United States Virgin Islands

GOLDEN GROVE ADULT CORRECTIONAL FACILITY

St. Croix, VI

FIFTH COMPLIANCE MONITORING REPORT

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

Kenneth A. Ray, M.Ed., Monitor
November 28, 2014

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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) as a tool to assist Defendants 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 fifth onsite compliance monitoring assessment was conducted September 22-25, 2014, and included an onsite Court status conference on Thursday, September 25th. 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 the final report.

The Monitor will advance each provision as certain levels of compliance progress are clearly demonstrated by the Territory. Generally speaking, the Monitor will advance provisions from noncompliance to partial compliance when compliance efforts demonstrate the following:

1. Policies, procedures, protocols, and/or plans required of a provision are properly approved;
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.

Provisions are eligible to advance from partial to substantial compliance when efficacious assessment and evaluation of implemented policies, procedures, protocols, plans, etc. quantitatively and/or qualitatively evidence: 1) that implementation efforts are producing outcomes intended in the Agreement and 2) that implementation outcome performance is reliable (assessments and evaluations evidence consistency in producing outcomes intended in the Agreement). 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 evidenced, this Monitor will and has reversed a compliance rating when the evidence supports doing so.

There was no change in compliance ratings for this assessment. As stated in the Fourth Compliance Assessment Report, 107 (89%) of the 120 substantive provisions (not including provisions in Section IX. Implementation) remain in noncompliance; one provision was reversed from partial to noncompliance due to new problems, as described in this report. The compliance ratings in this Fifth Compliance Assessment Report demonstrate virtually no substantive progress since the September 2013 Baseline assessment.

GGACF FIFTH COMPLIANCE ASSESSMENT SCORE CARD				
Areas of Compliance Per Agreement	Total Provisions	Non Compliance	Partial Compliance	Substantial Compliance
IV. Safety and Security	59	52	7	0
V. Medical, Mental Health Suicide Prevention	36	36	0	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	107	13	0
Percent Compliance	100%	89%	11%	0%
Primary Assessor:				
Mr. Kenneth Ray, Monitor	IV. Safety and Security			59
	VIII. Training			4
Mr. Manny Romero	VI. Fire and Life Safety			10
	VII. Environmental Health and Safety			11
Dr. Ronald Shansky	V. Medical			36
Dr. Roberta Stellan	V. Mental Health/Sucide Prevention			36

This Monitor intends to assign additional Provisions to Mr. Romero in an effort to further improve the quality and efficiency of the monitoring process, and to leverage Mr. Romero's expertise to add additional value to technical assistance and consultation provided to Territory officials per this Agreement.

Implementation (Section IX) provisions were not measured using these rating classifications but a narrative description of compliance is provided; the required evaluation standards may be applied in evaluating these provisions in future reports once the Monitor has more clarity about doing so from the Parties.

FIFTH ASSESSMENT FINDINGS OVERVIEW:

In early September, prior to the Fifth onsite visit, this Monitor and another monitoring team member, Mr. Manuel Romero, worked onsite with Territory officials to develop two, top priority policy and procedure drafts, Classification and Use of Force. Together, we worked for five days on these documents. BOC Director Wilson and other BOC and GGACF staff participated in all five days and provided information necessary to complete the policy drafts. Additionally, BOC staff worked tirelessly to quickly modify and print various versions of draft documents and forms in order to keep the process moving and on track. BOC participation and support of this process is very appreciated, and contributed to the production of two well-developed policy drafts.

To its credit, the Territory did provide to this Monitor and USDOJ numerous policy drafts prior to the onsite technical assistance visit described above. However, these documents were replete with various content, format, and other writing errors making the review and approval process by the monitoring team and USDOJ unnecessarily cumbersome and time-consuming. This Monitor provided Territory officials specific recommendations for improving draft documents and advised the Territory to only submit for review draft documents with content that appropriately focused on Provision requirements, and only documents mostly free of format and writing errors. Subsequently, the Territory virtually stopped submitting document drafts for review and failed to meet Schedule deadlines approved by this Monitor following the Territory's written request to do so. Ultimately, the Territory requested this Monitor to assist in writing all required policies and procedures, and upon agreement to do so, the Court ordered the Monitor to complete and submit all required policy and procedure drafts to the Territory no later than 12/31/14.

Concomitant to the Court ordering this Monitor to develop and submit policy and procedures drafts by 12/31/14, this Monitor, also per Court order, submitted a revised Schedule with new compliance deadlines to account for the 12/31/14 policy submission deadline. This Monitor complied with the Court order as directed in collaboration with USDOJ and the Territory. It is also important to note that both of these Court-directed tasks for the Monitor were agreed to by the parties in order for USDOJ to withdraw its contempt motion.

The revised schedule uses an abbreviated scheduling matrix setting deadlines that prioritize Settlement Agreement Provisions:

PRIORITY A: Most critical to safety, security, and health care.
PRIORITY B: Very important to safety, security, and health care.
PRIORITY C: Important to safety, security, and health care.

PRIORITY A

1. Staffing
   a. Staffing Analysis with realistic shift factors (IV.D.1a)
   b. Security staffing plan with implementation timetables (IV.D.1b)
2. Supervision of Prisoners
   a. Appropriate stratification of housing units (IV.A.1a)
   b. Post orders (IV.A.1.b)
   c. Rounds and supervision in general population housing units (IV.A.1.d)

   d. Rounds and supervision in special population housing units (to include A Dorm, RSAT, Lima, 9A, R/D) (IV.A.1.d)
   e. Rounds and supervision in all other areas of the facility (IV.A.1.d (ii))
3. Requirements for Locking and Unlocking Doors and Maintenance/Inspection of Locks (IV.C.1.c and IV.C.1.d)
4. Contraband
   a. Definitions (IV.B.1.a)
   b. Prevention (IV.B.1.b)
   c. Detection (IV.B.1.c)
      i. Supervision (IV.B.1.c (i))
      ii. Inmate searches upon return to housing unit (IV.B.1.c. (ii))
      iii. Regular and randomized searches of housing units and other common areas of facility (IV.B.1.c. (iii))
   d. Response (IV.B.1.d)
5. Use of Force and Use of Restraints (IV.H and IV.I)
6. Incident Reporting
   a. Procedures for reporting (IV.G.1.a)
   b. Procedures for supervisory review of incident reports (IV.G.1.b)
   c. Preservation of evidence (IV.G.1.c)
   d. Central tracking of incidents (IV.G.1.d)
   e. Reporting/reviews/corrective action (IV.G.2)
7. Discipline of Staff and Inmates
   a. Discipline of staff (IV.K.1.5)
   b. Discipline of inmates (IV.k.1.5)
8. Medical and Mental Health (V)
9. Fire drills and emergency evacuation exercises (VI.1.c and VI.1.g)
10. Adequate Supply of Drinking Water (VII.1.k) (including how and when water should be distributed in housing units)
11. Training (general) (VIII)
12. Auditing of Policies (this is necessary because the definition of "implementation" includes the need to track policy use through audit tools)

PRIORITY B

1. Staffing
   a. Staffing Analysis and Staffing Plan – Annual Review and Revision (IV.D.1.c)
   b. Staffing Analysis/plan implementation (IV.D.1.d)
   c. Pre-Employment Background Checks and Periodic Review (IV.C.1.e)
2. Radio Communications and Radio Control (IV.A.1.c)
3. Visitation and Escorts for Visitors (IV.B.1.e)
5. Inmate Identification (IV.C.1.b)
6. PREA (IV.E.1)
7. Classification (IV.F.1 and IV.A.1.a)
8. Prisoner complaints/Grievances
   a. Procedures for filing grievances (IV.J.1.a)
   b. Investigation of grievances and response (IV.J.1.b and IV.J.1.c)
   c. Tracking and management of records (IV.J.1.d)
   d. Review of grievance data to identify trends (IV.J.1.e)
9. Fire and life safety (VI – all provisions)

a. Creation of fire safety plan (VI.1.a)
b. Provision of adequate fire detection and suppression equipment (VI.1.f and VI.1.h)
c. Inspection of fire and life safety equipment (VI.1.b)
d. Security inspections of housing units and locking mechanisms (VI.1.d)
e. Training and evaluation of staff regarding fire and life safety procedures (VI.1.e)
f. Control of flammable materials (VI.1.j)
g. Medical treatment for persons injured as a result of fire (VI.1.i)

10. Environmental Health and Safety
    a. Sanitation
        i. General sanitation policies and procedures (VII.1.a)
        ii. Cleaning, handling, storing, and disposing of bio-hazardous materials (VII.1.f)
        iii. Chemical control (VII.1.h)
        iv. Use of cleaning materials (VII.1.e)
        v. Mattress care (VII.1.g)
    b. Ventilation (VII.1.b)
    c. Lighting (VII.1.c)
    d. Pest control (VII.1.d)
    e. Laundry (VII.1.i)

PRIORITY C

1. Uniforms
    a. Inmate Uniforms (IV.C.1.a)
    b. Staff Uniforms (IV.C.1.a)
2. Administrative Investigations
    a. Investigative procedures (IV.K.1.1)
    b. Writing of investigative reports (IV.K.1.2)
    c. Tracking and review of investigations (IV.K.1.3)
    d. Training of investigators (both pre-service and in-service) (IV.K.1.4)
3. Food Services (VII.1.j)

The schedule also differentiates completion deadlines following final approval of policies and procedures by the Territory. Training begins no later than the dates shown below and according to established priority levels for each Provision:

PRIORITY A: Not to exceed 60 days after final approval by the Territory
PRIORITY B: Not to exceed 90 days after final approval by the Territory
PRIORITY C: Not to exceed 120 days after final approval by the Territory

Additionally, training for all Provisions shall be completed no later than 60 days after the commencement of training, and the evaluation of Provision implementation shall begin no later than 150 days after training has been completed:

PRIORITY	Monitor Submits Drafts to Territory	Territory Submits Revised Drafts to Monitor/DOJ (30 Days)	Monitor/DOJ Returns Comments to Territory (45 Days)	Final Approval by Territory (14 Days)	Training Begins (60,90,120 Days)	Training Completed (60 Days)	Evaluation of Implementation Begins (150 Days)
A	**12/31/2014**	**1/30/2015**	**3/16/2015**	**3/30/2015**	**5/29/2015**	**7/28/2015**	**12/25/2015**
B	**12/31/2014**	**1/30/2015**	**3/16/2015**	**3/30/2015**	**6/28/2015**	**8/27/2015**	**1/24/2016**
C	**12/31/2014**	**1/30/2015**	**3/16/2015**	**3/30/2015**	**7/28/2015**	**9/26/2015**	**2/23/2016**

Despite this assessment finding no measurable progress to support advancing any of the compliance ratings, participation by Territory and GGACF remained active throughout the assessment process. And, although two U.S. Marshals provided onsite security to expedite our movement during campus tours, the Warden and/or the Security Chief maintained a consistent presence while touring.

During the Fourth Assessment exit meeting, this Monitor gained consensus from the parties to modify the onsite assessment process to include more time to discuss the Territory's specific progress toward compliance. This Monitor believes that this modification was extremely helpful for two specific reasons: 1) All GGACF compliance teams were able to discuss their compliance efforts, clarify barriers to progress, and identify potential options for removing those barriers, and; 2) we reviewed each substantive Provision and clarified GGACF staff understanding about how each Provision was assessed and rated, and what specific improvements were necessary to meet compliance requirements. The GGACF staff were exceptionally cooperative and informative during all of these meetings, and it is hoped that this change in the assessment process improves clarification of compliance expectations, responsiveness to the Monitor's request for information, and garners better communication between the Territory, USDOJ, and the Monitor.

The fundamental goal of this onsite assessment was to determine what, if any measurable progress was accomplished following the Fourth assessment. Although progress was reported and described by GGACF officials, no measurable improvement following the Fourth assessment was found by the monitoring team.

For example, the Warden stated that all items used by inmates to block cell door windows had been removed; however, this Monitor again found cell door windows blocked with paper, cardboard, or towels. This Monitor was also told that Supervisory staff had been directed in writing by the Warden to commence conducting rounds of all housing units to ensure staff were compliance with policies and procedures, and to ensure that staff had all equipment needed to operate their shift. However, this Monitor found inoperable flashlights, a housing unit with no suicide cut-down tool, and mixtures of obsolete and new post order and policy and procedure documents at most housing unit officer stations.

Regarding staffing, the Warden presented for review a revised shift schedule intended to improve post coverage and on-duty security staffing levels. This effort would seem promising but would has not adequately reduced penetration of dangerous contraband or the high levels of inmate-on-inmate or inmate-on-staff violence as demonstrated by the Incident Log and reported incidents prior to and following this assessment (as described in Provision assessment findings).

Additionally, inmates continue to set fires inside housing units due, in part, to inadequate staffing levels and GGACF's inability to eliminate methods use by inmates to ignite fires. This is extremely troubling due to the fact that the GGACF automatic fire detection and suppression system remains inoperable. GGACF officials discussed plans to repair and reactivate the automatic fire protection system within the next six months. No fire drills have been conducted since June of 2014.

The incident and use of force reporting process remains inconsistent and incomplete making it virtually impossible for GGACF officials to effectively assess and correct operational conditions and needs, or for this Monitor to consistently and accurately assess problems and progress. The Incident Log continues to omit reported incidents while use-of-force incidents appear to go either unreported and/or do not undergo administrative review as required under this agreement, or those documents are not being provided to this Monitor as requested.

Inmates continue to wear "street clothing", and cloak their identification cards under their shirts while outside their housing units.

Regarding sanitation, GGACF officials discussed plans to completely renovate the kitchen and replace some of the cooking equipment, however, no timelines for this work were available at the time of this assessment. Housing unit mold remains prolific, inmates continue to complain about not having ready access to drinkable water, and housing unit ventilation remains poor. The Territory is to be commended for maintaining improved sanitation, as found during the third and fourth assessments. Housing units and inmate cells did seem even cleaner than found during the previous visit. However, a few cells were still filthy.

Structural security remains very problematic. Several security doors are inoperable due to nonfunctioning electric motors and/or inoperable door locking devices. On one occasion, an inmate remained locked in his cell for several hours because his cell-door lock malfunctioned and would not release the door. Such occurrences can be deadly considering instances of inmate-caused fires occurring in housing units.

