the safety of inmates placed on suicide watch, and it at least appears that the level of observation by security staff continues to be intermittent and unpredictable at its best.

**RECOMMENDATIONS:**

1. Complete the process of training on suicide prevention and observation policy, implementation and monitoring.
2. System-wide training for this provision will be the last of the medical trainings offered because security must also be included. However, the facility is **strongly urged** to consider a method to ensure that inmates placed on suicide watch, between now and the time training is completed, are adequately supervised and that this supervision is documented according to policy.

**(ix) procedures to assure implementation of directives from a mental health professional regarding:**

**(1) the confinement and care of suicidal prisoners;**
**(2) the removal from watch; and**
**(3) follow-up assessments at clinically appropriate intervals;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted above (under section vii), the protocol for the ongoing mental health evaluation of suicidal inmates and the care of such inmates, including their placement on and removal from suicide watch, is being carefully followed by the mental health staff. Furthermore, a review of their work in this regard indicates that clinical decisions have been consistently appropriate, both during the period of an inmate's active suicidality and during the prescribed period of follow-up after an active level of suicidality has remitted. However, there continues to be concern about the implementation of directives that result from the evaluation and the development of care plans for suicidal inmates when such directive must be implemented by staff outside of the mental health unit.

**RECOMMENDATIONS:**

1. Assure that appropriate mechanisms are in place to facilitate the notification of all medical staff, especially nursing staff, of mental health directives and care plans for suicidal inmates; monitor the effectiveness of such mechanisms for notification; and monitor the implementation of the directives that nursing and any other medical staff are responsible for.

3. Assure that appropriate mechanisms are in place to facilitate the notification of security staff of mental health directives and care plans for suicidal inmates; monitor the effectiveness of such mechanisms for notification; and monitor the implementation of the directives that security staff are responsible for.

**j. Clinically adequate professional staffing of the medical and mental health treatment programs as indicated by implementation of periodic staffing analyses and plans.**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** The staffing currently consists of four RNs who cover roughly 8:00 a.m. to between 8:00 p.m. and midnight, seven days a week. However, there is between 8 and 12 hours per day not covered by onsite RN staff. This situation is likely to get worse before it gets better, in that one of the existing RN staff has accepted another job. The fill-in physician for the Medical Director has been problematic, but we understand this positions has been filled by a staff physician. It is up to the administration to arrange for matriculation of this physician. With the additional nursing and the fill-in physician, the medical staffing will be complete.

**RECOMMENDATIONS**:

1. Fill the nursing hours to complete 24/7 RN staffing.

**MENTAL HEALTH FINDINGS:** At present, the mental health staff includes the mental health coordinator (Ms. Murray, LCSW), a part time psychiatrist (Dr. Sang), a mental health counselor (Mr. Rosas, MHC), and at least a substantial amount of time from one of the nurses (Ms. Randolph, RN).

At least one additional staff person is required to address all of the provisions of this agreement. It was the understanding of this monitor that there was, in fact, a line for another mental health counselor; but this monitor has recently discovered that steps still need to be taken to actually fund that line. It is the understanding of this monitor that a prior candidate for that line had been identified, but since there was no movement in hiring that candidate, the candidate finally took another position. It is the understanding of this monitor that now another candidate has been identified, and given how difficult it can be to find qualified mental health professionals to do this work, hopefully the line will be funded quickly enough so that candidate will not also be lost.

**RECOMMENDATIONS:**

1. Fund and the fill the slot for an additional mental health staff person as quickly as possible.

2. As mental health staff continue efforts to address all of the provisions of this agreement, staffing analyses should continue to assure adequate staffing of the mental health unit.

**k. Adequate staffing of correctional officers with training to implement the terms of this agreement, including how to identify, refer, and supervise prisoners with serious medical and mental health needs;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** We were told that delays in accomplishing the computerized booking were in fact related to inadequate numbers of classification officers. In addition, whether it is the assignment of officers or the overall numbers, this program has been handicapped by officer availability even to escort nursing staff to accomplish the nursing intake screen. Also, when the officer in the medical clinic functions as the officer assisting the medication administration process, the medical program as well as mental health are closed down until that officer returns. There must be available at least two officers in the building in order to perform the escort service while someone remains in the medical clinic building to provide security for occupied infirmary beds as well as for outpatient traffic.

**RECOMMENDATIONS:**

1. Ensure sufficient staffing to accomplish all of the health care services in a timely fashion.

2. Ensure that trainees are not assigned the medical function with regard to medication administration or running the building.

**MENTAL HEALTH FINDINGS**: As per medical findings.

**RECOMMENDATIONS**: As per medical recommendations.

**l. A protocol for periodic assessment of the facility's compliance with policies and procedures regarding the identification, handling, and care of detainees and prisoners with serious medical and mental health conditions;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** The medical program now has a dedicated Medical Director in place who is providing leadership for the quality improvement program. She has begun by reviewing the chronic disease program, which she identified as problematic with regard to timeliness of visits, performance of professionals and compliance with disease guidelines. We intend to work with her on expanding the quality improvement program to include all of the services provided.

**RECOMMENDATIONS:**

1. The Medical Director and the medical monitor should discuss elements to be implemented in the quality improvement program.

**MENTAL HEALTH FINDINGS:** Except for the exceptions noted above, the mental health team is now collecting adequate data that can be used to assess compliance with policies and procedures regarding the identification, handling, and care of detainees and prisoners with serious mental health conditions. When the above noted exceptions are addressed, the team will also have the data required to assess the overall quality of services provided, and thereby identify any policies, procedures or practices that need to be revised in order to assure quality mental health service delivery.

Given the now ready availability of such data, the current focus should be on the development of a meaningful periodic review of this data for compliance with policies and procedures, and the development of an approach for employing this data to assess overall quality of mental health care.

It must be noted however that quality assurance with regard to mental health care is not entirely under the control of the mental health staff. For example, assuring the safety and adequate care of suicidal inmates requires the availability of suicide-resistant cells and monitoring by security staff. For example, the management of dual-diagnosis patients (with substance abuse difficulties and another major psychiatric illness) and the development of a plan to address patients with both mental health and other medical conditions who refuse treatment requires the cooperation of/coordination with the medical unit. In addition, the appropriate care of many of the seriously mentally ill inmates who are amenable to treatment requires access to a unit designed for inmates with such special needs that would allow for enhanced mental health programming, and those who refuse treatment require a mechanism to obtain treatment for them instead of placing them in segregation, which in some cases will involve the courts.

**RECOMMENDATIONS:**

1. The mental health staff should develop compliance reports that indicate any failures to comply with developed policies and procedures, and the result of investigations into the reasons any such failures to comply occurred.

2. The mental health team should also assess the overall quality of the mental health services provided, with an eye towards identifying, developing, and implementing any quality improvements that should be made.

3. Monthly or quarterly management meetings with medical staff and other department leaders should be occurring. Mental health staff should be using these meetings as an opportunity to continue to raise quality assurance issues that are not totally under their control. The raising of such issues and any identified approaches to addressing such issues should be documented in the minutes of these management meetings.

**m. Adequate dental care;**

**ASSESSMENT: NONCOMPLIANCE (Partial Compliance for Medical, Non Compliance for Mental Health)**

**MEDICAL FINDINGS**: We continue to find that access to dental services were subject to availability of airplane tickets for the dental staff. When the dental assistant/hygienist is unavailable, the dentist does not provide services. Within the month of November, there were three weeks in which the dental assistant was not able to be present onsite. This clearly is not acceptable. The officer escorting issue also needs to be resolved. It is not acceptable if health services are shut down while the only officer in the building is pulled to escort patients to the building.

**RECOMMENDATIONS:**

1. Fix the problem of transporting the dental staff to GGACF.

2. Provide sufficient officers such that access is unimpeded.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted in prior monitoring reports, mentally ill inmates, especially those suffering from serious yet untreated mental illness, may not focus on their need for dental services and therefore not seek the dental services that they require, even if they are in pain. Therefore, GGACF health, mental health and dental services must be proactive in monitoring the dental hygiene of this vulnerable population.

**RECOMMENDATIONS:**

1. GGACF officials should ensure protocols are in place and practices that ensure proactive oral health assessment of mentally ill inmates.

**n. Morbidity or mortality reviews of all prisoner deaths and of all serious suicide attempts or other incidents in which a prisoner was at high risk for death within 30 days of the incident triggering the review;**

**ASSESSMENT: NONCOMPLIANCE**.

**MEDICAL FINDINGS:** There is a Medical Director in place but neither deaths nor hospitalizations have yet been reviewed by her. This is an area that the medical monitor will discuss with her. Advancing this Provision may include review of a mock mortality review per a scenario-based event that involves all elements of this Provision and the approved policy and procedure.

**RECOMMENDATIONS:**

1. Have the new Medical Director perform a review of the care provided at GGACF for the patient who died.

**MENTAL HEALTH FINDINGS:** Similar to Medical Findings

**RECOMMENDATIONS:**

1. The clinical directors, Director of Nursing and Health Services Administrator should develop mechanisms to identify and review all cases of mortality and serious morbidity as part of the Quality Improvement process. These reviews should also include security leadership.

2. When such reviews result in the identification of issues that need to be addressed (whether failure to comply with policies and procedures or the possible inadequacy of existing policies and procedures), a plan for corrective action should be developed.

3. The incidences that prompt such a review and the review and its outcomes should be shared with the monitor.

**o. A protocol for medical and mental health rounding in isolation/segregation cells to provide prisoners access to care and to avoid decompensation;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** Although we do believe a nurse has been making rounds in segregation three days per week, we have not been able to receive a list of patients who were seen in the segregation on the rounds for which problems have been identified and treatment provided.

**RECOMMENDATIONS:**

1. Maintain a list of patients seen each day in segregation for whom the patient was seen either by the nurse or for whom a note was written.

**MENTAL HEALTH FINDINGS:** As previously reported, there is weekly mental health rounding in isolation/segregation cells performed by Mr. Rosas, and monthly mental health rounding in isolation/segregation cells performed by Ms. Murray. In both cases, all inmates in isolation/segregation are seen – not just those on the mental health caseload – and there are logs kept for both sets of rounding that indicate when the inmate was seen, the inmate's general well-being, the condition of the inmates' cell, and any specific mental health needs that the inmate might have.

During this monitoring visit, this monitor accompanied Mr. Rosas on his rounds, and found that he was clearly quite familiar with each inmate; that the inmates were familiar with him; and that the rounds were conducted in a competent and effective manner. Although this monitor did not yet accompany Ms. Murray on her rounds, this monitor discussed the rounding process quite extensively with Ms. Murry, and as previously noted, the prior

monitor did round with her and found that her rounds were also conducted in a competent and effective manner.

The primary focus of this monitoring visit was the meaningful integration of the information gathered and the mental health opinions rendered (based on that information and all other available information about each inmate) into the larger segregation review process. This involved two activities. The first was meetings with the mental health staff to discuss what role they should be playing in the larger segregation review process. More specifically, in addition to offering their findings, they should, for example, be making recommendations for addressing any mental health issues that might have contributed to such a placement, recommending therapeutic interventions for those adversely impacted upon by such isolation or segregation, and/or even recommending more appropriate alternative placements, regardless of whether or not any such recommendations are currently implementable (i.e., if only to repeatedly establish the need for such alternatives). During those discussions, it was clear that mental health staff had such recommendations, but had been reluctant to put such recommendations forward given current limitations. The second activity was meeting with security staff and the ultimate revision of the 'isolation/segregation review form', so as to begin the process of more meaningful integration of information from the mental health unit into the segregation review process. The second activity was meeting with security staff and the ultimate revision of the 'isolation/segregation review form', so as to begin the process of more meaningful integration of information from the mental health unit into the segregation review process.

**RECOMMENDATIONS:**

1. The Mental Health Coordinator will continue to keep documentation of weekly and monthly rounds, and will keep documentation of information provided and recommendations offered during the monthly isolation/segregations review process.

2. Monitor how mental health recommendations made during the monthly isolation/segregation review process are integrated into and impact on the monthly isolation/segregation review process.

3. Continue to document the need for certain alternative therapeutic interventions (most of which have been noted in other sections of this report) that would allow many mentally ill inmates to be removed from segregation, and continue to advocate for the provision of such interventions.

**p. A prohibition on housing prisoners with serious mental illness in isolation, regular review of prisoners in segregation to minimize time in segregation, and provision of adequate opportunities for out-of-cell time of prisoners in segregation;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As has been noted in prior monitoring reports, despite this prohibition, that there are still inmates with serious mental illness who are being held in isolation/segregation, and some of them have been held in isolation/segregation for many, many years. The seriously mentally ill inmates being held in isolation/segregation fall into several sub-groups, each of which raises different issues/concerns.

First of all, there are seriously mentally ill inmates who are not receiving any type of mental health treatment because they have reportedly refused such treatment, and as a result they continue to be acutely psychotic and/or otherwise seriously mentally ill. Two of the issues discussed above are particularly relevant for this subgroup – they are (1) the documentation by mental health staff (during the rounding process) of their mental health status and their need for an intervention other than locking them in isolation/segregation, and (2) a clear protocol for addressing the mental health needs of inmates who refuse treatment.

There is a second group of seriously mentally ill inmates who are in treatment, but reportedly are being held in isolation/segregation because, despite treatment, they continue to be too vulnerable to be placed in general population. In other words, they are reportedly being protected by being placed in isolation/segregation. These inmates are allowed two hours/day of congregant out-of-cell unstructured time and at least some of them are also now participating in the group therapy program. However, to date there is no planned housing alternative that would provide protection for this group of inmates, such as an open unit for this population of patients and others who might require similar protections. Therefore, there is also no opportunity to develop enhanced programming for seriously mentally ill inmates that would be a therapeutically sound alternative to locking them in isolation/segregation for the overwhelming majority of the day.

Then there is the group of seriously mentally ill inmates who are in isolation/segregation as a disciplinary sanction. As discussed below, there is no clearly documented evidence that the mental health status of most of these inmates was considered when reviewing their disciplinary infraction and/or when deciding whether or not isolation/segregation was the most appropriate response to their disciplinary infraction.

See also the above section on isolation/segregation rounds and the isolation/segregation review process.

**RECOMMENDATIONS:**

1. **As per the provisions of this Settlement Agreement, inmates with serious mental illnesses may not be placed in isolation**. This infraction should be repeatedly documented during the rounds of isolation/segregation cells performed by the mental health staff, and corrective action taken.

2. For those seriously mentally ill inmates who refuse treatment, the mental health staff needs to opine as to whether or not such inmates are a sufficient danger to themselves or others that they would require isolation/segregation. In addition, a protocol must be developed for that subset of inmates that are a danger to themselves or others, focusing

on attempting to get them to voluntarily accept treatment and outlining steps that should be taken for those who ultimately continue to refuse treatment.

3. With regard to those seriously mentally ill inmates who are currently in isolation/segregation for their own protection, the Bureau of Corrections needs to develop a corrective action plan with specific recommendations for capital improvements that will provide a more appropriate housing unit for such inmates, with dates to remedy this deficiency. In addition, once an alternative to the isolation/segregation of such inmates has been developed, mental health staff will need to develop enhanced programming for them.

4. With regard to those seriously mentally ill inmates with an alleged disciplinary infraction, see the next section of this report.

5. During the time that inmates with serious mental illnesses remain in segregation, mental health staff should be aware that these inmates should be offered a minimum of 10 hours per week of unstructured out-of-cell time by security. Additionally, mental health staff is encouraged to develop supportive group or individual therapeutic activities, generally recommended being a minimum of 10 hours per week per inmate in order to support the inmate's mental state as well as assist inmates in acquiring skills to move them off the segregated status and sustain themselves in the general population setting whenever possible.

6. Mental health staff need to repeatedly raise all of these concerns during management and administrative meetings as a reminder to all levels of staff that these concerns remain and must be addressed. In such management meetings there should be a particular focus on issues that clearly relate to security concerns, space allocation, and other above noted issues that are under the control of those outside of the mental health unit.

**q. Review by and consultation with a qualified mental health provider of proposed prisoner disciplinary sanctions to evaluate whether mental illness may have impacted rule violations and to provide that discipline is not imposed due to actions that are solely symptoms of mental illness;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS** A discussion between the monitors, mental health staff, security staff, and corrections administrators regarding this issue was also a major focus of this monitoring visit. Several issues emerged.

This monitor noted that mental health input should be occurring right from the beginning of the disciplinary review process versus an add-on after the disciplinary review process is completed and a sanction has been given. Corrections noted that when a disciplinary charge is filed, and the inmate appears to have some mental health issues, a behavioral checklist is or could be completed and sent to mental health, and mental health could begin to perform

an evaluation. It was also noted that if the inmate was already on the mental health caseload (which could be provided to the appropriate corrections administrator) mental health could be notified even if there were no obvious indications that the inmate's mental illness might have contributed to the disciplinary infraction, and mental health staff could begin to perform an evaluation specifically related to the disciplinary charge.

The more difficult issue that emerged was to what extent any mental health findings or opinions might impact on the disciplinary review process and the sanctions levied. The issue became such that even *if* some subset of inmates charged with a disciplinary infraction might be diverted to mental health or even given a lesser sanction than placement in isolation/segregation, it is yet to be determined who can make that decision and when could such a decision be made (i.e. can this decision be made without going through the entire disciplinary review process, especially in instances where the inmate's mental health status might make it difficult for him/her to adequately participate in/defend him/her-self during that process?).

Given the above, it would at least appear to this monitor that although there may be movement toward allowing some comment by mental health as part of the disciplinary review process, it is not at all clear how any information or opinion from mental health will be incorporated into the process and impact, if at all, on the sanctions levied.

It should also be noted here that another/related issue impacts on all of this, and that is what at least appears to be the lack of a range of disciplinary sanctions other than isolation/segregation that may be more appropriate for lower level infractions, regardless of the inmate's mental health status.

**RECOMMENDATIONS:**

1. GGACF should continue to work on the development of an effective policy and process to provide mental health review and input into the disciplinary process.

2. Mental health staff must be prepared to quickly assess inmates with alleged disciplinary infractions, with an eye toward determining whether or not the alleged infraction was likely a product of any mental illness that the inmate might be suffering from, and the likely impact of potential sanctions on the inmate's mental health status.
3. GGACF should develop a form that can be sent to the Mental Health Coordinator, completed by mental health staff and submitted to the disciplinary committee, which outlines the findings of the mental health assessment. The committee can use the same form to communicate back to the mental health staff the outcome of the hearing proceeding.

4. Mitigating factors discovered by the mental health professional must at least be considered by the disciplinary committee.

5. Mental health services should track the effectiveness of their input in mitigating sanctions or terminating sanctions as appropriate.

6. Alternative housing and treatment services are an essential component in diverting seriously mentally ill inmates committing infractions due to their impaired judgment and mental processing.

7. Again, it is recommended that GGACF provide appropriate staffing and housing alternatives for this population. (See V.1.p.)