The inmate disciplinary system remains inconsistent and flawed based review of reports provided by GGACF officials. However, the monthly Disciplinary Committee Report has not provided for review to fully assess documented progress, if any. The inmate complaint system also remains incomplete, inconsistently managed, and seeming erroneous in several ways. First, this process is not properly managed, which causes the grievance tracking log to be replete with errors and inconsistencies. Second, and equally troublesome, is the tracking log continues to consistently omit much of the information needed to determine what, if any, action was taken to resolve prisoner complaints.

The Territory has made some effort to provide staffing training in the areas of security locking, mental health, and suicide prevention. A review of the lock training found the curriculum was adequate but failed to include a pretest to assess learning. Additionally, not all required staff completed the training and the Territory has yet to verify if or when all staff would complete this training. The mental health and suicide prevention training was provided by two qualified instructors. However, the training materials provided was not based on policy and some of the information provided in the training appear outdated or incorrect; this training lacked many of the essential elements needed for use with correctional populations. Again, this training was

provided before the curriculum was approved by this Monitor or USDOJ, which is inconsistent with the terms of the Agreement.

Finally, inmate health care services remain troubling (as described in this report). It was also very troubling to again learn that from the Medical Director he has still not been paid for his services, there remains no contract with for pharmacy services, and no additional qualified mental health staff have been employed. This must be permanently corrected.

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: The Monitor assisted Territory officials in developing a very basic stratification matrix for GGACF. This matrix will not be shown in this report due to security and inmate confidentiality reasons. Territory officials submitted a revised stratification matrix to the Monitor following the transfer of 78 inmates off-island and closing four (4) housing units. Completion of the stratification matrix should include total beds and cell-types in each of the housing units, i.e. single/double bunk, etc.

Incident Report and Contraband Logs, incident reports, and classification documents again evidence that stratification for classification housing remains inadequate and inconsistent. As detailed in other sections of this report, the lack of appropriate screening instruments, housing stratification schemes, and policies and procedures regarding classification continues to place inmates at risk of harm. Monitor is providing technical assistance to defendants in developing policies and procedures which are expected to be completed by December 31, 2014.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Complete Stratification Matrix as discussed above to include 1) total capacity (beds) for each population stratified.
2. Include all housing buildings and units in the plan. Specifically, breakdown the data showing locations of all locations, total capacity of each, numbers of cells and beds, classification for each building and unit..
3. Show all bed-capacities for each custody level per housing building and unit.
4. Define custody levels more clearly and completely for all inmate classifications in each custody level.

5. Include intake unit - inmates are held and housed in that location.
6. Specific female unit uses – convicted (where), detention (where).
7. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
8. Refer to IV.F. regarding specific classification and housing policy recommendations.

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: The GGACF Warden issued a written directive shortly prior to this assessment requiring all supervisory staff to visit and inspect housing units routinely on a daily basis. The Warden developed and implemented a daily inspection compliance form for supervisors to complete for accountability purposes. However, assessment of this new process was not possible during this visit due to its recent implementation. This process will be assessed for consistency, completeness, and compliance during the 6th onsite visit. Nonetheless, GGACF remains dangerously understaffed, with an inadequate number of both correctional officers and supervisors.

The foundation of efficacious correctional safety and security, with regard to staffing and supervision, involves planned integration of the following elements:

1. Sufficient numbers of correctional officers and supervisors;
2. Correctional officers and supervisors are adequately trained and retrained to carry their duties assignments proficiently;
3. Correctional officers and supervisors continuously and consistently adhere to and apply sound correctional policies and procedures;
4. Officers and supervisors are held accountable for their performance and adherence to policies, procedures, and practices continuously and consistently;
5. Officers and supervisors who comply with agency performance requirements are rewarded; re-training and/or corrective action consistently occurs for performance deficiencies.

GGACF remains unable to meet any of these five elements, primarily due to staffing shortages. Corrections officer and supervisor staffing levels remain insufficient, pre-service and in-service training remains inadequate, continuous and consistent performance compliance monitoring is impossible due to insufficient staffing levels and inadequate training. Singularly or combined, GGACF's inability to meet these foundational elements creates and maintains a very unsafe and unhealthy work environment for all staff, inmates, visitors, and the community at large. The following comparative analysis clearly demonstrates GGACF staffing-level deficiencies:

An analysis of housing unit officer and supervisor staffing levels was performed similar to the analysis completed for the previous (4th) report. As before, officer and supervisor staffing data were collected from the Supervisor Log and analyzed to determine and compare the following staffing conditions:

1. Number of shifts that all 14 occupied housing units **WERE NOT** staffed by officers;

2. Percent of all 14 occupied housing units that **WERE** staffed by officers during the shift;
3. Number of shifts that each occupied housing unit **WAS NOT** staffed by officers;
4. Percent of shifts that each occupied housing unit **WAS** staffing by officers;
5. Number of supervisory staff per shift;
6. Percent of supervisor staff on-duty per shift.

An equivalent number of security and supervisory work-shifts were examined and compared for the following two periods:

4th Assessment: 30 Shifts – May 20 thru June 5, 2014
5th Assessment: 29 Shifts – August 22 thru September 22, 2014

Number of shifts that all 14 occupied housing units WERE NOT staffed by officers:

During August 22 thru September 22, occupied housing units were not staffed on 46 shifts compared to 55 shifts during May 20 thru June 5, 2014. This is a very slight, but insignificant improvement considering the fact that inmates in an entire housing unit are not supervised and monitored when the housing unit is not staffed during a shift. Unstaffed housing units expose inmates to constant potential and real risk of harm from other inmates, prevents inmates from getting immediate necessary medical attention, increases opportunities for inmates to share and collect dangerous contraband, increases escape opportunities, and prevents timely detection and suppression of fires – just to name a few of the constant potential and real risks to safety and security.

The two charts below provide a visual comparison of these shifts and the housing units that were occupied by inmates, but unstaffed, during the two periods compared (red indicates housing units not staff for each shift shown):

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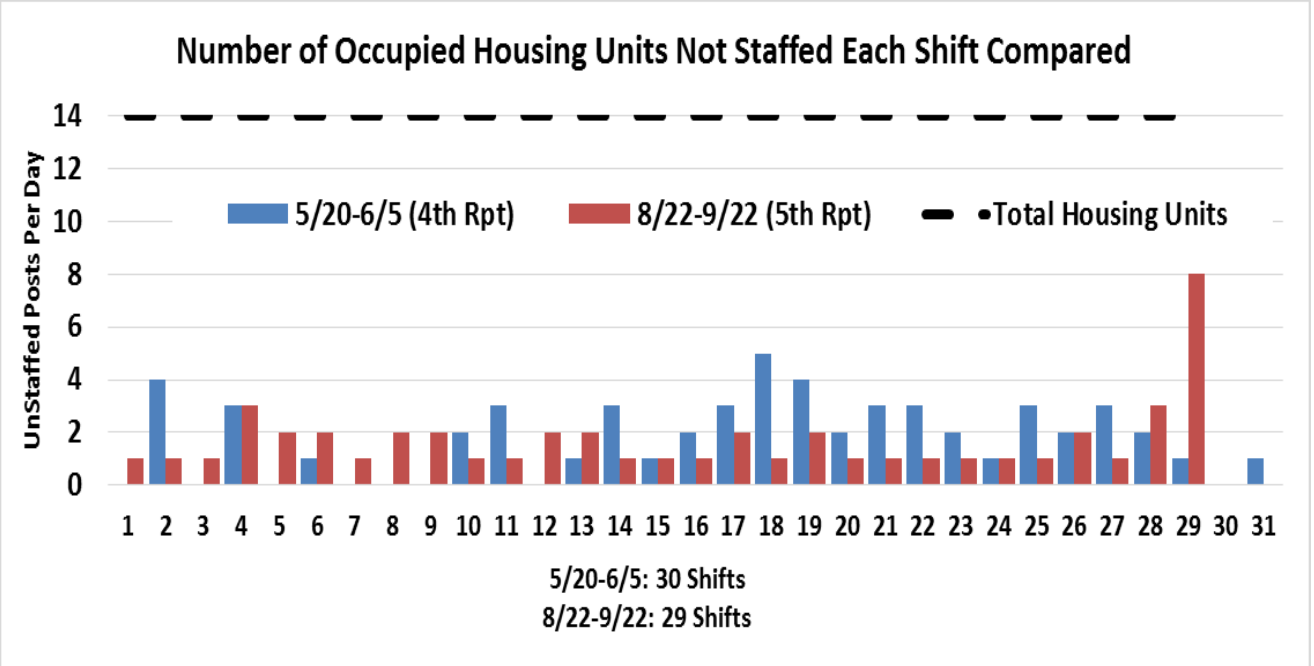
August 22 thru September 22, 2014 (5th Assessment)

DATE (2014)	8/22	8/23	8/24	8/24	8/25	8/25	8/26	8/27	8/28	8/29	8/29	8/31	8/31	9/1	9/1	9/2	9/3	9/6	9/7	9/7	9/9	9/11	9/11	9/17	9/18	9/20	9/21	9/21	9/22	
SHIFT	4p/12a	4p/12a	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	8a/4p	8a/4p	8a/4p	4p/12a	8a/4p	8a/4p	4p/12a	8a/4p	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	Not Staffed
A DORM	1	1	1	0	0.5	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	2.5
RSAT	1	0.5	0.5	0	0.5	0.5	1	0.5	0	0.5	0.5	0	0	0.5	0.5	1	0.5	1	0	1	1	1	1	0.5	1	0.5	0.5	0	1	12
Intake	0	0.5	0.5	0	1	0.5	1	0.5	0	0.5	0.5	0	0	0.5	0.5	0	0.5	0	0	0	0	0	0	0.5	0	0.5	0.5	0	0	19
X	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	2
G	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2
H	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	0
I	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	0.5	0	1.5
J	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	0.5	0	2.5
K	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	0	1
L	1	2	1	1	1	1	2	2	1	2	1	1	2	1	1	2	2	2	1	1	2	1	2	2	2	2	2	1	0	1
9A	1	2	2	2	2	1	2	2	2	2	2	1	2	2	2	1	2	2	2	2	2	1	2	1	2	1	1	1	0	1
9B	1	1	1	2	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	0	2
9C	2	1	1	2	1	1	1	1	2	1	1	1	1	2	1	2	1	1	1	2	2	1	2	1	2	1	1	1	1	0
9D	2	2	1	2	1	1	1	1	2	1	2	1	2	1	2	1	1	1	1	2	1	1	1	2	1	1	1	1	1	0
Total Staffing	15	16	14	15	13	12	14	14	15	15	15	12	15	15	15	15	16	15	13	17	16	13	18	15	16	13	14	11	7	
Not Staffed	1	1	1	3	2	2	1	2	2	1	1	2	2	1	1	1	2	1	2	1	1	1	1	1	1	2	1	3	8	
Total Posts	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	
Posts Staffed	93%	93%	93%	79%	86%	86%	93%	86%	86%	93%	93%	86%	86%	93%	93%	93%	86%	93%	86%	93%	93%	93%	93%	93%	93%	86%	93%	79%	43%	

May 20 thru June 5, 2014 (4th Assessment)

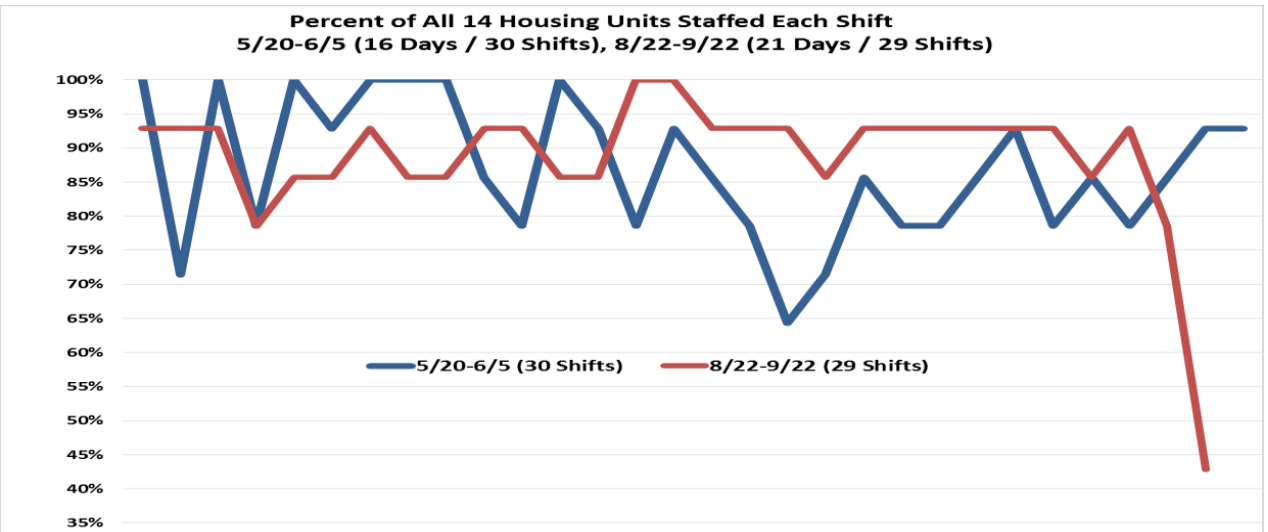
DATE (2014)	5/20	5/21	5/21	5/22	5/22	5/23	5/25	5/26	5/26	5/27	5/27	5/27	5/28	5/28	5/29	5/30	5/30	5/31	5/31	6/1	6/1	6/2	6/2	6/2	6/3	6/3	6/3	6/4	6/4	6/5	
SHIFT	4p/12a	12a/8a	4p/12a	12a/8a	4p/12a	4p/12a	4p/12a	12a/8a	4p/12a	12a/8a	8a/4p	4p/12a	8a/4p	4p/12a	12a/8a	8a/4p	4p/12a	12a/8a	8a/4p	8a/4p	4p/12a	12a/8a	8a/4p	4p/12a	12a/8a	8a/4p	4p/12a	12a/8a	4p/12a	12a/8a	Not Staffed
A DORM	1	0	1	0	1	1	1	1	1	1	0	1	1	0	1	1	1	1	0	1	1	1	1	0	1	1	0	1	1	1	7
RSAT	1	0	1	1	1	1	1	1	1	1	0	1	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	1	0	15
Intake	1	0	2	0	1	0	1	1	1	0	1	1	0	0	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1	18
X or X-Ray	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1
G	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0
H	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1
I	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0
J	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1
K	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	2
L	1	0	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	2	0	1	1	1	1	1	1	2	1	3
9A	2	1	2	1	3	1	2	1	2	1	1	2	2	2	1	1	0	0	1	1	0	1	2	2	2	2	1	1	1	1	3
9B	1	1	1	1	2	1	1	1	1	0	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	3
9C	1	1	1	1	2	1	1	1	1	1	1	2	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	0
9D	1	1	1	1	2	2	1	1	2	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	2
Total Staffing	15	10	16	11	20	14	15	14	18	12	11	16	14	12	13	12	11	10	10	12	12	11	13	14	12	13	11	12	14	13	
Post Not Staffed	0	4	0	3	0	1	0	0	0	2	3	0	1	3	1	2	3	5	4	2	3	3	2	1	3	2	3	2	1	1	
Total Posts	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	
Percent Posts Staffed	100%	71%	100%	79%	100%	93%	100%	100%	100%	86%	79%	100%	93%	79%	93%	86%	79%	64%	71%	86%	79%	79%	86%	93%	79%	86%	79%	86%	93%	93%	

The chart below shows the number of occupied housing units that were not staffed during each shift for the periods examined.