**r. Medical facilities, including the scheduling and availability of appropriate clinical space with adequate privacy;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** Progress has been made in that the exam rooms have been completed. The area that remains to be addressed is the infirmary area in the medical clinic building. We would like to see a plan for what yet remains to be accomplished in that building.

**RECOMMENDATIONS:**

1. Please provide us a plan with specific timelines of the remaining elements to be completed in the infirmary area with a timeframe for completion.

**MENTAL HEALTH FINDINGS:** The renovations of the examination offices on each of the housing units has been completed. It is the understanding of this monitor that mental health staff have access to these offices for individual sessions with inmates and psychiatric visits when other medical staff are not utilizing them, but the logistics of this (such as scheduling, the availability of keys, etc.) remains unclear.

However, the renovation of space already designated for mental health programming remains incomplete, thus such space can still not be put into use. These designated spaces include the renovation of multipurpose rooms on the segregations units so that the space can be used for mental health programming, the above noted renovation of cells to make them suicide-resistant (including the newly identified cell in the intake unit), and the renovation of space for the already expanded group therapy program.

**RECOMMENDATIONS:**

1. Continue with current renovation plans as quickly as possible.

2. Continue to assess the need for additional space for developing mental health programming.

**s. Mental health care and treatment, including:**
**(i) timely, current, and adequate treatment plan develop and implementation:**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MENTAL HEALTH FINDINGS:** The issues related to the timely, current, and adequate development of mental health treatment plans have already been discussed under other provisions of this agreement. As this monitor continues to review charts/mental health records during subsequent monitoring visits, this monitor will continue to review treatment plans, with regard to their timely completion, whether or not they were developed by the mental health treatment team as a whole, to what extent they were reviewed with and understood by the inmate/patient, and the relationship between the information obtained during the assessment process and the treatment plan in order to assess the adequacy of the treatment plan with regard to the inmates presenting mental health problems.

It must again be noted that this monitor recognizes that the adequacy of treatment plans might, at times, be compromised by some the above noted problems that are outside of the control of mental health staff. When this is the case, this monitor will expect to see any such required compromises noted in the treatment plan, so as to make it clear that there is a more appropriate intervention that is simply not currently available. Therefore, a treatment plan might note, for example, that a patient will be switched to a specific, more appropriate modality of treatment when such become available.

**RECOMMENDATIONS:**

1. Based on policy and developed protocol, treatment plans should be updated at set frequencies based on inmate need and changing conditions in the inmate status. It is strongly recommended that supervisory review occur to ascertain the appropriateness and completeness of the treatment plans generated.

2. When indicated, in-service training on treatment plan development is recommended to ensure consistency between staff members in developing measurable objectives toward marked improvement in those inmates followed by the mental health team.

**(ii) adequate mental health programs for all prisoners with serious mental illness;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As has been previously noted, mental health programming has been expanded to include various group therapy sessions and individual sessions as needed. Although I have recommended the expansion of the group therapy program, it is clear that the existing program has already proven itself to be quite beneficial to many of the inmates in need of mental health services. It is also clear that individual sessions have been judiciously used to help inmates in need of additional support.

As noted above, enhanced programming for seriously mentally ill inmates, especially those currently in isolation (both while they remain in isolation and even when a suitable

alternative to isolation has been developed), must be developed. In addition, a stepwise program of interventions for those who refuse treatment must be formalized and fully implemented.

**RECOMMENDATIONS:**

1. The mental health team will need to develop a global treatment menu designed to meet the needs of inmates at different levels of housing and treatment needs.

2. Group programming should be designed to meet the clinical needs of individuals who should be assigned to those programs based on their needs assessment and their individual treatment plan.

3. The facility should consider how it might create a special population housing unit that would provide a safe housing alternative to vulnerable mentally ill inmates and make the delivery of services more efficient to those who require enhanced mental health services.

4. Those who refuse needed treatment must be further assessed to determine if they are a danger to themselves or others. This assessment should be used to determine whether or not they require placement in isolation/segregation and whether or not a court intervention should be obtained that would require them to undergo treatment; and all the while, efforts should continue to convince such inmates to voluntarily accept treatment.

**(iii) adequate psychotropic medication practices, including monitoring for side effects and informed consent;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**MENTAL HEALTH FINDINGS:** Most of the issues related to this finding have been addressed in earlier sections of this report, but a few additional comments, including updates from the last report, need to be raised.

Communication between staff regarding medication compliance seems to be quite good, which has made monitoring of medication adverse effects and efficacy a more consistently meaningful process. All of this is well-documented in the medical records. However, it remains the opinion of this monitor that all mental health staff and nursing staff should be trained to look for possible major medication adverse effects – while even with training, staff would not be expected to diagnose medication adverse effects. Such training might help them suspect adverse effects and report their concern to the psychiatrist, and in so doing, the psychiatrist might see an inmate earlier than scheduled and thereby intervene more quickly.

**RECOMMENDATIONS:**

1. Continue to ensure communication between nursing staff and the psychiatrist with regard to inmate compliance with psychotropic medication orders.

2. Confirm the obtaining of 'informed consent' for medication in the medical records or consider a special form for this purpose.

3. Assure that medical and mental health staff are trained to suspect the presence of psychotropic medication adverse effects and report such a suspicion to the psychiatrist in a timely manner.

**(iv) comprehensive correctional and clinical staff training and a mechanism to identify signs and symptoms of mental health needs of prisoners not previously assigned to the mental health caseload;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Although training on this issue has not yet been fully completed, correctional staff are completing the 'behavioral checklists' and making referrals for mental health services for both inmates who are already on the mental health services caseload and those who are not. There are multiple potential benefits of this training, including the earlier identification of mental health difficulties (i.e., the identification of symptoms that precede a more full deterioration); even better use of/improved communication by way of the 'behavioral checklist'; increased understanding of the various ways that different types of mental illness can impact on an individual's ability to function; and an increased appreciation for taking an inmate's mental health difficulties into consideration when making important decisions concerning the inmate (such as classification/placement, the planned use of force, the use of isolation/segregation, disciplinary decisions, etc.).

Given the above noted, it also seems reasonable to at least discuss whether or not there is some ongoing way to provide feedback to corrections officers who complete a 'behavioral checklist', with the goal of continuing the learning process and further increasing their appreciation for the difficulties encountered by inmates with mental illness, while still preserving some sense of privacy for the inmate.

**RECOMMENDATIONS:**

1. Continue to utilize the Behavioral Checklist process.

2. Finalize and present mental health training for security staff.

3. Improve the incorporation of information obtainable from mental health assessments into security decision-making and review regarding disciplinary matters, the review of situations where there was use of force, the use of isolation/segregation, and the classification of inmates.

4. Consider a more formal process for providing feedback to security staff who complete a behavioral Checklist, regarding how helpful their effort to complete the checklist has been and also regarding any suggestions mental health might have that would help security staff better management and otherwise interact with the individual.

5. Conduct a facility quality improvement morbidity review that can be submitted to the monitoring team for review.

**(v) ceasing to place seriously mentally ill prisoners in segregated housing or lockdown as a substitute for mental health treatment.**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted above, seriously mentally ill inmates continue to be placed in isolation/segregation. Most such inmates are not receiving adequate mental health services, and some of them are not receiving any mental health services at all.

In addition, it has come to my attention that there is a related problem, and that is the placement of juveniles in what is essentially isolation/segregation. This is related in that although a juvenile might not be mentally ill, it has been well-documented that the immature level of development in all spheres (including immaturity with regard to brain development) renders juveniles extremely vulnerable to the development of clinically significant mental health difficulties when placed in isolation/segregation. In addition, at least at Golden Grove, the few juveniles who are placed here end up being placed on a unit of their own, and although it is not an isolation/segregation unit, they are, in fact, essentially isolated and segregated. Therefore, this is another issue that needs to be further explored and addressed.

**RECOMMENDATIONS:**

1. The Health Services Administrator needs to coordinate monthly Medical Administration Committee (MAC) and Quality Improvement meetings, documented by minutes and attendance sign-in sheets. This issue should be an important agenda item for such meetings. These meetings should include the Warden or the Warden's designee in order to assure that plans for addressing this issue take all aspects of the problem into consideration.

## VI. FIRE AND LIFE SAFETY

Defendants will protect prisoners from fires and related hazards by providing constitutionally adequate living conditions.

1. Accordingly, Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies regarding the physical plant, emergency preparedness, and fire and life safety equipment, including the following:

**a. An adequate fire safety program with a written plan reviewed by the Local Fire Marshal;**

**ASSESSMENT: NONCOMPLIANCE** - No substantive improvement from the previous assessment. However, with the continued assignment of a full-time fire safety officer, we continue to see incremental improvement in the conducting of monthly fire safety inspections of all areas of the facility and soliciting the expertise of the Fire Safety Marshal to help develop the GGACF fire safety program. The monthly fire safety inspections are conducted in a consistent manner and deficiencies are being identified. However, corrective action on noted deficiencies needs to be addressed. We continue to note fire and life safety discrepancies dating back to May 2015 that have not yet been corrected.

**FINDINGS:** The Territory continued working with Corrections Corporation of America (CCA) to help develop the facility fire and life safety related policies and procedures. The fire and life safety policies and procedures have been finalized and approved and now require that staff be trained on them and that they be implemented.

Staff training and implementation of these policies and procedures remains vital. Inadequate housing unit staffing levels and contraband control practices continue to enable inmates to ignite various materials in the housing units as evidenced by our December 2015 inspection of the housing units. During these inspections, I continue to observe the smell of smoke in several housing units.

The automatic fire detection and suppression system remains inoperable, inadequate staffing levels and contraband control leaves housing units deleteriously under-controlled and unmonitored, inmates apparently have undetected and uninterrupted access to items to ignite materials, and inmates obviously have no inhibition about igniting materials.

During this monitoring visit, it did not appear that there were any reported fires in the housing units. However, due to the ease by which inmates can access fire ignition sources and given the state of disrepair with the facility electrical system, i.e., exposed electrical wiring and heavy fire loads in the inmate cells, this area remains volatile from a fire and life safety perspective.

During our inspection, I also observed exposed electrical wiring in various areas of the Facility, including the kitchen, housing units and maintenance shops. In the kitchen I continue to observe boxes stacked in the dry storage area nearly up to the ceiling (should be stacked no higher than 30 inches below the ceiling). This was an identical finding in our previous reports. These findings, in addition to previous findings, reveal the urgent need to develop and implement a comprehensive fire safety program at GGACF.

Officer Samuel has continued to serve as the full-time fire safety for the facility. There is still no documentation available to demonstrate that evacuation plans have been approved by the VI Fire Marshall. The fire evacuation diagrams within the Facility remain woefully outdated and offer no assurance that they would be effective in routing staff and inmates from a fire or smoke related emergency. In fact, some diagrams still do not outline the appropriate route. On a positive note, Officer Samuel continues to conduct systematic inspections of fire safety needs for the facility. A comprehensive fire evacuation plan that would incorporate all areas and buildings within the confines of GGACF and the contents of the overall fire safety program, such as the finalized and approved fire safety policies and procedures, needs to be provided to the VI Fire Marshal for review.

Staff reported and documents reflect that the BOC has secured an MOA with the VI Fire Service for helping GGACF come into compliance with the fire safety provisions of the SA. However, as we reported in our previous reports, it must be expressed that the BOC/GGACF are the primary entities for demonstrating compliance with the fire safety provisions of the Settlement Agreement.

**RECOMMENDATIONS:**

The Monitor continues to request the reports for all drills and exercises conducted. It is also imperative that when the GGACF Fire Safety Program and the Fire Safety Plan are finalized and that they be provided to the Fire Marshal and with a copy to the Monitor and USDOJ.

1. Implement the approved fire safety policies.

2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.

3. Train all staff on this plan.

4. Install self-contained breath apparatuses (SCBAs) or an appropriate alternative at all locations where staff would need to search for or evacuate people.

5. Conduct and document quarterly fire drills for all shifts and document those activities.

6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.
7. Additional part-time fire safety officers should be selected from the officer corps, trained, and participate in the administration of a comprehensive fire safety program. It is unrealistic to expect one expert to develop and oversee such a complex program.

8. Supervisors should conduct routine, scheduled and unscheduled physical inspections of occupied structures, taking particular note of fire risks and hazards, document and report those findings to administration for timely and appropriate corrective action.

9. The fire inspection program was detailed in the draft fire safety policies and procedures that the monitor provided to the parties, and they should become a fundamental element of pre- and in-service training once policies and procedures are finalized, approved, and implemented.

**b. Adequate steps to provide fire and life safety to prisoners including maintenance of reasonable fire loads and fire and life safety equipment that is routinely inspected to include fire alarms, fire extinguishers, and smoke detectors in housing units;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Almost identical to previous Monitor's reports, we found that the Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, and cell and housing unit sprinklers are non-functional. We noted an improvement in the housing units whereby inmates were not using the fire sprinklers to support personal clotheslines; however, we did note that some inmates were using makeshift clotheslines in other areas of their cells. The primary fire detection and suppression system was designed to automatically detect and extinguish fires within most of the housing areas. However, the older housing units are not equipped with this system. The detection system does not function and the sprinklers are either broken or clogged by inmates. The only way to alert staff and inmates of a fire or smoke hazard is to use hand-held air horns that are located in the control rooms of the housing units.

Adequate supplies of handheld fire extinguishers were found in housing units, kitchen areas, the medical unit, and shops. All devices were tagged showing current inspections and all gauges showed positive pressures. The Fire Safety Officer has incorporated the inspecting of fire extinguishers in his monthly inspection reports, which is a positive step in improving fire safety. However, as the approved fire and life safety policies and procedures are implemented, GGACF staff must start taking deliberate steps in addressing discrepancies that are identified by the Fire Safety Officer.

The Director of Corrections reported the Fire Department will be conducting an evaluation of the newer housing units to identify fire and life safety related discrepancies. However, it does not appear that a plan is underway to fully address the fire sprinkler system for the entire facility. The scope of work for the kitchen is now more defined, the Director of Corrections reported the funding has been secured and the renovation project is going out to bid as well as the project for installing exhaust and blower fans in the housing units. Moreover, GGACF plans to continue to house individuals in the "older" buildings, and has no plans to update or install fire suppression equipment in those buildings. As reported in earlier monitoring reports, GGACF will never come into compliance with these provisions if that remains the case.

Although it is commendable that the Fire Safety Officer has systematically embarked in identifying fire safety discrepancies and fire safety needs, the resources to correct those deficiencies must be provided. For example, the Monthly Fire Safety Inspection Reports for the months of October, November 2015 continue to identify missing or non-functional smoke alarms and inoperable emergency lights dating back to May 2015; therefore, funds need to be made available in order to purchase missing smoke alarms and for purchasing adequate stocks of batteries for them. We were informed that the Fire Safety Officer now reports to the Physical Plant Manager, which may better help to resolve maintenance related discrepancies more promptly.

**RECOMMENDATIONS:**

1. Refer to recommendations above (a).

2. Consider purchasing fire safety program software from NFPA and/or the American Correctional Association to assist in program development and monitoring.

3. Continue to support fire safety officer.

**c. Comprehensive and documented fire drills in which staff manually unlock all doors and demonstrate competency in the use of fire and life safety equipment and emergency keys that are appropriately marked and identifiable by touch;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Documentation demonstrating compliance with this Provision was not provided during this assessment. In our previous reporting, GGACF staff indicated that fire drills have not been conducted on a regular basis. The Fire Safety Officer had commenced a process for conducting fire drills; however, documents evidencing this process were not made available during this reporting period.

During this site visit it appeared that security staff continue to have a better awareness of emergency key management. With a few exceptions, staff were able to identify emergency

keys. In the housing units we inspected, there were emergency keys available. However, this area needs continuous monitoring and staff need to be trained and retrained on a continuous basis on the Key Control Policy and Fire Safety policies and procedures. In future site visits we will continue to inspect this area of fire safety. The Fire Safety Officer and security management should conduct drills to see how prompt cell doors can be manually be unlocked

Emergency keys are not appropriately marked and identifiable by touch. A system for marking and identifying all emergency keys that match the proper door locking mechanism needs to be developed and systematically implemented.

**RECOMMENDATIONS:**

1. Develop and implement a valid and reliable emergency key system as described above. Train and drill staff as discussed on system use.

2. Develop emergency key and locking mechanism inspection and reporting system as discussed above.

3. Implement competency-based staff training as discussed above.

4. Exercise fire safety program using onsite, scenario-based drills; include community responders in exercise planning and exercise events.

5. Send the training officer and part-time fire safety officers to the National Fire Institute, National Emergency Training Center, Emmetsburg, MD for additional training.

**d. Regular security inspections of all housing units that include checking:**
**(i) that cell locks are functional and are not jammed from the inside or outside of the cell; and;**
**(ii) that all facility remote locking cell mechanisms are functional;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Almost identical to our previous monitoring reports, documentation demonstrating compliance with this Provision was not provided during this assessment. However, compliance with this Provision and its actualization of its intended outcomes will remain virtually impossible without adequate staffing levels for housing units, supervision, and facility maintenance.

The Maintenance policy has been approved. However, there is not a written preventative maintenance program or a regular security inspection program in place for checking that cell locks are functional and are not jammed from the inside or outside of the cell, nor a system for ensuring that all facility remote locking cell mechanisms are functional. During this monitoring

visit we were pleased to observe little evidence of inmates compromising the cell locks by inserting various materials in the locking mechanisms. We did, however continue to observe housing unit grills whereby the locking mechanism was inoperable and the grills left open. We also noted improvement in other housing units where the entry door locks and doors had been repaired and were functional such as in detention housing.

**RECOMMENDATIONS:** Same as above.

1. Also refer to recommendations related to security provisions, contraband, and inmate manipulation of cell door locking systems.

2. Repair all remote cell locking notification technology.

**e. Testing of all staff regarding fire and life safety procedures;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No records have been provided to verify that all staff have been trained and tested on safety procedures. The Fire Safety Officer reported that some hands-on training on the fire extinguisher is occurring. However, this provision of the Settlement Agreement requires a more comprehensive program for testing of all staff regarding fire and life safety procedures.

**RECOMMENDATIONS:**

1. Maintain records proving that staff have been trained and tested on emergency procedures. GGACF officials should create a statistical report showing percentages of staff who have and have not completed required testing.

2. Provide this Monitor documentation evidencing compliance with this Provision.

**f. Reporting and notification of fires, including audible fire alarms;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The fire reporting and notification system remains inoperable as reported in previous Monitor reports. There is no automatic audible fire alarm system at GGACF; each housing unit is issued a hand-held air horn to alert inmates' evacuation. This system may be useless, however, since all cell doors must be opened manually and the central control panels for the housing units remain inoperable. As identified in previous Monitor reports and consistent with this inspection, the only means of adequately detecting and responding to fire emergencies is having an officer physically present at the scene of the emergency.

The Director of Corrections reported that he has asked the Fire Department to conduct an evaluation of the facility for fire and life safety discrepancies.