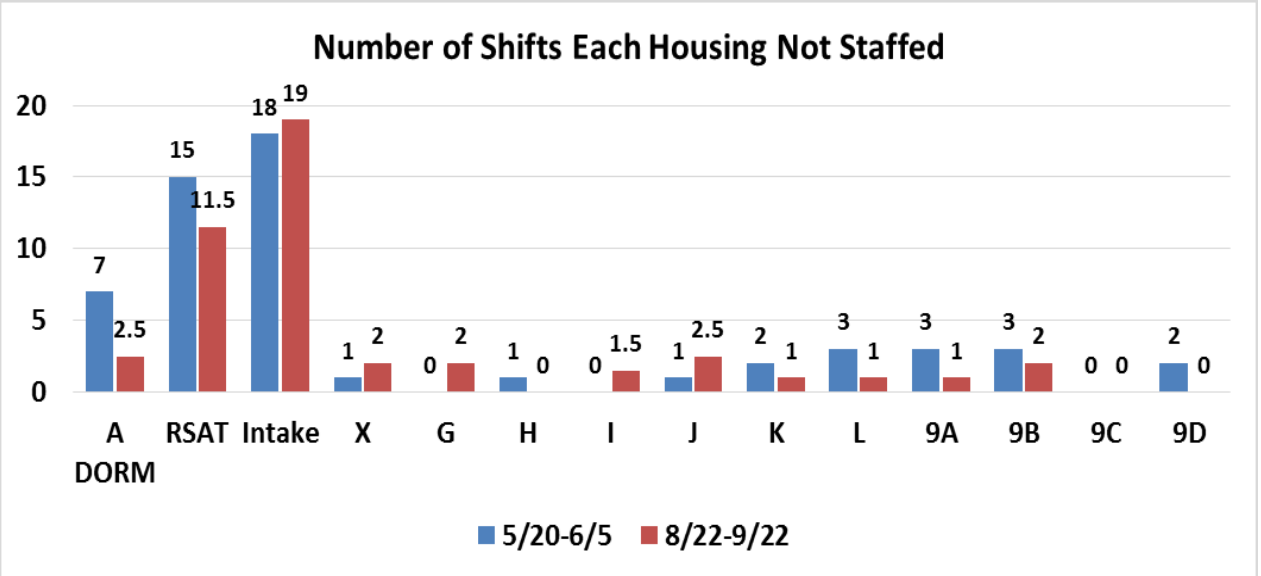
Percent of all 14 occupied housing units that **WERE** staffed by officers during the shift;

As shown in the graph below, at least one housing unit went unstaffed for almost all shifts in both of the time periods examined. In fact, the data indicate all housing units were staffed for only two shifts during the 8/22 period. For the last reporting period, in the time period examined all housing units were staffed only 7 times. It is reasonable to conclude that inmates went unsupervised and monitored for a majority of shifts for both periods examined and more often during the 8/22 period.



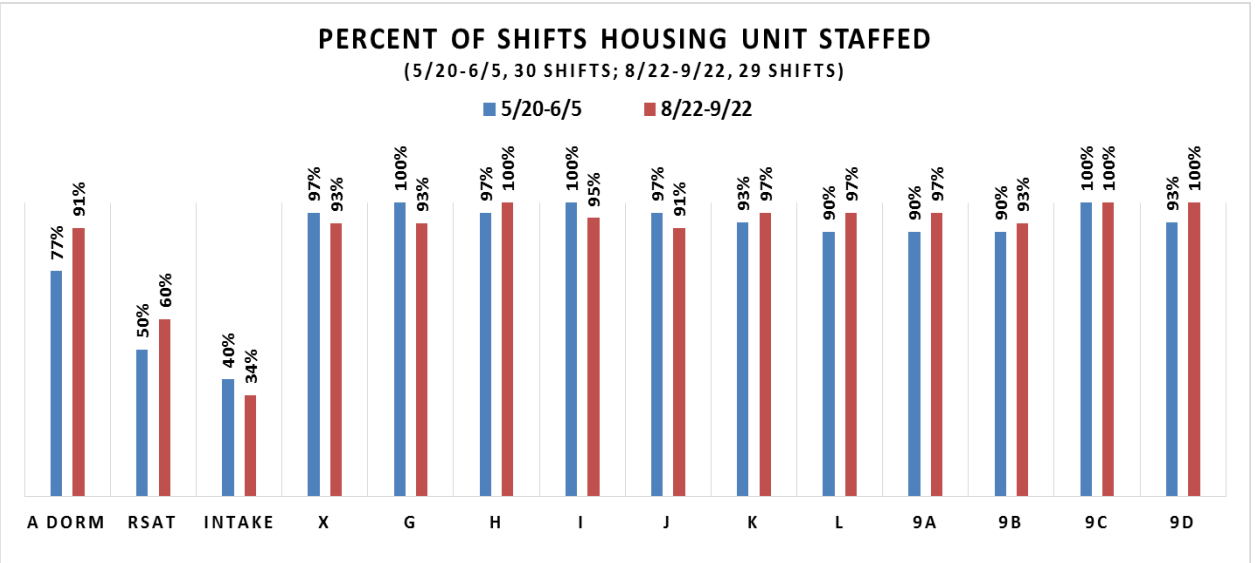
Number shifts that each occupied housing unit WAS NOT staffed by officers:

Staffing levels were examined and compared for each of the 14 housing units. This analysis further demonstrates the number of times (shifts) inmates went without officer supervision and monitoring for the periods examined. The graph below shows these comparisons.



Percent of shifts that each occupied housing unit WAS staffed by officers:

The Supervisor Log reported that only three of the 14 housing units (H, 9C, 9D) were consistently staffed on all shifts examined for the 8/22 period. This is a significant increase in housing units that were not staff compared to the previous (5/20) period where



Number of supervisory staff per shift:

Shifts examined and compared continue to demonstrate lack of adequate officer supervision as required under this Provision. Inadequate supervision during any period of correctional operations enables serious risk of harm to people and can promote unprofessional and potentially unconstitutional staff behavior. But for the vast majority of staff, who strive to perform as professionals, inadequate supervision and supervisory support is frustrating and increases officer stress levels when they are making every effort to professionally monitor and manage prisons. Adequate levels of shift supervision helps to consistently and routinely ensure officers 1) comply with agency rules and regulations, 2) perform proficiently, and 3) are provided timely feedback to correct and/or praise performance.

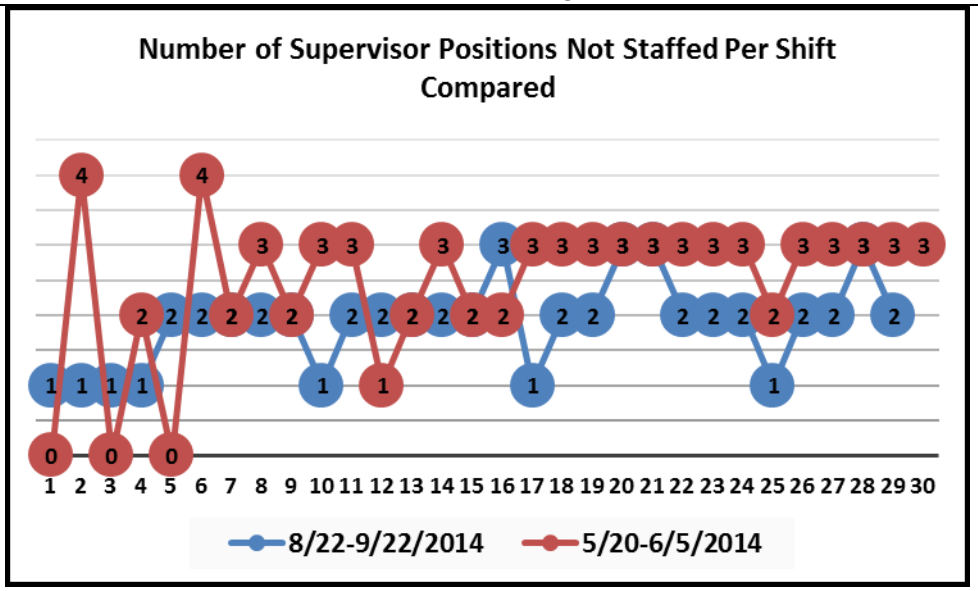
There are four (4) supervisor positions (posts) for each shift, according to GGACF officials; these staffing levels appear to be adequate if shifts are consistently staffed at these levels.

1- Tour Commander (TC)
3- Assistant Tour Commanders (ATC)

According to Supervisor Log entries for the periods examined (8/22-9/22; 5/20-6/5), none of the 29 shifts examined during the 8/22 period were fully staffed by supervisors. In fact, according to these logs, and as shown in the table below, only seven shifts were staffed with three (3) supervisors; 18 with only two (2) supervisors; and, two (2) shifts operated with only one (1) supervisor. In sum, none of the shifts were fully staffed with four (4) supervisors, and most operated with only two supervisors.

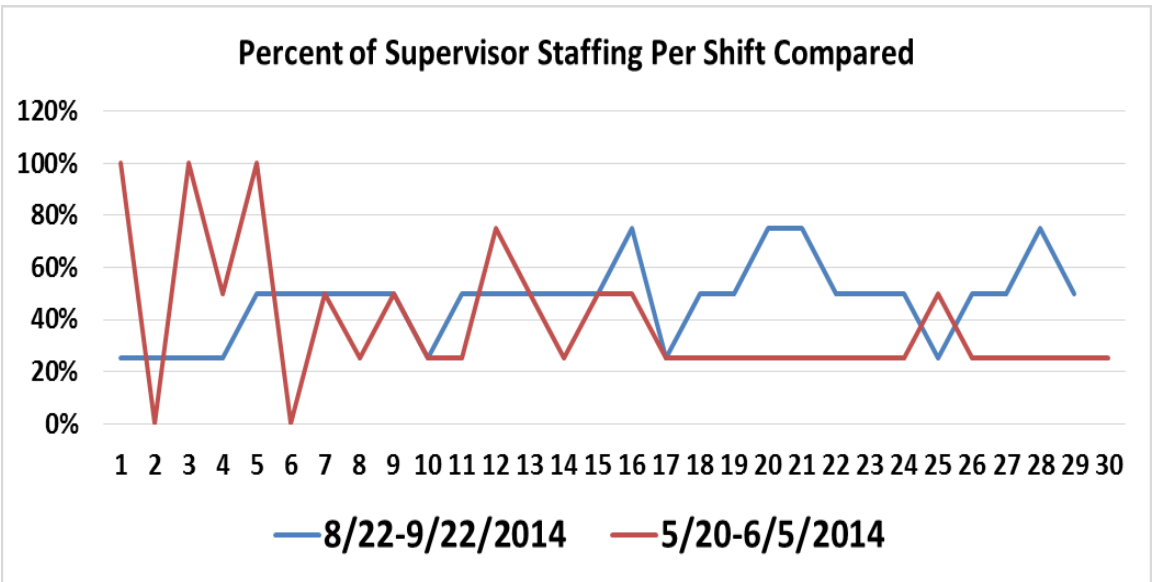
The 8/22-9/22 period demonstrates virtually no improvement in supervisor staffing compared to the 5/20-6/5 period. As shown in the chart below, two (2) of the shifts for the 5/20-6/5 period (red) were not staffed with any supervisors (red/4). By comparison however, this shift period was staffed more frequently with three (3) supervisors per shift than was the 8/22-9/22 (blue) period. The 8/22-9/22 period was more often staffed with only two (2) supervisors, and these shifts were always staffed with at least one supervisor.

All shifts must be fully staff consistently without deviation to help ensure maximum safety and security of the facility as well as staff and inmate oversight. Additionally, it will be impossible for the Territory to comply with this Agreement at these supervisor staffing levels. There were only three (3) shifts (5/20, 21, 22) out of all 59 shifts examined that operated with a full complement of supervisors.



Percent of supervisory staffing per shift:

Finally, we examined percent of shifts having full complement of supervisors. As stated above, there were only three (3) of combined 59 shifts examined that operated at 100% or better. The chart below demonstrates none of the 8/22-9/22 shifts were fully staffed.



The following charts visually demonstrate supervisory staffing deficiencies for all shifts during the two periods compared.

8/22-9/22 Shift Period (29 Shifts):

DATE (2014)	8/22	8/23	8/24	8/24	8/25	8/25	8/26	8/27	8/28	8/29	8/29	8/31	8/31	9/1	9/1	9/2	9/3	9/6	9/7	9/7	9/9	9/11	9/11	9/17	9/18	9/20	9/21	9/21	9/22		
SHIFT	4p/12a	4p/12a	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	8a/4p	8a/4p	8a/4p	4p/12a	8a/4p	8a/4p	4p/12a	8a/4p	8a/4p	4p/12a	8a/4p	4p/12a	8a/4p	Not staffed	% staffed
T/C (Tour Command)	1	1	1	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	3	90%
Asst. T/C	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	0	0	1	1	1	1	1	1	1	1	3	90%
Asst. T/C	1	1	1	1	0	0	0	0	0	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	21	28%
Asst. T/C	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	29	0%
Total Staffing	3	3	3	3	2	2	2	2	2	3	2	1	2	2	2	1	3	2	2	1	1	2	2	2	3	2	2	1	2	2.1	
Post Not Staffed	1	1	1	1	2	2	2	2	2	1	2	2	2	2	2	3	1	2	2	3	3	2	2	2	1	2	2	3	2	1.9	
Total Posts	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
Percent Posts Staffed	25%	25%	25%	25%	50%	50%	50%	50%	50%	25%	50%	50%	50%	50%	50%	75%	25%	50%	50%	75%	75%	50%	50%	50%	25%	50%	50%	75%	50%	47%	

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5/20-6/5 Shifts Period (30 Shifts):

DATE (2014)	5/20	5/21	5/21	5/22	5/25	5/25	5/25	5/26	5/26	5/27	5/27	5/27	5/28	5/28	5/29	5/30	5/30	5/31	5/31	6/1	6/1	6/2	6/2	6/2	6/3	6/3	6/3	6/4	6/4	6/5		
SHIFT	4p/12a	12a/8a	4p/12a	12a/8a	4p/12a	4p/12a	4p/12a	12a/8a	4p/12a	12a/8a	8a/4p	4p/12a	8a/4p	4p/12a	12a/8a	8a/4p	4p/12a	12a/8a	8a/4p	8a/4p	4p/12a	12a/8a	8a/4p	4p/12a	12a/8a	8a/4p	4p/12a	12a/8a	4p/12a	12a/8a	Not staffed	% staffed
T/C (Tour Command)	1	0	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2	93%
Asst. T/C	1	0	1	1	1	0	1	0	1	0	0	1	1	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0	19	37%
Asst. T/C	1	0	1	0	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	26	13%
Asst. T/C	1	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	27	10%
Total Staffing	4	0	4	2	6	0	2	1	2	1	1	3	2	1	2	2	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1.6	
Post Not Staffed	0	4	0	2	4	4	2	3	2	3	3	1	2	3	2	2	3	3	3	3	3	3	3	3	2	3	3	3	3	3	2.6	
Total Posts	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
Percent Posts Staffed	100%	0%	100%	50%	0%	0%	50%	25%	50%	25%	25%	75%	50%	25%	50%	50%	25%	25%	25%	25%	25%	25%	25%	25%	50%	25%	25%	25%	25%	25%	35%	

It is very important to point out that these data and analyses are based on Supervisor Log information. These logs are typically incomplete and inconsistent. It is possible that some of the shift housing units and/or supervisory staffing levels were higher than reported, but it is impossible to know for sure considering the variation used by supervisors to document shift staffing activity. It is, therefore, vital that GGACF officials standardize these documentation procedures.

Finally, it is equally important to commend Territory officials for very recent action to increase staffing levels in occupied housing units. Five officers started at GGACF this summer after completing the Academy. The Territory reported that it is trying to recruit another class. As of the last day of the visit, 6 candidates had been vetted.

The Territory recently transferred 78 inmates to mainland facilities. This action emptied four (4) housing units and reassigned those officers to remaining housing units. This is a step in the right direction for improving safety and security of the facility. The efficacy of these efforts will be evaluated during the 6th onsite assessment in December 2014.

Although those efforts are to be commended, they are not sufficient to correct the severe staffing shortage at Golden Grove. It is unclear when the next training academy will start. The Territory has not provided any additional information on its plans to start new recruits at GGACF before sending them to the full peace officer academy. Even if six new recruits start before the end of 2014, that is still insufficient to ensure adequate coverage. The Territory needs to meaningfully commit its resources to building up staffing levels. Until that occurs, the Territory will remain noncompliant with many of these provisions. The Territory has provided no additional information regarding plans to add additional correctional staff since the onsite status conference with the Court.

National Institute of Corrections Staffing Analysis

The staffing analysis required by this Agreement was completed by the National Institute of Corrections on July 14, 2014 and provided to Territory officials. This comprehensive analysis assessed several factors with regard to providing and maintaining sufficient security-staffing levels. Based on that analysis, the Report issued the following "*Urgent Recommendations*":

1. Occupancy should be reduced as much as possible in order to reduce staffing needs at the facility. This will reduce the gap between staffing needs and the actual number of staff deployed. This will probably require boarding offenders in another jurisdiction. Closing the three large sentenced buildings would reduce security staffing needs by 27%. While this is not enough to eliminate the staffing gap, it is a good start.

2. Occupancy of GGACF should not be increased until relieved security staff deployment has increased consistently for a period of at least two months. The number of prisoners who are brought back should correlate to the increase in the number of deployed security staff.

3. Technical assistance should be requested to review current detainee classification, separation, and programming practices. Detainees should be allowed to participate in

programs and to work inside the perimeter of the facility, consistent with classification findings.

4. Overtime must be reduced from current levels by approximately half. No more than 25% of the employees working on any shift should be working overtime hours. New policies must be developed to set limits on the total number of hours an employee may work consecutively, the total overtime hours allowed per employee within a pay period, and the time away from the facility before returning to work after an overtime shift.

5. Employees should be paid at the rates established in the compensation plan. Annual increases should be routinely awarded, consistent with employment contracts. Failing to pay employees at the rates that were promised when they were hired undermines morale, force employees to work overtime, and increases staff turnover.

The Territory has reduced its inmate (convicted) population by transferring 78 inmates off-island and subsequently closed five housing units. Territory officials reported that the officers assigned to the closed housing units were redeployed to increase staffing levels at housing units that remain open. Although this is a good start to improving facility security, on-duty supervisor and officer staffing levels from dangerously inadequate. Overtime remains extraordinarily high, most shifts operated with insufficient supervisor staff, and inmate-occupied housing units continue to operate with insufficient security staff or without any security staff for entire shifts.

The Territory has provided no additional information regarding is plan to fully implement the NIC staffing plan as required under this Agreement and need to improve staffing levels remains extremely urgent.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Rapidly implement the NIC Staffing Analysis recommendations.
2. Create a staffing plan, as required under the Agreement, that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff
3. Continue immediate steps to either reduce the inmate population commensurate with existing staffing levels or increase staffing levels commensurate with current inmate population volume. Using the staffing analysis, determine net additional staffing levels needed once inmate population is reduced.
4. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff who work overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.
5. Improve consistency, accuracy, and reliability of supervisor logs entries.
6. Contact the VI Guard to provide temporary internal and perimeter security presence until staffing levels are adequate.
7. Use off-duty VIPD officers to cover unstaffed housing units.
8. Hire PRN nurses with trauma care experience until approved FTEs are onsite.
9. Reassign correctional leadership/supervisory/specialty staff across all shifts to ensure post coverage and consistent inmate monitoring and supervision.
10. Use enabling statues that allow for immediate procurement of security hardware and systems services.

11. Request emergency funding from the Governor and/or legislator for rapid hiring of additional officers pursuant to the Staffing Study; remove ALL administrative and bureaucratic barriers that have and can impair rapid hiring of qualified candidates.
12. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.
13. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.
14. 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.
15. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues to be known and resolved in a timely manner.
16. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Functioning radios were observed in all housing units, and only one officer was observed not wearing their radio because it was charging in the officer booth. Each officer should wear their radio at all times while on-duty, especially when assigned to a housing unit. Additional radios or batteries should be assigned to each housing unit to enable this recommended practice.
It was very impressive to find the new phone system installed and operational throughout the housing units. Although some of the officers remain uncertain about how to fully operate the new phones, all seemed very pleased to have a reliable phone system. Post orders should be created and training should occur to ensure all officers are aware of how to use the phones.

RECOMMENDATIONS:

1. Timely repair, replace nonfunctioning radio and telephone communications equipment throughout the facility, and add additional communications equipment where indicated.
2. The Monitor will continue to review radio equipment inventories and functionality during each onsite assessment.
3. Ensure adequate supply of radio batteries enable officers to carry radios on their person at all times. Issue directives requiring officers to carry radios on their person at all times while at the facility and anytime they are supervising/monitoring inmates.

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: GGACF remains noncompliant with elements of this Provision due to inadequate correction officer and supervisor staffing levels. One of the reasons why these provisions remain in noncompliance is the Territory's seemingly torpid response to chronic understaffing discussed throughout this report and throughout previous reports. Until such time that all occupied housing units and shift supervisor posts are consistently and appropriately staffed 24/7, the facility, inmates, staff, and the public remain at risk of real and present harm.

Examination of GGACF records and personal observations during this assessment also demonstrate continued noncompliance with this Provision. Adequate rounds in accordance with this provision could prevent or reduce the following problems, all of which have been identified in earlier reports and remain uncorrected:

1) Continued presence of dangerous contraband
2) Continued covering of cell-door windows with various items,
3) Drying of clothing on lines tied to sprinkler heads and other anchors in their cells,
4) Fires being started by inmates in their housing units
5) Continued failure by inmates to wear official ID cards, or covering the ID cards with clothing,
6) Inmates wearing non-issued inmate apparel,
7) Supervisors not adequately inspecting housing unit logs and taking steps to remedy problems identified therein.

Supervision of inmates and staff remains inconsistent and inadequate; security inspections of housing units and the campus by correctional officers and supervisory staff lack routine and consistency. Noncompliance with Provision ensures ongoing risk of harm to staff and inmates as demonstrated, for example, by ongoing contraband control problems, inmate's continuing to block cell-door windows preventing safe visual inspection of cells, and inmates manipulated cell-door locking devices.

Additionally, there is no schedule for conducting regular rounds by medical and mental health care staff during each shift to ensure that special needs inmates (suicidal, mentally ill, medical infirm, vulnerable, etc.) are monitored more frequently and by qualified health care staff. This population MUST be regularly monitored to ensure their health needs are consistently assessed and monitored, to detected signs and symptoms of psychological and medical decompensation, to ensure basic needs are being met, to monitor medication compliance; efficacy; and need, and to making timely decisions to ensure all health and safety requirements are compliant. This is not happening and the Territory has demonstrated no substantive actions or plans to correct this basic constitutional requirement for this population.

RECOMMENDATIONS: Some 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, medical 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: PARTIAL COMPLIANCE

FINDINGS: Territory officials and monitoring team members recently developed very good Contraband policies and procedures that include all elements of the Contraband Provisions. Those documents are now in final review and approval process. Upon approval, these policies and procedures will be set for staff training, implementation and evaluation according to the newly adopted Schedule. However, inadequate correctional officer and supervisor staffing levels will continue to disable the Territories best efforts to comply with Contraband Provisions until those staffing deficiencies are permanently corrected. Until such time, contraband prevention and control will remain at very limited levels as demonstrated by Incident Log entries, incident reports, and continued assaults on officers and inmates.

RECOMMENDATIONS:

1. Issue a post order or memo that clearly defines what constitutes contraband and require supervisors to daily ensure compliance by staff.
2. Finalize and implement approved Contraband policies and procedures.
3. Provide Monitor accurate, complete, and current Evidence Collection Logs on a monthly basis.

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 above Assessment and Findings.

RECOMMENDATIONS:

1. Continue positive efforts in searching people before entering the facility.
2. A "stop and check" protocol for inspecting staff packages after initial entry into the facility must be developed and implemented.
3. Provide handheld metal detectors for contraband inspections at facility entry points and as needed for on-campus inspection.
4. Be prepared to thoroughly discuss current vehicle, mail, and package inspection methods and process during the 5th assessment.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to 1B above.

An examination of the Incident Log, June 20 thru September 14, 2014 found numerous incidents involving contraband of various types, including sharp objects used by inmates to assault and seriously harm other inmates, create fires in housing units, cause self-inflicted harm, etc.

Approximately 51 incidents were reported on the Incident Log from June 20 thru September 14. Log entries included 13 assaults, 1 cell phone confiscation, 12 "possession of contraband" incidents (type of contraband not identified), 3 fires, 2 drug confiscations, 6 fights, 2 inmate-on-inmate stabbings, and 1 inmate who caused "self-harm". Most of the events logged involved some kind of contraband.

Inadequate corrections officer and supervisory staffing levels impair compliance with all Contraband Provisions. In addition, GGACF officials reported that contraband control practices were further limited by temporarily changing GIST schedules, which will not be discussed further for security reasons. To compensate, the Warden has issued directives that housing unit

officers and supervisors increase rounds and inspections in housing units and cells. Again, however, inadequate staffing levels will significantly impair staff compliance with this directive. The efficacy of these directives will be assessed during the 6th monitoring visit in December 2014.

As stated in previous reports, this Monitor intentionally looked for but did not observe any inmate searches while touring the yard, housing units, or other areas observed. The failure to conduct inmate searches was discussed in each of the previous reports. Inmate searches must become a routine practice to help control contraband and dampen inmate motivation for smuggling.

RECOMMENDATIONS:

1. Refer to above, expand application of recommendations to provision c (i-iii) above.
2. See recommendations regarding staffing levels.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Refer to above findings.

Examination of Supervisor and Incident logs, incident report, and discussions with GGACF managers and line staff confirm ongoing efforts to confiscate and preserve and destroy evidence. An examination of the Evidence Collection Log further evidences these positive practices.

RECOMMENDATIONS:

Review and implement relevant recommendations for Contraband contract above, specifically B1a.

1. Continue to ensure staff access to appropriate equipment and supplies needed to safely collect and preserve contraband while maintaining evidentiary integrity.
2. Continue to ensure adequacy of chain-of-custody methods and procedures.
3. Develop a Uniformed Incident Reporting system (discussed further in this report) that provides cross-referencing and continuity between all reports and logs involving detection and confiscation of contraband.
4. Develop and implement a continuous quality improvement (CQI) protocol to evaluate adherence to Contraband policies and procedures and reporting.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Security staff posted at the main entrance conducted a reasonable and consistent search of the monitoring team during this visit. The Monitoring team was appropriately escorted throughout the campus, but did not witness escorts of visitors. USDOJ representatives invited

two US Marshalls to assist with security escorts due to GGACF staffing problems during previous visits that caused long delays for the inspection process.