**RECOMMENDATIONS:**

1. Install and routinely test the stored file alert notification system without delay.

**g. Evacuation of prisoners threatened with harm resulting from a fire;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The fire evacuation policies and procedures have been approved and now staff must be trained on them and implemented to include full scale evacuation drills.

**RECOMMENDATIONS:**

1. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.

**h. Fire suppression;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as previously stated. There is no functional fire suppression system, with the exception of the kitchen's cooking area.

**RECOMMENDATIONS:**

1. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.

2. Repair the automatic fire detection, notification, and suppression system.

3. Replace cell sprinklers with tamper proof mechanisms.

4. Monitor staff response to fires, ensure they comply with basic fire safety principles, and implement appropriate staff corrective action as needed.

**i. Medical treatment of persons injured as a result of a fire; and**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: The requirements for this provision are addressed in the final and approved Fire and Life Safety policies and procedures. The next step is to ensure that staff are trained on them and they need to be fully implemented.

**RECOMMENDATIONS:**

1. Implement approved policies and procedures.

2. The comprehensive fire safety program development must involve health care leadership to ensure that policies and procedures include adequate provisions for timely medical and mental health response to persons injured during a fire event.

3. Medical and mental health staff should be appropriately trained in relevant fire safety program components and drilled quarterly to ensure compliance with program response requirements.

4. Policy components involving medical and mental health staff should provide for their safety and security when involved in fire incident responses.

5. Qualified medical staff should participate in the development of fire program training topic that involves burns and smoke inhalation concerns. Qualified mental health staff should participate in the development of training related to critical incident recovery and emotional injury and recovery.

**j. Control of highly flammable materials.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Many inmate cells still contain considerable personal property, thus creating a fire and safety risk. During our previous site visit, the Director indicated that they would be purchasing bins for prisoners to store their personal belongings; however, this initiative has not yet been accomplished. Identical to previous reporting, flammable storage areas/cabinets in the Carpentry shops do not appear to be properly vented.

**RECOMMENDATIONS:**

1. It is anticipated that staff will be trained on the approved policies and procedures concerning the control of highly flammable materials as well as implementing them.

## VII. ENVIRONMENTAL HEALTH AND SAFETY

Defendants will protect prisoners from environmental health hazards by providing constitutionally adequate living conditions.

1. Accordingly, Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies regarding the physical plant and environment, including the following:

**a. Written housekeeping and sanitation plans that outline the proper routine cleaning of housing, shower, and medical areas along with an appropriate preventive maintenance plan to respond to routine and emergency maintenance needs;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Documentation in the form of logbooks and memorandum was provided during this monitoring visit that demonstrated ongoing efforts by GGACF officials and maintenance staff to assess, improve, and monitor facility sanitation and hygiene. Cleaning supplies were more readily available in the housing units. Some housing units and cells were cleaner than others and the need to consistently conduct routine and sustained cleaning of all facility areas remains a challenge to GGACF staff.

Again, however, housekeeping and sanitation plans will not meet compliance with this Provision without adequate staffing levels as previously stated.

The Maintenance Supervisor maintains preventative maintenance schedules for various components of the GGACF physical plant, including the emergency generator. The emergency generator has been problematic for some time. However, the Maintenance Supervisor reported that the necessary parts to repair the emergency generator had arrived in the Island during our site visit.

The Director of Corrections reported that one of his next priorities will be to address the issue of non-functional drinking fountains in the housing units.

**RECOMMENDATIONS**:

1. Replace, repair, and install reliable sinks in all cells and housing areas that provide safe drinking water for inmates.

2. Prohibit allowing inmates to use toilets, sinks, and described clotheslines for cleaning clothes and linens.

3. Laundry exchanges of clean, institution issued linens and clothing, should occur at least twice per week.

4. Replace, repair, and install working shower heads and plumbing to provide reliable personal hygiene, adhere slip-resistance materials at shower entrance points to reduce fall risks, repair water draining to eliminate standing water in unit and cell floors.

5. Develop a mold control/mitigation plan that includes routine inspection and cleaning activities. Control access to related cleaning chemicals and train staff and inmates in the proper use and storage of those chemicals.

6. Develop and implement a sanitation management plan that monitors and mitigates sanitation problems and hazards.

7. Improve practices involving mattress cleaning and ensure inmates and staff involved in this program are trained in proper cleaning methods and use of materials and chemicals. Ensure mattress storage areas are sanitary at all times.

8. Repair all housing/cell windows to prevent penetration by insects.

**b. Adequate ventilation throughout the facility;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: As stated in previous reports, ventilation throughout all housing units remains troubling. High summer temperatures and humidity make the housing units and cells constantly uncomfortable for breathing. High temperatures and poor ventilation can contribute to and exacerbate pulmonary illness, and potentially jeopardize the health of inmates on psychotropic medications (many such medications can cause harmful reactions when body temperatures are elevated).

As reported earlier in this report, the Director of Corrections is prioritizing the project for the installation of exhaust and blowers fans for the housing units.

**RECOMMENDATIONS:**

1. Timely complete an air quality assessment performed by a qualified provider.

2. Implement necessary improvements that reduce housing area and cell temperatures and increase air flow.

3. Medical and mental health staff should monitor all inmates for heat and airflow-related health risks. All inmates in segregation or who are locked in their cells should be monitored by medical and mental health staff for signs of health conditions.

4. Train all staff in detecting and responding to health conditions related to heat and air circulation contributors.

5. Install environmental health condition monitoring devices, e.g., temperature, humidity, and air quality readers. Require regular monitoring and recording of readings and take timely action to mitigate environmental conditions that create health risks caused by those conditions.

6. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

**c. Adequate lighting in all prisoner housing and work areas;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Attention to lighting repair and replacement remains positive. However, some security staff continue to allow inmates/detainees to cover their cell lights, which is creating a fire hazard.

**RECOMMENDATIONS**:

1. Develop a comprehensive campus/facility lighting plan that ensures constant illumination of all required internal and external perimeters, housing areas, support services structures and areas.

2. Maintain an ongoing lighting repair log that evidences repair activities.

3. Ensure rapid repair and replacement of inoperable lighting, add additional external and internal illumination where indicated by a comprehensive security lighting needs assessment.

4. Provide for adequate staffing levels to support lighting plan and maintenance.

5. Increase illumination in all occupied cells for improved security and inmate wellness.

6. Prohibit inmates from blocking cell door windows and from erecting anything in their cells that impedes good visibility from the cell door window.

7. Ensure that all emergency lights in housing units (and other occupied areas in the facility) are reliably operational.

**d.** Adequate **pest control for housing units, medical units, and food storage areas;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Very little change since previous inspections. This provision remains in partial compliance but no significant decline in performance was found. Identical to our previous inspection, we noted that the overhead door to the storage area of the Kitchen is not properly sealed and rodents and vermin can easily infiltrate the Kitchen. Inmates in the housing units complained of insect presence. We also observed missing or broken screens on many facility windows.

The BOC has a contract with a private vendor (Oliver Exterminating of St. Croix) to provide pest control services at GGACF. It does not seem that the contract provides for individual cell extermination, but perhaps it should. In one of the housing units (K-Unit), an inmate reported the presence of cockroaches in his cell. I inspected this cell and there did appear to be evidence of cockroach infestation, however, the cell was also unsanitary and contained many food items, food particles and debris.

**RECOMMENDATIONS**:

1. Review, revise, develop, train, implement, evaluate environmental pest control policies and procedures that provide for both incidental and scheduled pest control inspections and mitigation.

2. Ensure that inmates involved in pest control activities are properly trained, equipped, and clothed for requirements of those activities.

3. Replace all missing and broken unit and cell window screens to prevent access by insects.

**e. Prisoner and clinic staff access to hygiene and cleaning supplies;**

**ASSESSMENT: PARTIAL COMPLIANCE**
**FINDINGS**: There was no substantive improvement from previous assessments. Inspection of housing units, cells, kitchen, and medical areas again show consistent presence of personal hygiene and cleaning supplies. However, similar to previous site visits, there were a number of inmate complaints in the Housing Units claiming they do not have sufficient quantities of cleaning materials to properly sanitize the showers. We observed that many inmate showers are in deplorable condition from a sanitary standpoint, including mold problems and physical

plant deterioration. We also observed that some showers have been repaired from our previous site visit.

**RECOMMENDATIONS:**

1. Ensure that all inmates have access to hygiene products upon admission to the facility.

2. Continue to provide adequate supply of these personal care items in control pods or housing units to ensure timely exchange of use-for-new products.

3. Prohibit inmates from bartering these supplies and from hoarding empty containers in their cells and living areas.

**f. Cleaning, handling, storing, and disposing of biohazardous materials;**

**ASSESSMENT: NONCOMPLIANCE** – No substantive improvement from previous assessment.

**FINDINGS:** No substantive change from previous assessment.

There is no formal sanitation plan or protocols covering compliance with this Provision; nor is there a formal training program for staff or inmates on this topic. Staff and inmates must be trained and demonstrate competence in handling bio-hazardous materials, provided and instructed on the proper use of bio-protective clothing and supplies, and supervisors must closely monitor biohazard clean-ups. Remaining in noncompliance with this Provision can jeopardize the health of staff and inmates.

Spill clean-up kits were available in the medical area.

**RECOMMENDATIONS:**

1. Develop, as part of medical infection control policies and facility sanitation plans, a comprehensive bio-hazard control plan that includes:

a. OSHA and CDC standards and protocols for biohazard safety and exposure control;
b. Written and enforced procedures and protocols for biohazard handling; cleaning, disposal, storage, inspections, and clean-up;
c. Staffing and inmate training on the plan and proper handling and disposal of biohazards;
d. Consistently maintain adequate supplies of feminine hygiene products and disposal bags for all bio-waste;
e. Locate adequate supplies of bio-hazard disposal and clean-up supplies in or at all locations where biological waste and/or spills do and could occur;

f. Provide appropriate clean-up apparel and training in the use of that apparel.