RECOMMENDATIONS:

1. 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.

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 - No substantive improvement from previous assessment.

FINDINGS: This Monitor observed most prisoners wearing appropriate prison attire. However, many inmates continue to wear "street clothes", which creates a real and present risk to facility safety and security. As mentioned in the previous report, this practice aided in the May 11, 2014 escape. This practice, as previously recommended, must stop. All inmates must wear only standard prison attire at all times.

RECOMMENDATIONS:

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.
9. Revise inmate ID card policies to ensure inmates visibly wear their ID as discussed above, monitor.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above Findings.

The monitoring team and USDOJ were issued visitor identification each day of the visit.

The recently implemented inmate identification card system requires improvement. The Warden stated that the policy, as stated on the card itself, is somewhat confusing in that only requires prisoners to carry their ID on their person at all times outside of their housing units. However, the Warden stated that the policy was intended to require prisoners to visibly display their IDs in at all times outside housing units. During the tour, the Warden engaged several prisoners outside housing units to check for IDs. All prisoners checked possessed their ID but none wore their ID visibly. These prisoner interactions made clear that prisoners are confused about the policy but are complying with their understanding of this requirement. The policy must be revised to clearly require ID to be visibly worn at all times while outside housing units, and to require inmate workers to visibly wear their ID at all times when working in housing units other than their own.

RECOMMENDATIONS:

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 - No substantive improvement from previous assessment.

FINDINGS: Territory officials have not provided documents demonstrating full compliance with this training following the previous report as reiterated below. The training report previously provided showed a 65 percent training complete rate. The Monitor patiently awaits requested training records demonstrating a 95 percent minimum successful completion rate.

4th Report Findings;

The Territory submitted a draft document ("Supervision of Inmates and Detainees" Policy) intended to satisfy this provision on June 6, 2014. However, the document submitted was not fully responsive to this provision and was rejected for failing to include basic elements and formatting. On July 21, 2014, the Territory submitted lesson plan documents pertaining to locking and unlocking doors and gates. This Monitor provided the Territory written recommendations and feedback regarding this lesson plan. On August 22, 2014, the Territory

submitted to this Monitor and USDOJ documents demonstrating that this training was conducted July 21 thru August 1, 2014. These documents included:

- Lesson Plan
- Post Test
- Attendance Rosters
- Training Completion Statistical Report

The training completion statistical report is very difficult to interpret for understanding what percent of required staff complete this training but suggests that approximately 65% (30+ staff were not trained) of required staff complete the training. This needs to be clarified and a minimum of 95% of required staff must successfully complete this training before it meets the requirements of this work plan item.

The training plan is acceptable overall but did not include instruction on relevant policies and procedures as those document have not been completed and approved for implementation. It is important that training curricula is based not only on principles of security but must include current policy and procedure to ensure staff compliance can be measured adequately in accordance with policies and procedures. The lesson plan was well written and included basic principles of door locking and unlocking principles. The course was taught by the Warden, a highly qualify correctional professional, and included a ten question post-test. Unfortunately, a post-test cannot measure learning without a pre-test to assess baseline topic knowledge among students. All future training must include a pre-test to ensure learning has been attained.

During this assessment, this monitor found all internal housing unit gates and officer stations to be locked upon entry. However, none of the exterior security slider-doors were locked. These doors – often referred to as the "sally port" doors – were left standing open or unlocked upon entry into the units; we were once again advised that the electronic locking mechanisms are inoperable. Although the various security gates throughout the facility were locked when the Monitoring team first approached, the gates were not locked behind the team when the monitoring team toured the housing units. Moreover, on several occasions during the onsite inspection, the monitoring team/USDOJ representatives were able to simply open the outer perimeter gate upon arrival at GGACF, revealing that the gate did not always lock. These observations clearly support a security culture that lacks enforcement and consistency; it also demonstrates the need for additional training, monitoring, and supervision by GGACF leadership. GGACF staff must consistently practice good security habits by keeping security doors and gates closed and locked. Officers still report that inadequate staffing levels require them to not lock security gates upon entry into the housing units for safety reasons. Housing unit logs report that fire escape doors and locks are inoperable. There was improvement found in yard-gate security, but some of the locking mechanisms remain inoperable and prevent the gates from being locked. Most notably, the last gate from the yard to the administrative building (which provides access to the outside of the facility) was broken. The supervisor bubble that looks out at this gate is frequently unstaffed, meaning that inmates can enter or exit the administrative building area as they please.

Despite some progress to fixing locks, there are still delays and many non-functioning locks. Logbook entries continue to report key door/lock issues not being timely addressed. For example, the Detention R&D entrance door was observed by this Monitor nonfunctional requiring use of a

metal pipe to secure it closed. The door must be operated manually, keys don't work, a metal pipe must be placed behind the outer sally port door to provide security to the area, etc. It appears that the lock work report does not mention this door.

Another example is X Pod, which is the housing unit for sentenced and un-sentenced female inmates. This unit is monitored by one officer, but has gone for hours with no officers assigned according to unit log books. This building is divided into two housing units with a door separating the two populations. This door is not always locked, according to the unit officer. This means that sentenced and un-sentenced inmates have access to one another, which should not occur. The lock on this door must be fixed, if broken, to ensure secure separation between these populations. If not broken, policy and procedure must direct officers on this post to keep this door locked at all times.

RECOMMENDATIONS:

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 upgrading existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.
10. Improve video surveillance of internal 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.
13. Consistently enforce security locking policies and procedures with staff and inmates.

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: Preventive and ongoing lock maintenance remains problematic due to inadequate maintenance staffing levels as previously discussed. Examination of locking system maintenance records show continued inspection, replacement, and repair of electronic and mechanical locks and locking mechanisms. However, inadequate maintenance staffing levels

prevent timely inspections, repairs, and replacement of these security devices considering that the small maintenance team serves the entire facility.

RECOMMENDATIONS:

1. Employ and maintain adequate maintenance staffing levels.
2. As requested in the previous two reports, develop an "all-locks" maintenance plan for review with the Monitor. The plan should include a complete inventory of all locks, locking mechanisms, date lock found non-functional, date 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: BOC officials concurred that the current background process is problematic. They advised that correctional trainees are on occasion dismissed from the Academy due to background investigation results. As a result, the trainee's employment is terminated and the recruitment process to fill the position restarts. The hiring process is, therefore, inefficient and very problematic. All conditions of employment should be fully completed before an applicant is employed and trained. Territory officials should assess history of terminations, identify determining factors, and realign completion of pre-employment practices to avoid post-employment terminations.

RECOMMENDATIONS:

1. Territory officials should assess history of terminations, identify determining factors, and realign completion of pre-employment practices to avoid post-employment terminations.
2. This Monitor again requests inspection personnel records including employment applications; criminal history checks, and background investigations for all housing unit staff working Units 9A/B during the reported escape attempt occurring June 7, 2014. **Please have these documents at GGACF for the upcoming site visit.**
3. Ensure access to applicant and staff records is adequately controlled and protected, and that access to these records is based on a legitimate, work related "need to know" basis.
4. Ensure there is an adequate centralized information tracking system in place to support periodic supervisory review of staff records for professional development, counseling, and corrective action decision-making.
5. Make records available to the Monitor for inspection and verification of compliance.

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: PARTIAL COMPLIANCE

FINDINGS: The NIC Staffing Analysis has been completed and remains under review by Territory officials. This staffing analysis included realistic shift factor calculations for all security staff and GGACF. This Monitor has provided Territory officials draft basic staffing plans but the Territory has not provided any follow-up communication with the Monitor with regard to these draft plans. This Monitor remains available and committed to assist the Territory in finalizing and implementing approvable staffing plans.

RECOMMENDATIONS:

Complete and approvable Staffing Plan that accounts for the recent closing of four housing units.
Secure funding to comply with Plan staffing requirements.
Revise staffing hire process to improve its efficiency and timely hiring of officers.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Refer to previously discussed housing unit and supervisor staffing deficiencies. The Territory has not completed a security staffing plan, using the NIC security staffing analysis, as required by the Settlement Agreement. This is a critical next step for the Territory to complete. The staffing plan should be completed as soon as possible, taking into account the Territory's experiences recruiting and hiring staff on-island and the need to potentially advertise for positions off-island as well. On site, the Territory said they would try to complete this by December, but the Monitor received no notification of progress prior to writing this report.

RECOMMENDATIONS: See 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: Refer to the above findings. No change since previous visit.

RECOMMENDATIONS: See above.

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

ASSESSMENT: See above

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

RECOMMENDATIONS: Refer to previous recommendations.

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: During the previous assessment this Monitor spoke with an inmate who reported being fondled by another inmate while he was experiencing a seizure and semi-conscious. This inmate stated that while he was semi-conscious another inmate groped his groin area, according to other inmates. This inmate stated that when he regained full consciousness other inmates told him about the event and that he does not have clear memory of the event. This inmate presented a written complaint he was preparing to submit to GGACF officials about the event. The inmate was encouraged to follow through with filing the complaint and allowed VI counsel participating in the on-site assessment tour to have a copy of the complaint. This matter will be reviewed for PREA compliance during the next visit in September 2014.

1. Investigate and resolve the PREA complaint described above.
2. Compare the investigative process and outcomes to the PREA requirements and draft policy to determine compliance with PREA requirement and needed policy revisions, if any.
3. Provide this inmate written communication advising him that his complaint is being investigated and results of the investigation.

RECOMMENDATIONS:

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. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:

F. Classification and Housing of Prisoners

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: There has been no change since the previous reports. Although this Monitor assisted the Territory in the development of a Classification policy, the classification instruments require validation to ensure that the instruments and classification process is objective. However, according to Territory officials, a national expert in classification validation is expected to be onsite for this purpose by the end of 2014.

Additionally, the Territory has not responded to the Monitor's request to provide classification forms to be used in the application of the new policy in order to complete the policy.

RECOMMENDATIONS: Recommendations previously provided 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 found in the previous reports, detainees and convicted offenders are generally held in separate buildings, except for sentenced and un-sentenced female inmates who are in separate wings of the same building. Inmates are generally housed according to their security level based on their offense of conviction or their charged offense and whether their background includes violent criminal acts. Inmates are also housed according to administrative, disciplinary, special needs, and/or work assignments. This is a very basic but dangerously unreliable practice for managing inmates and is not based on a reliable classification system. Such a practice is

known to facilitate violence against inmates and staff, the introduction of contraband, and can create substantial barriers to inmate health and wellbeing. For example, some inmates with serious mental illness (SMI) are being housed in segregation/lockdown unit for unknown reasons and without justification. Many of these inmates are placed on lockdown units because of their mental health problems; GGACF's lack of an effective and valid classification system prevents GGACF staff from identifying other more appropriate and less punitive housing placements. Indiscriminately housing prisoners on 23 hour-a-day lock down units can exacerbate inmate behavior management problems, their mental illness, and is specifically prohibited by the Order per Provision V.1.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;"*

Recommendations provided in previous reports remain appropriate. Failure to appropriately classify and separate inmates will remain problematic and contribute to ongoing introduction of contraband, violence, and harm to mentally ill inmates. It will also result in the continued housing of inmates with serious mental illness in isolation/lock-down units, in violation of the Agreement. Refer to previous recommendations.

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 Order's prohibiting housing seriously mentally ill inmates in isolation cells or locked-down housing units. Direct mental health staff 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 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 - No substantive improvement from previous assessment.

FINDINGS: As reported previously in this report, there was some positive improvement observed in the locking of housing unit security gates. However, this system remains flawed because it is inconsistently applied: officers continue to leave these gates unlocked when inside the housing area. Current staffing levels and gate locking practices impair GGACFs ability to comply with this Provision. The May 12th escape and June 7th escape attempt clearly demonstrate this ongoing problem.

Additionally, the lack of housing unit security cameras or other monitoring equipment frustrates GGACF staff's ability to monitor inmates effectively to detect and potentially prevent them from obtaining unauthorized access to each other. Furthermore, until all locking systems are repaired and maintained consistently, as described above, inmates will be able to disable cell locks and access each other with both social and dangerous intentions.

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 - No substantive improvement from previous assessment.

FINDINGS: This provision reverts to noncompliance due to there being no action taken to improve grievance and incident report tracking, as described in the previous report. Additionally, a review of classification records and interviews with classification staff clearly demonstrate serious flaws in the re-classification process. For example, a review of one initial and re-classification record showed that the inmate was correctly classified as maximum security upon initial entry into the facility. Later, the inmate was re-classified as minimum risk, but placed in a medium security housing unit. The inmate then escaped from that housing unit.

This inmate's classification should not have been reduced to minimum risk simply based on his known history of serious criminal violence; he should have remained as a maximum security detainee and housed accordingly. However, classification decision-making and housing is moot if housing units are not adequately staffed to control inmates.

Interviews with GGACF classification staff revealed no consensus on how to use the current initial and re-classification system.

As stated in previous reports, there is current practice and general policy for reclassifying inmates following incidents involving violence and disciplinary events. However, this process, as previously stated, should be empirically validated.

Additionally, an examination of Grievance and Discipline Logs continues to show they are incomplete and inconsistent. The Grievance Log is missing several important entries indicating that some important grievances go unanswered. The Discipline Log and disciplinary documents provided evidence that many disciplinary cases are dismissed because timely due process was not provided to the inmate.

Hearing and Disciplinary Committee Monthly Report(s) for April and May both state, "*The numbers of Due Process Violation submittals have decreased tremendously*", but reported due process violations increased in April and May. These reports were not provided for June thru August so it is assumed there has been no change in this practice.

The accuracy and completeness of these records are very important for making consistent and reliable re-classification decisions. Otherwise, as is indicated in the disciplinary reports, inmates under disciplinary action are given "time served" and released from restrictions without being afforded their right to due process. This will be discussed further in this report.

RECOMMENDATIONS:

1. Refer to previous classification findings and recommendations.
2. Refer to recommendations related to grievance and disciplinary policies and procedures.
3. Ensure accuracy of monthly disciplinary committee reports.
4. The Territory must correct problems reported in the monthly disciplinary.
5. 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; and..(f).

ASSESSMENT: PARTIAL COMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As stated in the 3rd report:

Implementation of a new Incident Reporting Log was described in the Baseline Report and remains in effect. However, as previously reported, a review of this log shows it is often incomplete and illegible. This log cannot provide an accurate account for incidents because it contains multiple entries for the same incidents using the same or different incident numbers. This makes using this log for compliance with this provision virtually impossible and its uses should be revised.

The GIST (Gang Intelligence and Search Team) program is inadequately staffed to provide the level of evaluation and intervention needed to meet the apparently high volume of incident activity reported in the incident reports, supervisor, and housing unit logs. Staff should be added to this program and a comprehensive evaluation and intervention program developed.

Additionally, errors and missing incident reports, as reported in the monthly disciplinary report, impede accurate collection, analysis, and tracking of data to comply with this provision.

RECOMMENDATIONS: Previous recommendations remain appropriate:

1. Develop 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 - No substantive improvement from previous assessment.

FINDINGS: As reported previously, there remains no formal mechanism or process for regularly reviewing status and conditions of inmates housed in segregation. Additionally, the Monitor was provided no evidence that GGACF tracks and monitors inmate lengths of stay in segregation or why inmates are segregated. When viewed in combination with the flawed disciplinary process, outdated classification system, and the incomplete grievance tracking process, it is clear that segregated inmates are not provided adequate levels of due process, monitoring, and review. This practice is very serious and remains in direct violation of the Agreement. It is also clear that mental health staff are not involved in the decision to place a prisoner in a segregation unit, nor do they conduct evaluations or otherwise monitor the mental health of prisoners on these units. This is discussed further below.

Additionally, the frequent practice of "modified" or "full" lockdown due to staffing shortages remains very troubling. This practice, though apparently necessary for security purposes, effectively creates facility-wide segregation/lockdown conditions for days at a time. This can only be corrected by ensuring that all shifts consistently maintain sufficient staffing levels.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, evaluate segregation housing policies to a) minimize segregation time, b) provide adequate opportunities for out-of-cell time for inmates, c) ensure regular and consistent monitoring by medical and mental health staff, d) ensure inmate hygiene is maintained while housed in segregation, and e) develop a tracking log for documenting segregation housing conditions of confinement and inmate status.
2. Ensure inmates with special needs are monitored more frequently as indicated by a security and health risk/needs assessment. A routine schedule for conduction these rounds must be regularized and continuously monitored for compliance.
3. Develop and implement a monthly segregation housing unit log that tracks lengths of stay and compliance with this provision.
4. Defendants are reminded that segregation should never be used to punish or as a treatment for inmates who are mentally ill.

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; 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 - No substantive improvement from previous assessment.

FINDINGS: These policies have not been submitted as required.

The GGACF incident reporting system remains woefully inaccurate and flawed. For example, a review of incident reports and logs show that more over 50 incidents had no corresponding incident report; 21 incidents with corresponding incident reports were not recorded in the log; and, where multiple incident reports were written regarding the same incident, the narrative accounts given are inconsistent and no attempt was made to correct or otherwise investigate the inconsistencies.

Incomplete, inaccurate, and inconsistent reporting of incidents makes it impossible to effectively manage GGACF resources and facility safety.

Moreover, because incident reporting is so inconsistent, the Territory makes no effort to identify patterns and trends and take corrective action. This renders the incident reporting system meaningless. Incidents should not be reported simply for reporting sake; they should be reported and acted upon, and internal changes should be made in accordance with the results of proper investigations. This is not happening. There is no quality control or evidence of review for accuracy.

RECOMMENDATIONS:

1. Complete and submit policies as indicated.
2. Integrate the Incident Tracking system into this policy.
3. Develop protocols for current tracking system to improve data validity and reliability; this document is replete with duplication and misleading entries.
4. Develop a unified incident coding system for valid and reliable information and data collection, reporting, and analysis.
5. 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.
6. Train staff in applying adopted policies and use of forms, implement a continuous quality assurance protocol.
7. 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: PARTIAL COMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As previously reported, senior staff now participate in GIST meetings to review incident activity, but additional work is needed for compliance. Moreover, there are no policies or procedures governing or directing this process, and the group does not meet regularly. Furthermore, and as previously discussed, the incident reporting system requires revision before it is a valid and reliable document for incident evaluation purposes.

It is also worth noting that GGACF does not have a Chief Investigator. Warden Redwood was serving in this role prior to being named interim Warden. Mr. Redwood is no longer working for the BOC. USDOJ and the Monitor inquired whether and when the Chief Investigator position would be filled, but the Territory has not provided an answer. Without a Chief Investigator, the Warden becomes responsible for investigating all incidents. This places too much on the Warden's plate and also potentially sets up a conflict of interest. The Warden is both conducting the investigation and signing off on it, meaning there is no additional layer of review to correct errors or suggest areas for follow up. It is also unclear what, if any, experience or training the acting warden has in investigations.

RECOMMENDATIONS:

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Refer to previous section on contraband control as it also pertains to confiscation and preservation of evidence

RECOMMENDATIONS:

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Refer to previous findings regarding incident reporting and tracking.

RECOMMENDATIONS:

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.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Such a policy has not been provided.

RECOMMENDATIONS:

1. Include this element in the required policy and procedure.
2. Establish reasonable timeframes as indicated.
3. Develop and implement corrective action protocols for staff noncompliance with adopted policies and procedures.

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: Territory officials and members of the monitoring together completed Use of Force policies and procedures. USDOJ provided written comments and recommendations to those documents and the documents are pending final approval and implementation

A review of incident reports provided by BOC staff document there were at least ten (10) incidents between 6/20 and 9/17 involve officer use of force against inmates. However, the Monitor was provided documentation of supervisory review for only two (2) of the ten (10) incidents. It is unknown whether 1) all use of force incidents were reported, 2) all use of force reports were provided to the Monitor, 3) all force incidents received the required supervisory review, and/or 4) whether the Monitor was provided with documentation for all completed supervisor reviews. The Monitor has experienced considerable frustration with Territory officials not consistently providing all use of force documentation requested well in advance of each onsite visit. In most instances, not all requested documents are being provided during the onsite visit, and/or are very disorganized and incomplete, and/or are provided, if at all, well after the visit.

This Monitor submits to the Territory a request for documents in advance of each visit. The Monitor and monitoring team require the requested documents to help focus their onsite work and to efficiently maximize the completeness of the onsite visit, timely completion of the Monitor's reports, and to contain monitoring costs, as required, to the authorized budget. However, during none of the onsite visits were all requested documents provided.

Additionally, the Monitor has not yet submitted to the Territory the list of documents and information required for "routine" monitoring as set forth in the Agreement. This partly due to the Territory's consist non-responsiveness to providing all requested pre-visit documents, and its non-responsive or very late responses to post-visit requests. Documentation required for routine monitoring will be expected regularly on a monthly. *The Monitor will have no other option but to seek Court intervention if documents requested for routine monitoring are not consistently provided as requested.*

The ten use of force incident reports provided document that force was used by officers to 1) stop inmate physical violence against staff or other inmates, and 2) effect inmate compliance with officer instructions intended to maintain facility security. The types of force used by officers include:

Impact Weapon (expandable baton) Force: x4
Hands-on / Restraint Control Physical Force: x6
Electronic Stun Shied: x1

Although incident reports appear to justify all force and force levels used, the Monitor is unable to assessment compliance with this Provision without reviewing adequately completed supervisory review documentation, which was, again, not provided.

This provision will remain in noncompliance until approved policies and procedures are adequately implemented to include consistent submission to the Monitor of all required documentation for compliance evaluation purposes.

RECOMMENDATIONS:

1. Implemented draft use of force policies and procedures upon approval and according to the new Schedule.
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 document are 1) complete, 2) accurate, and 3) comprehensive.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change since previous reports. See above.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.

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:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.

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: Refer to findings in H.a. above, and findings and recommendations for Training Provisions. There has been no change since previous reports.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. See recommendations regarding Training Provisions and apply to use for force requirements.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since previous reports. Per the 4rd report, "Documents were provided that show the names of several officers who participated in weapons qualifications. However, these documents do not clarify whether all officers currently authorized to carry weapons are trained in accordance with the Agreement. The term "weapon" should include any device issued to staff in the use of force against an inmate. This includes, but is not limited to: firearms, batons, impact weapons, chemical weapons, etc." It is unclear whether the officers involved in recent uses of force, as described above, were ever trained in the use of those types of force (batons, electronic shields, etc).

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.

2. Refer to Training Provision recommendations and apply to this requirement.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Dates shown on incident reports involving use of force seemed to show timely submission of reports. However, some of the reports are missing page numbers, clear description of the event, and other elements. Supervisors must review all reports to ensure compliance with this Provision before approving any report.

RECOMMENDATIONS:

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.

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: This Provision is included in the draft policies. However, this practice can and should be initiated pending finalization and implementation of this policy.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.

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: As previously reported, no change since previous reports. Security towers remain inconsistently operational due to inadequate staffing and physical plant problems, rendering them an unreliable security control post. Policies and procedures pertaining to this provision were not yet submitted to this Monitor and USDOJ for review and comment.

RECOMMENDATIONS:

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 draft use of force policy contained provisions for medical evaluation and treatment of inmates following a use of force event, but does not include a requirement for photographic documentation of injuries but will.

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: As stated above, this Monitor is unable to evaluate compliance with this Provision without being provided all supervisory review documentation for all incidents involving use of force.

RECOMMENDATIONS:

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 above.

RECOMMENDATIONS: Same as above

l. Administrative investigation of uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above

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: This Provision is included in the draft policy. However, the current grievance log remains very problematic. This log continues to be incomplete. It frequently omits necessary information, including information about dispositions. There remains no structured, organized, and accurate system in place to comply with this Provision. Training on the new policy and supervisory oversight will be vital to ensuring this provision is met.

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: The draft use of force policy includes a provision for supervisor review of use of force incidents to determine whether and what corrective action is required. This is not occurring consistently yet. Hopefully the new policy will improve compliance with this provision. In the meantime, while the Territory finalizes the policy, immediate directives could be issued (as noted in the Recommendations section) and the Warden should review for compliance with the directives.

Refer to previous Findings regarding supervisor review of use of force incidents.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Training records were again not provided to the Monitor for review during this visit.

It is impossible for GGACF to fully comply with this Provision until supervisors comply with use of force review requirements.

RECOMMENDATIONS:

1. Produce staff training records for review by this Monitor during the next onsite visit.

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: The Territory and the Monitor jointly developed a draft policy on Use of Force that also including information on proper and improper use of restraints. USDOJ provided detailed comments on the policy but it is unclear when the Territory intends to finalize the policy. Until this policy is finalized and all staff are trained on it, the Territory will remain noncompliant with this provision and all other provisions related to use of restraints.

RECOMMENDATIONS:

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:

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 inmate grievance process remains ineffective and problematic with no improvement since the previous assessment.

As previously stated:

1. The log fails to: consistently record complaint types and descriptions; include the date the complaint was received; assign a complaint identification number; note the housing location from which the complaint was submitted; and note the date the complaint was sent to the chief for response.
2. Although most complaints include the date the complaint was submitted to the chief, very few included the date when the complaining inmate received a response or a description of the response.
3. It is exceptionally troubling that only one of the inmate health care complaints for this time period was provided a response by responsible GGACF officials, based on log entries. Some of the most serious inmate complaints logged in the Grievance Log included issues involving medical and/or mental health concerns for which disposition information is not recorded.
4. The grievance system is especially important given that there is inadequate medical and mental health care staff to conduct regular rounds on each housing unit.

5. The grievance system may be one of the only ways for prisoners to get access to such staff. However, when the grievance system is not functioning properly and grievances are not tracked, logged, and timely responded to, prisoners will not get the help they need.
6. The GGACF prisoner complaint / grievance system does not provide a reliable mechanism for inmates to obtain legitimate relief and/or resolution for serious and important issues and concerns. The complaint system's records management is very problematic because of log omissions, noted inconsistencies, and its unresponsiveness to inmate complaints. Furthermore, if the grievance log is an accurate reflection of the system's management, it would be virtually useless for proving exhaustion of administrative remedies required under PLRA.

Additionally troubling is the chronic lack of administrative oversight of the grievance process and log. According to the Warden, these responsibilities were assigned to the Assistant Warden, who was in that position up until Warden Redwood resigned in early October. It is unclear who is now monitoring this system. And, despite this Monitor reporting the same deficiencies in each compliance report, the grievance system has not substantively improved. This situation must be permanently corrected. Inmates must have access to a reliable and responsive complaint process.

RECOMMENDATIONS:

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 oversight of the inmate complaint process and logs to a staff person who will provide the process consistent, dedicated, and comprehensive attention.
4. Develop from a valid and reliable tracking a quality management statistical report for monitoring inmate and facility needs and problems.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No substantive improvement since previous assessment. See above description of current complaint system deficiencies.

RECOMMENDATIONS: Same as above.

c. Corrective action taken in response to complaints leading to the identification of violations of 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: See above description of current complaint system deficiencies.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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 - No substantive improvement from previous assessment.

FINDINGS: See above description of current complaint system deficiencies. The current complaint tracking system remains mismanaged, incomplete, inconsistent, and inaccurate.

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: Same as above. Deficiencies in the Inmate Grievance Log continue to demonstrate the absence of a systematic and reliable process for reviewing prisoner complaints, tracking trends, and addressing individual and systemic issues.

RECOMMENDATIONS: Same as above.

1. Conduct monthly administrative reviews of the inmate complaint/grievance tracking reports. Use data from those reviews 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 elements of this Provision will be included in Monitor's policies and procedures.

The vacant Investigator position remains unfilled; former Warden Redwood stated that he continued to conduct administrative investigations or assigned them to the Security Chief with the Warden overseeing the Chief's work. The administrative investigation process remains very problematic because with Mr. Redwood's resignation, there is now absolutely no qualified staff person dedicated to conduct investigations and inadequate supervision levels severely limit oversight of staff conduct. Lack of adequate supervisory review of use of force reports prohibits further demonstrates the Territory's noncompliance with this Provision. It is very likely that administrative investigations have not been initiated at all, or timely initiated, on various policy and procedure violations. Mismanagement of the inmate complaint process, as previously discussed, further evidences insufficient attention and a laissez faire approach to staff accountability. Revised administrative investigation policies and procedures will be ineffective until the staff accountability measures consistently implemented, beginning with supervisory/management staff.