2. Commence deep cleaning of all housing and cell area walls, floors, showers, and other living areas to remove all dried bio-products and waste. Do the same in the kitchen, medical areas, intake, and all washrooms throughout the facility.

3. Develop a bio hazardous control program that involves regular inspections of all potential contamination areas.

4. GGACF officials should consult an environmental specialist to assess these conditions and assist them in developing appropriate mitigation plans and policies.

5. This provision can advance to Substantial Compliance once related policies and procedures have been approved and implemented according to the Agreement.

**g. Mattress care and replacement;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** The related policy has been approved by the United States and the Monitor. I did not see this area to be problematic during this monitoring visit. There were no inmate complaints regarding their mattresses and the ones I inspected were adequate. However, GGACF staff have not yet substantially addressed the Monitor's previous recommendations below.

**RECOMMENDATIONS:**

1. Refer to previously discussed sanitation recommendations.

2. Issue clean and usable mattresses to all inmates.

3. Complete a full inventory of non-usable mattresses and remove them from the supply.

4. Do not issue mattresses to inmates until after properly inspected for damage and contraband, cleaned and sanitized.

5. Maintain reliable records that verify mattress inventories, cleaning and maintenance requirements.

**h. Control of chemicals in the facility, and supervision of prisoners who have access to these chemicals;**

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** No substantive change since previous assessment. Implementation of the approved policies and procedures, and a quality assurance tracking system will aid in advancing this provision to Substantial Compliance. Although chemical storage appears appropriate, there is no training program for staff or inmates responsible for handling and controlling these chemicals. Additionally, staff that supervise inmates and are allowed to handle these chemicals must be properly trained in that role and those responsibilities. This has yet to occur. In the area of Material Safety Data Sheets, we did note an improvement in that facility staff have prepared notebooks that contain material safety data sheets and are being circulated to various areas of the facility including the housing units.

**RECOMMENDATIONS:**

1. Implement approved policies and procedures.

2. Develop comprehensive control plans for cleaning supplies and chemicals, chemical inspections, inventory control, and inmate training in use of supplies. Ensure adequate record keeping, monitoring, and property control logs.

3. Ensure the cleaning chemical control plan is coordinated with medical staff for harmful exposure mitigation, response, and recovery protocols.

4. This provision can advance to Substantial Compliance once related policies, procedures and plans are approved and implemented according to the Agreement.

**i. Laundry services and sanitation that provide adequate clean clothing, underclothing, and bedding at appropriate intervals;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As previously reported, housing unit/cell inspection and inmate interviews found no substantive improvement. As stated in previous reports and found during this monitoring visit, inmates continue to routinely wash personal and issued clothing in cell sinks and toilets. Unfortunately, unlike our previous site visit, during this visit we observed inmates drying these items in their cells using clotheslines anchored to walls, window frames, bunks, etc. This was a negative development from our previous site visit and in large part, is exacerbated by the lack

of staff presence in the housing unit and lack of supervision. We also continue to observe worn out linens and dirty linen in many inmate cells.

**RECOMMENDATIONS:**

1. Implement approved policies and procedures.

2. Cease the practice of allowing inmates to wash personal and issued clothing in toilets and sinks.

3. Cease the practice of allowing inmates to dry clothing on make-shift clotheslines in their cells.

4. Routine and consistent replacement of damaged mattresses, mattress cleaning, cleaning of bedding.

5. Review, revise, develop, train, implement, and evaluate a comprehensive laundry management plan that governs total laundry operations.

6. Consider replacing all wood laundry carts made of non-absorbing materials that can be sanitized and completely cleaned. Discontinue the practice of moving laundry on carts that have not been cleaned and sanitized.

7. The initial issue of inmate supplies should include, at minimum: one (1) corrections issue shirt/pants, jumpsuit, undergarments, towel, bedding, mattress, sheet and blanket. Clothing should be exchanged with clean items twice per week at minimum, sheets and towels once per week at minimum. Blankets should be exchanged monthly at minimum. Any clothing, linens or bedding should be changed immediately if they appear damaged and/or unsanitary, or appear to present a risk to health.

8. Ensure that inmate handbooks provide clear rules and information about the laundry program, how to access clothing, linens, and bedding. Cease the practice of allowing inmates to wash clothing in housing unit or cell sinks and toilets.

9. Staff and inmates involved in the laundry work program should be properly trained and supervised.

10. Laundry equipment should reliable and properly maintained.

**j. Safe and hygienic food services, including adequate meals maintained at safe temperatures along with cleaning and sanitation of utensils, food preparation and storage areas, and containers and vehicles used to transport food;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The Director of Corrections reported that funding has been secured to refurbish the Kitchen and they are in the bidding process. This is a very positive development. In addition, the food services policies and procedures have been finalized and approved.

The physical plant of the Kitchen remains in a state of substantial deterioration as does the food service equipment. Overall, the kitchen was clean. The dishwasher is still not working properly.

There is still an inoperable walk-in refrigerator that was cleaned from our previous site visits; however, there is still evidence of insect and rodent infestation that staff are trying to address. It appears that part of the scope for the kitchen refurbishing project will be the permanent removal of all inoperable and useable food service equipment.

During this inspection I did note that there was hot water in men's bathroom.

The kitchen doors are not rodent proof. We observed evidence of mold and rust in various areas of the Kitchen that staff is attempting to temporarily address; however, a permanent fix to the problem still needs to be made to the overall structure of the kitchen. The kitchen officer is still working on finalizing a chit check out system for the utensils and dangerous implements.

**RECOMMENDATIONS:**

1. Implement approved policies.

2. GGACF officials should review food service requirements promulgated by the National Correctional Association and National Commission on Correctional Health Care.

3. Develop a food service training program that includes inmate and staff training records and ensure that all training is well-documented.

4. Policies and procedures developed should include controls for the use of caustic, toxic, and hazardous materials used in the kitchen. Material Safety Data Sheets should be posted conspicuously.

5. Timely complete planned renovations to the kitchen and food service support areas.

**k. Sanitary and adequate supplies of drinking water.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No major improvement was again observed in the housing units during this assessment with the exception of X-Dorm.

The lack of constant reliable access to drinkable water further prevents GGACF from ensuring that inmates live in a healthy environment. Similar to previous reporting, many of the cell sinks were still inoperable and inmates rely on officers to provide water before and during lock down. Access to drinkable water is generally available during the "out of cell" periods but inmates must rely on the presence and actions by officers following lock down. Inmates have no access to drinkable water when there are no officers on the units to provide it, and water from cell-sinks is considered not safe for drinking. In previous site visits, inmates consistently complained of seeing particles of rust in the ice that is provided to the housing units. During this visit there were some complaints regarding contaminated ice with rust and particles. A long-term solution to the problem still needs to be addressed through the installation of refrigerated water fountains in the housing units.

In X-Dorm we had been reporting a consistent problem regarding the lack of drinking water for this unit. However, since our last three site visit GGACF officials have addressed this problem by installing portable water bottles in the dorm.

**RECOMMENDATIONS:**

1. Develop and implement a corrective action plan that ensures inmates have consistent and reliable access to safe drinking water.

2. Ensure that all inmates are provided consistent access to sanitary drinking water.

## VIII. TRAINING

**Defendants will take necessary steps to train staff so that they understand and implement the policies and procedures required by this Agreement, which are designed to provide constitutional conditions.**

**1. Accordingly, Defendants will develop and submit to USDOJ and the Monitor for review and approval facility-specific policies regarding the following:**

a. **The content (i.e. curricula) and frequency of training of uniformed and civilian staff regarding all policies developed and implemented pursuant to this order;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Draft training policies and procedures remain under review and revision for final approval. These documents must include the required content listed in this provision.

At least 95% of health care staff have been trained on most of the approved health care-related policies and procedures but achieving a minimum passing score of 80%. All security-related policies and procedures have not yet been approved nor has any training curricula been approved for this purpose. The Territory is currently engaged in procuring a vendor to develop training curricula and provide training for these purposes.

**RECOMMENDATIONS: Previous recommendations remain appropriate.**

1. Implement training policies and curricula once approved.

2. Provide this Monitor and United States all requested training documents.

**b. Pre-service training for all new employees;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The draft training policies and procedures include requirements for pre-service training for new civilian, correctional, and supervisory/management staff. These documents remain under review and revision for final approval.

**RECOMMENDATIONS:** Finalize and implement approved training policies and procedures.

**c. Periodic in-service training and retraining for all employees following their completion of preservice training;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The draft training policies and procedures include requirements for in-service training for new civilian, correctional, and supervisory/management staff. These documents remain under review and revision for final approval.

**RECOMMENDATIONS:** Same as above.

**d. Documentation and accountability measures to ensure that staff complete all required training as a condition of commencing/continuing employment.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Draft training policies and procedures generally include the required elements of this provisions. These documents remain under review and revision for final approval as scheduled.

**RECOMMENDATIONS:** Implement training policies and procedures once approved**.**

## IX. IMPLEMENTATION

1. **Defendants will begin implementing the requirements of this Agreement immediately upon the effective date of the Agreement. Within 30 days after the effective date, Defendants will propose, after consultation with the Technical Compliance Consultants ("TCCs"), a schedule for policy development, training, and implementation of the substantive terms of this agreement. The schedule shall be presumptive and enforceable until the Monitor is appointed.**

**FINDINGS:** The schedule is in place for completion of required policies and procedures. The parties have adjusted this schedule by mutual agreement but all security-related policies are not yet completed; training and implementation schedules are pending. Training has been completed on most health care policies and the implementation process is underway.