RECOMMENDATIONS:

1. Fill the vacant investigator position.
2. Supervisory / management must be consistently held appropriately accountable for adherence to agency rules, regulations, policies, and procedures.

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.

Additionally, and as previously discussed, even if an investigation determines that an inmate deserves some form of punishment for a disciplinary infraction, that punishment is often not determined or enforced because due process proceedings often do not occur. Recommendations provided in the previous report remain appropriate. There were no administrative investigations initiated to look into staff misconduct, to the best of this Monitor's knowledge. These investigations must also be conducted, reviewed, and tracked.

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: Same as above.

RECOMMENDATIONS: Fill the currently vacant Chief Investigator position.

1. Create a formal pre- or in-service training program to train staff who are involved in initial and/or administrative investigation.
2. 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.
3. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.
4. 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.
5. 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: As previously reported, regarding staff discipline, GGACF officials reported (but did not provide any documentation of) several instances of disciplining staff where their involvement in misconduct was determined. This Monitor requests full review of these instances during the upcoming site visit.

Regarding inmate discipline, no substantive improvements were found since previous reports. As previously stated:

1. The current system remains ineffective for delivering fair, reliable, consistent, and meaningful inmate discipline for multiple reasons, as demonstrated by a review of numerous documents and an interview with the discipline coordinator.

2. The monthly disciplinary hearing reports continue to report a high number of inmate disciplinary cases being dismissed as a result of due process violations. The coordinator continues to document the following problems with the disciplinary and discipline committee process:

   - In ability to form a consistent disciplinary committee to conduct hearings;
   - Late reports from supervisors;
   - Incident reports containing inconsistencies, inconsistencies, writing errors;
   - Inconsistent use of the new report form and staff failure to include all information requested on the incident report form;
   - Facts not being properly documented;
   - Duplication of incident report numbers;
   - Inconsistent / inaccurate completion of the Incident Log.

This assessment demonstrates chronic lack of quality control and staff and supervisor accountability that should be corrected without delay. The inmate discipline system is not only ineffective due to lack of adequate staffing, but lacks sufficient oversight and organization to deliver meaningful and consistent outcomes.

The problems noted above with the administrative investigations system also demonstrate noncompliance with all provisions of the Agreement that rely on a valid and reliable incident reporting system.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Review and revise current regulations on staff disciplinary actions and penalties to ensure completeness and efficacy.
2. Integrate the information in the above into the administrative policies and procedures previously discussed.
3. Record and maintain onsite records of staff misconduct investigative reports and determinations.
4. 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.
5. Provide training to supervision staff in the appropriate use of this information for staff supervision, counseling, discipline, promotion, etc. purposes.
6. 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.

OVERALL NOTE: Due to the absence of approved policies the reader will notice that no provision can yet be moved to partial compliance. The monitoring team has now been instructed to provide technical assistance in reviewing and modifying all of the proposed policies generated by the GGACF staff. Both the health services administrator and the psychiatrist have worked diligently to prepare the initial mental health policy drafts which we will now collaboratively modify for final submission to BOC and DOJ by the end of this year.

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: NONCOMPLIANCE – No substantive improvement from previous assessment.

MEDICAL FINDINGS: With regard to medical screening, we have been provided a policy that demonstrates a substantial number of provisions which had previously not been included. In addition, the Health Care Administrator along with the Medical Director have developed an acuity prioritization scale that will enable the nursing staff who perform the medical screens to determine the scheduling of the intake comprehensive health appraisal based on the acuity and complexity of the problems identified. There is real, significant progress being made in the policy area. In fact, it was clear that the Health Service Administrator had accomplished a great deal in the area of policy drafting since the June visit. I was presented with and reviewed more than 30 policies. A majority of them are directly related to the Settlement Agreement. I had suggestions for additions or revisions for about 25. But it is important to note that the vast majority of those 25 needed relatively few significant changes. There were a few policies and procedures that needed to be completely revised and we provided the Medical Director and the HSA with copies of policies that have been approved on these specific topics in other jurisdictions. We expect to continue to work with the HSA and Medical Director and are hopeful that we will be able to approve the policies before the time of our next visit in December. USDOJ would then be able to review the policies for approval, in accordance with the Settlement Agreement. We reviewed the policies which have been drafted in a manner that is consistent with the National Commission on Correctional Health Care standards but also related the policies to the relevant paragraphs or sections of the Settlement Agreement. We also identified specific language in the Agreement that needed to be addressed in certain of the policies. Therefore, we are extremely optimistic that the final steps will be accomplished.

We were informed that beginning on August 8, 2014, only nurses are performing the intake screen. At the time of this visit there were three registered nurses, which includes the head nurse, and two LPNs. There is a plan to recruit two part-time registered nurses to cover the weekends and add one additional LPN. We were also provided with a log of the intakes processed through over the prior six weeks. However, the log began on August 21, but this log includes inmates who arrived several days before, thus many of the screens were not conducted within the required timeframe of "as soon as possible but no later than 24 hours." There were also a few names on the log of people who were released before the screen could be conducted. The first case is an example of some of these problems.

Patient #1
This is a 22-year-old who entered in mid-August. and the custody screen yielded a history of asthma. The nurse screen was performed a week after the prisoner entered the facility. The nurse also learned that the prior attack was two years ago. This patient had no peak flow conducted, which is an assessment of his asthma status, and he also did not have the comprehensive initial health appraisal because in fact there has been no physician onsite due to problems yet to be worked out with the Medical Director. Although his skin test was performed and read as negative, his laboratory tests were not performed.

Patient #2
This is a 32-year-old detainee who arrived in late August. Two days later, the screen was attempted but the patient refused. He has had no recent labs and does not need a PPD. His refusal was because he had been incarcerated recently. The policy on screening needs to include a description of the frequency with which to repeat the intake screen and how that should be conducted (whether an interval history will suffice for returnees out less than 90 days) if someone has had a screen within the last three months. In general, when people refuse for any reason there must be an effort documented to offer the screen daily.

Patient #3
This is a 31-year-old who arrived in early August and was screened the next day. He had a history of taking mental health meds and had suffered from PTSD and depression and anxiety. He also had a wound on his left thumb. He was seen as an acuity scale 1 on 8/13, but the comprehensive intake appraisal form was not utilized. He indicated to the doctor that he had been on medication for hypertension but this was not written in the plan and no laboratory tests were ordered. His PPD was negative.

The following problems exist with the medical process:

1. Screens must be conducted as soon as possible after entry. My understanding is that there is nursing coverage 8:00 a.m. to 8:00 p.m. daily and therefore the longest duration without a screen should be 12 hours. We have also discussed with the Medical Director designing a form that will allow a nurse who is on call to address questions over the telephone to the patient who is newly arrived. If these questions suggest instability, the nurse will call the doctor and have the patient sent to the hospital. If, on the other hand, the questions suggest stability, then the patient can wait the 12 hours until the nurse comes in the morning and conducts the screen.
2. The second part of the problem is there was some information on some of the forms which should have been collected but was not and this is obviously a training problem, although the nurse screens are a vast improvement over what was present on our earlier monitoring visits.

3. The acuity scale did not always assess the patient correctly and this is a matter of training and feedback.
4. The policy on refusals needs to be addressed.
5. Without a regularly scheduled advanced level clinician, (either physician, PA or nurse practitioner) available regularly, there cannot be compliance with the health appraisal policy.

RECOMMENDATIONS:

1. Continue to refine the screening policy, including how to handle refusals as well as rapid returnees.
2. Develop the telephone triage to be used between 8:00 p.m. and 8:00 a.m.
3. Add the additional weekend nursing coverage.
4. Stabilize the advanced level clinician schedule so that the nursing staff can predictably insure that patients are seen timely in compliance with the policy.
5. The refusal policy must include daily rescheduling and offering of intake physical exams.

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: GGACF has implemented an intake screening form which is completed by nursing staff. However, the current form does not correlate with the prompts on the correctional officer's intake screening so that when the officer indicates a positive history for depression and treatment, these indicators are not necessarily addressed on the medical intake screen. During the site visit the discussion was conducted with the psychiatrist and health services administrator to create a separate mental health intake screening form with greater detail while remaining simple in its completion to better aid in the identification and referral of inmates to a mental health professional.

A review of 24 randomly pulled intake records of current detainees revealed continued problems in the identification of inmates with potential mental illnesses. Six inmates -- or 25% -- either had a positive history of mental health treatment or a mental health condition on the officer's intake but were not referred for a mental health evaluation. Two detainees were referred and promptly seen by the psychiatrist.

RECOMMENDATIONS:

1. Detainees or inmates entering the system with a positive mental health screen, particularly with a history of prior mental health treatment and complaints of depression or oddities in behavior and thought should be referred by the registered nurse performing the intake screen to the psychiatrist or a qualified mental health professional (once one is hired) for a comprehensive mental health evaluation to determine the need for further treatment or the lack of risk and assignment to "as requested" services.

2. This monitor will draft a new intake screening form for the facility with review and input by the psychiatrist. The new intake screen for mental health will be developed and hopefully implemented within the next several months and should include a triaged acuity level.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We have submitted a new intake screening form which includes an acuity scale that determines the urgency of the intake health appraisal. Unfortunately, there has been no stability to the scheduling of the intake health appraisal and we identified records where the appraisal was either were not done within the required timeframe or was performed very late. Also, we reviewed one record in which, because the form was not utilized, all of the necessary data was not collected and the policy with regard to chronic disease was not followed. Again, due to contractual problems and the obtaining of the correct license, Dr. Burton has not been available since the middle of August, including all through September. He was present for our monitoring visit and participated fully. We hope that his license for the upcoming year is available as he expects by the end of September and also that the pharmacist contract is approved, because he was clear that he would not work in the absence of a licensed pharmacist. It is also clear that the clinician staff needs to be reminded by the nursing staff that when they perform a comprehensive intake they must use the appropriate form and complete all the required information, including developing an initial problem list and a diagnostic and therapeutic plan for each problem. As commented earlier, this is impossible without a stable schedule so that the nurses can refer based on their intake screen and the acuity scale.

RECOMMENDATIONS:

1. The comprehensive health appraisal form should be modified so that it creates space for an initial problem list and space to make the appropriate referrals, including the chronic care program, mental health, dental and any other appropriate referrals.
2. The policy should also be modified such that for acuity level 1 and level 2, they should all be reviewed at the end of a week by the Medical Director, who can insure that there is appropriate follow up based on both laboratory and TB skin test results. Since the 1s and 2s are likely to be seen for their appraisal before the data is available, the Medical Director can insure that the approach is comprehensive. This should be added to the policy. Also, the QI program performed by the HSA should review the compliance with the timeliness of the health appraisal in relationship to the acuity designation. This should be monitored with data monthly.

MENTAL HEALTH FINDINGS: Those inmates referred to the psychiatrist are seen by her in a very prompt manner. However, the current form that is in place is not guiding documentation to reflect her comprehensive assessment of the inmate and her initial treatment plan. Therefore it is suggested that a different form be utilized to better guide the process.

RECOMMENDATIONS: While on site, I electronically provided sample forms to the psychiatrist that she can modify or completely redevelop to better suit her documentation needs. I anticipate the new form will be in use before the next site visit.

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

MEDICAL FINDINGS: We were provided a log for the sick call encounters. However, the log does validate that most patients were not seen timely, especially in August, and many were not seen at all. In addition, some notes lacked any subjective or objective data. In addition, some patients referred to a doctor two weeks before our visit had still not been seen.

From our record review as well as discussion with staff, it appears that some of the patients may not have been seen due to an absence of escort or an absence of medical staff. Therefore, the log must be modified to contain a field that explains the reason the patient was not seen. When the reason the patient was not seen is due to an absence of either availability of medical staff or an absence of custody, the patient must be rescheduled. The absence of custody when onsite services are scheduled can be mitigated by the presence of exam rooms in the housing units which currently are functional only in the lockdown units. Therefore, it is important to create exam room availability on each of the housing units that has such an exam room. This capability includes a clean and sanitary environment which is properly equipped with an exam table and supplies, including those necessary to maintain professionally appropriate sanitation. If there is no capability for running water, hand sanitizer must be provided. If there is plumbing in place it must be made operational. Appropriate equipment includes equipment to perform vital signs. The exam table must include appropriate paper to be utilized for each patient on the exam table. Examples of opportunities for improvement in the nursing performance follow.

Patient #1
This is a 43-year-old who requested service in late August and he was seen the day following admission. However, the nurse note has no subjective or objective data; in fact, the entire note consists of requesting Benadryl.

Patient #2
This is a 47-year-old who complained of knee pain in mid September. He has not had either a nurse or physician assessment.

Patient #3
This is an 83-year-old who in mid September requested service regarding a cough and chest congestion. He was seen four days later (not within the required timeframe) and the note is appropriate, accept for the subjective, which only says "as above." It does not indicate the duration of his problem, whether he had coughed up blood, what is the description of what he coughed up and whether he has any other associated symptoms.

Patient #4
This is a 65-year-old who requested service in late August because of pain in her ribs and waist and she had blackouts. She had been seen by a physician 10 days earlier and only complained of the rib pain at that visit. The nurse did not address the waist pain and the blackouts and thus two of the three problems were not addressed.

RECOMMENDATIONS:

1. Stabilize the nursing and advanced level clinician schedules so that patients can be seen timely for a nursing assessment as well as in follow up if needed by an advanced level clinician.
2. The nursing performance and the quality and completeness of their notes should be reviewed with them on a regular basis so expectations are clear.
3. There should be a logbook for referrals to the physician so that it can be tracked and even if patients are not seen timely, they are all seen or there is an explanation and a description of the reason that they are not seen.
4. It must be reviewed with the nurses that when a patient has multiple complaints, every complaint must be addressed during the nursing assessment.
5. The log should be modified to include an explanation of why the visit did not take place. The potential reasons are patient refusal, absence of medical staff or absence of custody staff.

I have used this letter (c) to address acute care, including sick call. Subsequently I will address chronic diseases.