2. **Upon appointment, the Monitor will adopt the schedule as proposed or as amended by the Monitor after consultation with the parties and the TCCs. Either party may seek a modification to the schedule by making a request to the Monitor, or the Monitor may modify the schedule as necessary. If the parties disagree with each other or with the Monitor and cannot resolve it with the Monitor, either party may submit the dispute to the district court.**

**FINDINGS:** This Monitor continues to monitor compliance with Court-ordered schedules. Additionally, this Monitor continues to support schedule revises when those revisions result from collaboration and mutually agreement between the parties. This Monitor continues to participate in resolution of disputes as requested.

3. **Defendants will implement every policy, procedure, plan, training, system, and other item required by this Agreement. Each policy required by this Agreement will become effective and Defendants will promulgate the policy to all staff involved in its implementation within 45 days after it is submitted to the United States, unless the United States or the Monitor provides written objections. The Monitor will assist the parties to resolve any disputes regarding any policy, procedure, or plan referred to in this document. If the parties still cannot resolve a dispute, either party submit the dispute to the district court.**

**FINDINGS:** All health care-related policies and procedure are in the implementation process. Several approved security-related policies and procedures were provided to the Monitor and United States. The Monitor and the Parties continue to collaborate in finalizing the balance of outstanding policies. We have participated in several policy-related phone conferences during this assessment period. These activities have been exceptionally productive for finalizing draft policies and procedures. Disputes involving the Territory's proposed Staffing Plan has been submitted to the court for resolution.

4. **Defendants will conduct a semiannual impact evaluation to determine whether the policies, procedures, protocols, and training plan are achieving the objectives of this Agreement and to plan and implement any necessary corrective action. The Monitor will assist Defendants in identifying and analyzing appropriate data for this evaluation. The evaluation and all recommendations for changes to policies, procedures, or training will be provided to the United States and the Monitor.**

**FINDINGS:** There have been no semiannual impact evaluations submitted by the Territory. The reports submitted do not include descriptive analysis of progress. The monitor has provided the Territory assistance in identifying and analyzing appropriate data for evaluation while onsite, during conference calls, and in compliance reports.

5. **Defendants may propose modifying any policy, procedure, or plan, provided that the United States is provided with the 14 days' notice in advance of the action. If the United States or the Monitor provides written objections, the Monitor will assist the parties to resolve any disputes regarding these items. If the parties still cannot resolve a dispute, the parties agree to submit the dispute to the district court.**

**FINDINGS:** This Monitor has no evidence at this time to believe the Territory is not complying with this requirement.

6. **Defendants shall provide status reports every four months reporting actions taken to achieve compliance with this Agreement, Each compliance report shall describe the actions**
**Defendants have taken during the reporting period to implement each provision of the Agreement.**

**FINDINGS:** The Territory filed its Eighth Status Report 12/10/15 (ECF 945-1). This report documents status representations stated during the 12/16/15 conference. Content of this report articulates progress toward compliance with the Agreement in several more areas than contained in previous status reports. Unfortunately, this report was filed about 30 days early and likely omits progress occurring during that period. Nonetheless, this status report shows improvement in Territory's progress documentation efforts.

7. **Defendants shall promptly notify the Monitor and the United States upon any prisoner death, serious suicide attempt, or injury requiring emergency medical attention. With this notification, Defendants shall forward to the Monitor and the United States any related incident reports and medical and/or mental health reports and investigations as they become available.**

**FINDINGS:** The Territory notifies this Monitor and the United States of serious events as they occur and provides related records either with those notifications or upon request. Additionally,

the Territory submits monthly incident reports and medical emergency logs to this Monitor and the United States for examination. Additional information and records are typically provided by the Territory as requested but receipt of those records can be untimely on occasion. Timelier responses would improve the efficiency of routine monitoring and compliance reporting.

8. **Defendants shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Monitor and USDOJ at all reasonable times for inspection and copying. In addition, Defendants shall also provide all documents not protected by the attorney-client or work product privilege reasonably requested by USDOJ. The parties will discuss a protective order for other documents over which Defendants may claim privilege.**

**FINDINGS:** The Territory continues to provide requested compliance-related information and records. Occasionally, documents requested during onsite visits are provided post-visit due to GGACF resource limitations. Providing documents timelier would improve the efficiency of the monitoring process. Some documents appear to contain incorrect information. For example, a chronic care log sent to the Monitor and United States in January 2016, contains repeated references to housing units that have been closed and a prisoner who is no longer at the facility. The Territory acknowledged that the document contained errors, but as of February 18, 2016, the Territory has not submitted a corrected document for the Monitor and United States to review.

9. **USDOJ and its attorneys, consultants, and agents shall have sufficient access to Golden Grove, prisoners, and documents to fulfill its duties in monitoring compliance and reviewing and commenting on documents pursuant to this Agreement. Except to the extent that contact would violate the Rules of Professional Conduct as they apply in the Territory of the Virgin Islands, USDOJ and its attorneys, consultants, and agents shall have sufficient access to Golden Grove's staff.**

**FINDINGS:** The Territory continues to cooperate in providing access to the facility and needed documents as requested.

10. **Excluding on-site tours, within 30 days of receipt of written questions from USDOJ concerning Defendants' compliance with the requirements of this Agreement, Defendants shall provide USDOJ with written answers and any requested documents unless the Defendants obtain relief.**

**FINDINGS:** The Territory continues to provide access to requested records.

## X. Monitoring

**D.1. Monitoring Access: Within 30 days of appointment by the Court, the monitor will conduct the first site visit and submit to the parties for their review and comment a description of how the Monitor will assess compliance with each of the Compliance Measures, how the monitor intends to gather information necessary for the assessment, and what information the Monitor will require the defendants to routinely report and with what frequency.**

**FINDINGS:** This Monitor wishes to thank Territory officials for submitting monthly compliance reports, even as the document request grows.

**D.2. Monitoring Access: With reasonable advance notice, the Monitor will have full and complete reasonable access to the Golden Grove Correctional Facility and Detention Center, all facility non-privileged records, prisoners' medical and mental health records, staff members, and prisoners, Defendants will direct all employees to cooperate fully with the Monitor, Reasonable advance notice must be provided to the Bureau of Corrections prior to conducting any on-site compliance reviews. Other than as expressly provided in this Agreement, this Agreement shall not be deemed a waiver of any privilege or right the Territory or Defendants may assert against a third party, including those recognized at common law or created by statute, rule, or regulation against any other person or entity with respect to the disclosure of any document. All nonpublic information obtained by the Monitor will be maintained in a confidential manner.**

**FINDINGS:** The Territory has provided this Monitor and monitoring team full and complete access to GGACF as required under this provision.

## APPENDIX A - ASSESSMENT METHODOLOGY

This compliance assessment involved activities before, during, and following the onsite visit by the monitoring team and the Parties.

Pre-visit activities ensured involvement and input from officials and legal counsel representing the Territory (defendant) and the United States (plaintiff) in the planning of the site visit. Pre-visit activities included conference calls and exchange of relevant documents intended to maximize clarity and mutual understanding for assessment visit purposes and scheduling, and monitoring compliance expectations in general.

Pursuant to Section X.D.1 of the 2013 Settlement Agreement, the Monitor provided the following information to the Territory and U.S. Department of Justice officials for review and comment. This information intended to provide to the Parties: 1) the description of how compliance with the Agreement will be assessed; 2) how information necessary for on and off site assessment work will be gathered; and, 3) what information the Monitor will require the defendants to routinely report and with what frequency.

1. Description of how the Monitor will assess compliance with each of the Compliance Measures.

In general, compliance assessment will include the following activities:

A. Discussions and meetings with facility officials, staff, providers, and inmates.
B. Discussions and meetings with community agency officials providing inspection or other regulatory oversight of GGACF.
C. Discussion and meetings with officials and staff of contract providers and community agencies who provide services within and/or for GGACF and inmates held in its custody.
D. Discussions and meetings with other pertinent staff, personnel, and community members, either as requested by the parties or who, in the determination of the Monitor, can provide relevant information for the purposes of monitoring.
E. On-site tours of grounds, perimeter security barriers, perimeter access control and entrance points, all external security technology and methods, building and structural exteriors, roofs, and utility systems.
F. On-site tours of all buildings, housing units, special environments, health care facilities, receiving and discharge areas, segregation units, all cell areas, food service and storage areas, utility closets and chases, utility technology and systems, fire prevention and suppression systems, life safety locations and equipment, other interior areas and location relevant to determine compliance.
G. Examination of all security equipment and systems used for perimeter, external, structural, internal, and special security operations purposes.
H. Examination of health care equipment, supplies, materials, technology and other material methods and processes used for inmate health care assessment, diagnosis,

treatment planning, treatment (long and short-term), follow-up, and discharge planning.

I. Examination of agency motor fleet including all cars, busses, trucks, vans, and any other motorized vehicle used for correctional operations purposes.

J. Examination of any and all available records, data, and/or information relevant to compliance and compliance monitoring not limited to the following:

- Administration
- Budget
- Personnel
- Operations
- Training
- Facility construction, renovation, repairs, and maintenance
- Equipment, supplies, and materials
- Inmate case files
- Medical and mental health screenings, assessments, evaluations, diagnoses, treatment plans, progress charts and notes, medication logs and records, drug formularies, appointment calendars, invoices, etc.
- Labor contracts
- Incident reports and logs
- Evidence / contraband reports and logs
- Use of force incidents and logs
- Inmate grievances and disciplinary records and actions
- Policies, procedures, protocols, guidelines, post-orders, logs, memos, and other documents and information that support accurate compliance assessment and progress determinations
- Employee complaints, grievances, claims, etc. directly or indirectly related to the compliance provisions
- Other information required to determine compliance and compliance progress

The information described above is intended to assist the Monitor to determine compliance and the degree to which each of the compliance ratings (Noncompliance, Partial Compliance, and Substantial Compliance) apply to each provision assessed. Additionally, the Monitor will collaborate with the parties to develop metrics and core measures for qualitative and quantitative measurement of progress and compliance. Core measures and metrics should specifically pertain to the conditions set forth in the Settlement Agreement, and generally consider accepted standards and recommendations promulgated by the National Correctional Association, American Jail Association, National Commission of Correctional Health Care, American Psychiatric Association, American Nursing Association, ASIS International, National Fire Protection Association, Centers for Disease Control (CDC), OSHA, Territory regulations, and other nationally accepted standards for compliance assessment and management. Additionally, specific measures articulated in the

Order of the Court dated May 14, 2013 [Dkt 742] (the "Order") shall be followed. The following compliance management terms are suggested for assessment and compliance monitoring:

- Compliance Control: Implies activities designed and intended to inspect and reject defective or deficient performance, processes, services, equipment, etc. when applied.
- Compliance Assurance: Implies activities designed and intended to identify performance and services that assure compliance when applied.
- Compliance Improvement: Implies activities designed and intended to correct and/or improve compliance in performance and services.
- Compliance Management: Implies activities designed and intended to ensure targeted compliance outcomes.
- Domain: A core aspect of the organization's performance, such as *access* to care, *costs* of care, or *quality* of care (e.g., consumer level of functioning, relapse and recidivism rates, or consumer satisfaction).
- Performance Indicator: A defined, objectively measurable variable that can be used to assess an organization's performance within a given domain. For example, within the domain of consumer satisfaction, a performance indicator might be: "the percentage of consumers who state that they received the types and amounts of services that they felt they needed."

2. How information necessary for on and off site assessment work will be gathered.

Monitoring will involve gathering various forms of information both on and off site and not limited to:

- Communications with Territory and U.S. Department of Justice Officials as authorized in the Order
- On-site visits, tours, meetings, individual and group meetings and interviews • Collection and examination of electronic, paper, and photographic records, information, and data
- Photographs taken during inspections (not to be used in any report without expressed written agreement of both parties)
- Online media information
- Online public records
- Electronic and standard mailing of information
- Email communication and phone consultations

3. What information the Monitor will require the Defendants to routinely report and with what frequency.

It is understood that the Territory will use existing records systems and processes to provide routine reports. However, new records and information systems and methods may become necessary to accurately report progress compliance and related performance. It is this Monitor's desire to assist the Territory in developing records and

information methods and processes that yield accurate, complete, and efficient reporting of compliance efforts and progress. Therefore, it is assumed that the compliance reporting process will evolve throughout the life of the Order.

Compliance reporting should include statistical reports, narrative descriptions of compliance activities and progress, improvement plans, case reviews, incident reports, and other information and data that helps the parties and the Monitor understand compliance progress as well as to identify issues and concerns that challenge compliance efforts. As recommended in both previously reports, a monthly compliance report is proposed until the reporting system and compliance progress evolves to justify less frequent routine reporting.

Non-exclusive information required for assessments and monitoring include the following.

**A) Corrections Information:**

1. The most recent census report.
2. Last five (years) admission, release, average daily inmate population.
3. The housing unit floor plans for all facilities and housing units.
4. A copy of the facility's policies and procedures manual(s), including the facility's Use of Force policy. [If you have the policies and procedures in electronic form, we would request all of them prior to our visit. Otherwise, we request only the Use of Force policy prior to our arrival]. 5. The Use of Force Log for the past twelve (12) months and a few sample Use of Force packages [we request only the Use of Force Log prior to our arrival]. Please indicate any use of force on an inmate on the mental health case list.
6. The Serious Incident Report Log for the past twelve (12) months.
7. The Inmate Disciplinary Log for the past twelve (12) months.
8. The Contraband Log for the past twelve (12) months.
9. The Administrative Investigations Log for the past twelve (12) months.
10. A copy of the Inmate Grievance Policy.
11. A copy of the Inmate Grievance Log for the past twelve (12) months.
12. All forms and documents used by staff for inmate intake, assessment, classification, release, housing, supervision, disciplining, etc. Generally speaking, any form, report, log book, etc. used in the course of a corrections officers work day.
13. Documentation reflecting the current classification system, including policies and procedures related to such classification system.
14. Documentation reflecting any training facility staff has received, including any corrections officer training manuals, pre-service and in-service training completed by all staff over the past 36 months.
15. Current staffing schedules for security positions and shifts.
16. Job descriptions for all non-health care staff.

17. Copies of any self-evaluation reports, grand jury reports, American Correctional Association surveys, National Institute of Corrections reports/evaluations, National Commission on Correctional Health Care reports/evaluations, or any other outside consultant reports regarding the facility.
18. Any questionnaires, intake forms, or inmate handbooks provided to inmates upon their entry to the facility or during their stay in the facility.
19. The most recent Staff Manpower Report/Matrix that shows all authorized positions and which ones are vacant.
20. Reports and data showing turnover information and statistics for security, medical, mental health, and other staff positions budgeted and authorized for the previous 36 months.
21. Any staffing improvement plan, applications for technical assistance, and Territory budget proposals/authorizations to address staffing shortfalls.
22. Facility maintenance requests and work orders for the past 12 months.
23. Records and/or lists of physical improvements, repairs, and renovation completed to correct security problems and deficiencies over the past 36 months.
24. Past 36 months of agency budgets.
25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.
26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.

**B) <u>Medical and Mental Health Information:</u>**

27. A mock or blank chart containing all forms used, filed in appropriate order.
28. <u>The infection control policies.</u>
29. The names of inmates who have died in the past year, and access to/or copy of both their records and mortality review.
30. The names of any inmates diagnosed with active TB in the past year and access to/or a copy of their records.
31. To the extent not provided above, the policies and procedures governing medical and mental health care.
32. A staffing roster with titles and status, part time or full time, and if part time, how many hours worked per week.
33. The staffing schedule for the past two (2) months for nursing and providers, including on-call schedules for the same time period.
34. Job descriptions for medical staff and copies of current contracts with all medical care providers, including hospitals, referral physicians, and mental health staff.
35. Inter-local professional services agreements with health care providers, companies, to include health care policies under which those persons and/or entities provide inmate health care.

36. Tracking Logs for consults and outside specialty care services provided, chronic illness, PPD testing, health assessments, and inmates sent to the emergency room or off-site for hospitalization listing where applicable name, date of service, diagnosis and service provided.
37. A list of all persons with chronic illness listing name, location, and name of chronic illness.
38. A schedule of all mental health groups offered.
39. Minutes of any meeting that has taken place between security and medical for the past year. 40. Quality assurance and Medical Administration Committee minutes and documents for the past year.
41. A list of all emergency equipment at the facility.
42. A list of current medical diets.
43. Sick call logs (i.e., lists of all persons handing in requests for non-urgent medical care to include in the log presenting complaint, name, date of request, date triaged, and disposition) and chronic illness appointments for the past two (2) months.
44. A copy of the nursing protocols.
45. To the extent not provided above, a copy of any training documentation for security and medical staff on policies and procedures and emergency equipment.
46. A list of all the inmates housed at the facility by birthdate, entry date, and cell location.
47. To the extent not provided above, external and internal reviews or studies of medical or mental health services including needs assessments and any American Correctional Association and National Commission on Correctional Healthcare reports.
48. List of all inmates placed in restraints, and all inmates receiving mental health treatments, under suicide watch, or taking psychotropic drugs.
49. Current mental health case list including inmate name, number, diagnosis, date of intake, last psychiatric appointment, next psychiatric appointment, and any case lists of inmates followed only by counseling staff with last appointment date and follow-up appointment.
50. Documentation reflecting any training that facility staff have received on suicide prevention, including certificates and training materials.
51. All documents related to the any suicide occurring within the past year.
52. List of all persons on warfarin, Plavix, digoxin.

**C) Suicide Prevention Information:**

53. All policies and directives relevant to suicide prevention.
54. All intake screening, health evaluation, mental health assessment, and any other forms utilized for the identification of suicide risk and mental illness.
55. Any suicide prevention training curriculum regarding pre-service and in-service staff training, as well as any handouts.
56. Listing of all staff (officers, medical staff, and mental health personnel) trained in the following areas within the past year: first aid, CPR/AED, and suicide prevention.

57. The entire case files (institutional, medical and mental health), autopsy reports, and investigative reports of all inmate suicide victims within the past three years.
58. List of all serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) within the past year.
59. List of names of all inmates on suicide precautions (watch) within the past year.
60. The suicide watch logs for the past year.
61. Clinical Seclusion logs for the past year.
62. Use of clinical restraint logs for the past three years.
63. Any descriptions of special mental health programs offered.
64. A list of all uses of emergency and forced psychotropic medications in the past year
65. A list of any use of force associated with the administration of psychiatric medications for the past year.
66. A description of medical and mental health's involvement/input into the disciplinary process and clearance for placement in segregation.
67. List of all inmates referred for off-site psychiatric hospitalization in the past three years.

It is also understood that the above lists are not all inclusive and the Monitor retains the discretion to request additional information and documents deemed necessary for legitimate monitoring purposes and within the scope of conditions provided within the Agreement.