MENTAL HEALTH FINDINGS: This will be covered under the mental health sections of this agreement.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: I was not sent the medication policy but I was told that I will be sent this policy. It is not one of the more than 30 policies that I reviewed. Therefore, on the policy I cannot report on any progress. I am aware that there is a serious issue in obtaining licensed pharmacy services and the Bureau must resolve this as urgently as possible since it jeopardizes the availability of the Medical Director. There are legitimate concerns about not only the appropriateness but the legality of some of the practices. We were not able to perform a review of medication administration, but in our discussions it was apparent that the current practices remain problematic. The delays in access to nursing assessments and intake screens suggests that, in fact makes it inevitable, that there are delays in patients receiving medication timely. The staffing issues are paramount to resolve.

RECOMMENDATIONS:

1. Insure that there are sufficient nursing hours and physician hours to provide the services timely.
2. Resolve the contract and licensing issues with the pharmacist so that she can continue the work that she has begun.
3. Send me the latest version of the medication policy so that I may review and comment.
4. The lead nurse should work with the Medical Director in order to develop a procedure that allows the nurses to not only carry the medications with them to the cell houses but also bring the

medication administration records so that at a minimum they are recorded no later than when the nurses are ready to leave each housing unit.

5. The officers' post order should require that they perform a mouth check after each medication administration and we believe there should be an officer who is assigned to the nurse and they perform this as a team at each medication administration.
6. There is a draft policy regarding discharge medications. We have discussed this and we have suggested some revisions. Those should be implemented and a strategy to insure that inmates receive especially chronic medical and mental health medications needs to be implemented.

MENTAL HEALTH FINDINGS: Staff reported that mouth checks are not reliably done at the time of medication administration.

RECOMMENDATIONS: defer to Medical recommendations

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: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: During our review of records we found that the documents were frequently not filed chronologically or not filed within the correct section. This is a result of all medical staff sharing the responsibility to file and it is clear that several people are not performing this responsibility conscientiously. The records are now filed by Bureau of Corrections terminal digits and there are stickers with identifying information on each document in the chart. I do believe the rate of retrieval of actual records has improved but the filing within the medical records has yet to improve, thus inhibiting the provision of services. We were also told that a permanent medical records clerk is being sought.

RECOMMENDATIONS:

1. Hire a medical records technician as soon as possible, hopefully before our next visit.
2. The medical records policy should include timeframes for filing of documents and for reviewing, initialing and dating by clinicians.
3. There should be guidelines for thinning the records and in particular, what documents from the inactive record need to be moved to the active records. Those documents that should be in the active record include intake information and documents in progress notes, consultations, laboratory and x-ray from at least the most recent year.

MENTAL HEALTH FINDINGS: Currently the facility has retained a temporary medical records clerk for 90 days. Recruitment for a permanent medical records clerk was reported as successful with a full-time clerk starting the week following this audit. The efficacy of the new records clerk's work will be assessed on-site in December. The health services administrator is proposing that the new medical records clerk also do a weekly audit as part of the quality improvement process in the medical records department.

Despite attempts by the health services administrator to better organize the chart via the use of section tabs, the medical records remain very disorganized, out of chronological sequence, and lacking critical documents such as prior medication administration records. The latter were identified at the time of the last site visit as being stored in the nursing station and to date remain un-filed. One record, randomly selected from a stack of records, is for an inmate receiving chronic psychotropic medications. The last filed medication administration record in that chart is from February 2013.

The health services administrator has implemented significant improvements in the medical record process by:

1. Generating computer printed labels with the patient identifiers stored in each record for easy use by staff. As a result there are far fewer documents currently generated that lack patient identification on the form.
2. Staff are now filing charts based on the BOC# and not the inmates name for better accuracy in the event there are inmates with the same or similar names.
3. The medical records clerk is also now assigned as the only person who will file and remove records from the file room.
4. Doctors' orders are entered on an order sheet along with other task orders.

RECOMMENDATIONS:

1. At the time of the next site visit the review will be done of recent records to determine if the organization and quality of records filed has improved with the presence of a permanent records clerk.
2. A review of the site medical records audits will be conducted at the time of the visit.

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: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This item was dealt with under letter (c), including recommendations for the policies.

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: The clinic has implemented a written behavioral health checklist/sick call requests log that identifies:

1. the patient's name,
2. date initiated by patient,
3. date received by medical,
4. date received by mental health,
5. date resolved.

Since July 2014 there have been a total of 120 behavioral health checklists and sick call requests. During the initial tracking there were several examples of significant delays between the time received by medical and the time received by mental health. However, since September 9, 2014, there were no delays in the delivery of these documents to mental health. The psychiatrist has done an excellent job in seeing people promptly upon receipt of the sick call request or referral from security.

RECOMMENDATIONS:

1. The development of the current log is a significant improvement for the facility. It is recommended that these logs be maintained in electronic form to ease the manipulation of the data for quality improvement study purposes.
2. The mental health log should indicate whether the document received is a sick call request or a behavioral checklist generated by a correctional officer for tracking purposes.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This is already dealt with under letter (c), including recommendations for this provision.

RECOMMENDATIONS: This is already dealt with under letter (c), including recommendations for this provision.

MENTAL HEALTH FINDINGS: The psychiatrist has created and implemented an Excel worksheet that provides information on all indicators previously recommended by this monitor to aid her in ensuring inmates are seen for timely follow-up. Once a mental health professional is hired, this tracking form will also enable her to track whether they are being seen in counseling too. While on site the psychiatrist and I electronically modified the current form to make it easier to sort the data and also added some fields useful in monitoring the caseload.

RECOMMENDATIONS: Continue using the tracking form.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This section addresses the medical chronic care program. Our record review demonstrated both an absence of care being provided as well as a delay in care being provided, along with an absence of collection of required data by the clinician per the policy and this was frequently due to utilization of the wrong form (initial vs. follow-up) by the clinician. The chronic care clinician has not been conscientiously adhering to his agreed upon schedule. Examples follow.

Patient #1
This is a 56-year-old female whose record includes no problem list. The patient arrived in October of 2013. The screen identified both diabetes type 2 and hypertension. The form was not completely filled out correctly and there have been no follow-up visits until recently. This patient, based on degree of control, should have been seen within a month. The initial form was not completely filled out. The patient was on insulin as well as medications for the diabetes type 2 and hypertension. The form lacked the page for documenting objective data as well as assessment. The patient was seen recently on 9/15/14. The clinician did not use the appropriate follow-up visit form. The lab report in the record showed the diabetes hemoglobin A1c was 10.2, which is consistent with poor control and requires a follow-up visit in one month or less.

Patient #2
This is a 74-year-old with hypertension and type 2 diabetes who entered in June of 2014. His initial chronic care visit was documented on 7/18, which is more than a month after intake. According to the acuity scale, this patient should have been seen within three days for his initial comprehensive assessment, which could also have included a chronic care visit. He was on medication for his diabetes and hypertension. He received no medications until one week after the delayed initial chronic care visit. The incorrect chronic care form was used, thus a follow-up visit form was used rather than an initial visit form, and therefore the subjective data collected was insufficient. The patient was assessed as being in fair control for both the diabetes and the hypertension, but a 90-day rather than a 60-day follow-up was scheduled. The initial labs were not ordered and even though the initial assessment was done on the day of the screening, labs were not ordered at that time either.

Patient #3
This is a 59-year-old who arrived in August 2013 with diabetes and asthma. He was seen in chronic care on 11/29/13, but then had no follow up until August 2014. At that visit, his diabetes was assessed as being in fair control even though there had been no recent lab data for one year, including his hemoglobin A1c. Thus the assessment of fair control was made based on data that was a year old. At the 2014 visit, none of the appropriate laboratory tests were ordered.

The log used to track chronic care must include a field which explains why the patient was not seen on the scheduled date. When the reason is patient refusal, there must be a signed refusal in the chart. The other reasons may be absence of custody resources or absence of clinicians. In either case, the patient must be rescheduled. If the reason is patient was released that should also be documented.

RECOMMENDATIONS:

1. The clinicians must be retrained on the chronic care guidelines and the appropriate use of the initial and follow up forms. This should be done by the Medical Director.
2. Add a field that explains why the patient was not seen. If the reason is patient refusal, there must be a signed refusal in the medical record. If the reason is absence of custody support or absence of clinician, the patient must be rescheduled. If the reason is patient was released that should also be documented.

MENTAL HEALTH FINDINGS: The mental health program remains without written clinical practice guidelines for chronic and acute psychiatric/mental health assessment, care, and follow-up. Clinical policies and procedures should be grounded in written evidence-based clinical practice guideline for the inmate population and include assessment, treatment, and care for all conditions of

mental illness. Following websites are provided to assist GGACF health care staff develop and implement clinical mental health practice guidelines for this population:

1. American Psychiatric Association Clinical Practice Guidelines at: http://www.psychiatry.org/practice/clinical-practice-guidelines
2. United States Veterans Administration Clinical Practice Guidelines at: http://www.healthquality.va.gov/
3. International Society for Traumatic Stress Clinical Practice Guidelines at: http://www.istss.org/InternationalPracticeGuidelines.htm
4. United States Department of Health and Human Services, AHRQ Clinical Practice Guidelines Clearinghouse at: http://www.guideline.gov/content.aspx?id=33135

RECOMMENDATIONS: Develop and implemented evidence-based, written mental health clinical practice guidelines for assessment, treatment, and follow-up up.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There is a draft emergency services policy which lacks provisions addressing urgent problems. We had a discussion and provided a policy from another facility which had been approved through the DOJ process as a basis for helping understand what should be included. We did review some records and this describes some of these cases. The biggest problems are related to the periods when there are no nurses available onsite. This should be mitigated by expansion of the availability of hours to initially 12 hours and ultimately 16 hours of onsite nursing service. Those problems relate to inappropriate assessment before the patient is sent offsite, but there are also problems about follow up by a clinician upon return.

Patient #1
This is a 24-year-old who was sent out on 8/3/14 for self-inflicted injuries. He was seen at 11:00 at night and sent out. There were no health staff involved since there is no coverage by health staff after 8:00 p.m. He returned within a few hours, which again means there were no health staff involved. He has had no follow-up on return and as far as we could see no referral for onsite services. Finally, on 8/15 he saw a nurse and appeared paranoid and not eating for two weeks. There was no weight taken and there were no orthostatic blood pressures, and as far as we can tell there was still no site referral.

Patient #2
This is a 42-year-old seen on 8/11/14 by a physician and sent out to the emergency room for chest pain. He returned the following day with a diagnosis of costochondritis and was appropriately followed up by the physician. None of the patients, either on return or subsequently, had the appropriate emergency room report in their record to be utilized by the follow up physician for both patient education and for scheduling appropriate follow up.

Patient #3
This is a 24-year-old sent out for a facial contusion on 8/14/14 from a basketball injury. He was sent to the emergency room but had no follow up until three weeks later. There is no ER report.

Patient #4
JL 251259 This is a 29-year-old sent out on 8/25/14 for chest pain. He also had no follow-up visit until a sick call request on 9/3, and at that point was referred to the physician. There was also no emergency room report.

We do not have documented training of staff by a Medical Director regarding recognizing serious injuries and life-threatening problems. There is also no training by the Medical Director in first aid procedures for serious injuries and life-threatening conditions, and other than in the basic officer training, there is no training to recognize and timely respond to emergency medical crisis.

RECOMMENDATIONS:

1. The offsite service coordinator must insure that the emergency room report is made available to the facility timely (this may require a high level discussion between the hospital and the HSA and Medical Director).
2. The Medical Director should provide the training to officers and this should be documented in their training file.
3. The unscheduled services log should contain a field for whether the patient was seen in follow up and if not, the explanation as to why not and if the explanation is absence of clinician or custody, the patient must be rescheduled.

MENTAL HEALTH FINDINGS: Mental health training was provided by the mental health professional from St. Thomas after our last site visit. The psychiatrist provided additional training for security and health staffs and plans on developing the curriculum for future training for correctional officers and health staff at GGACF.

Security staff continues to generate excellently detailed and useful behavioral checklist referrals to mental health.

RECOMMENDATIONS:

1. Future training curricula will need to be presented to the monitoring team for review and approval.
2. Continue tracking timeliness in response to behavioral checklists.
3. A continued reminder by supervisory staff regarding the location and use of cut down tools is needed and can be enhanced by incorporating these tools into disaster drill scenarios.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: The Health Services Administrator has appointed an offsite service coordinator who is responsible for both scheduling and retrieving the offsite service documents, be they consultations or procedures or emergency services reports. She has been logging all of these things. Although we had difficulty finding some of the reports in the record, she was able to find them and the log had documented that they were available. This is a problem related to filing which must be addressed. Her log does include a field for follow-up visits and some of these cases documented both reports and follow-up visits, but we could not find either the report in the chart or the follow-up visit note. Chart notes continue to be incomplete. Examples follow.

Patient #1
This is a 60-year-old who arrived in Early May. In early August, a note requests a urology appointment. This appointment was scheduled for 8/12. We could not find the report in the chart. The offsite service coordinator was ultimately able to find it. The log indicated the follow-up appointment had occurred, but there was no note in the chart documenting a follow-up visit.

Patient #2
This patient was scheduled for an appointment with gastroenterology services in mid-August. Unfortunately, the note from the gastroenterologist only indicates, "change meds and follow up by physician." There is no explanation of what was found and why the changes.

Patient #3
This is a 23-year-old who has no problem list in his chart and there was an order for an ultrasound to be requested in mid-July. The ultrasound was performed on 8/1 and the report was not reviewed until 8/18, almost three weeks later. There is a note, however, on the report itself which indicates this report was discussed with the patient.

Patient #4
This is a 72-year-old seen by the chronic care physician mid July, who ordered a Doppler and a special stress test to be done off-island. He did have an echo done in the chronic care physician's office but he has not yet brought in the report. He also had a Doppler study which showed narrowing of an artery in each leg and the follow-up was scheduled to be done on the Friday of our visit.

RECOMMENDATIONS:

1. Retrieved reports must be brought to the appropriate physician or Medical Director for review and signature and follow up must be carried out, including a follow-up visit with the patient.
2. The offsite service coordinator should be in touch with the chronic care physician's office in order to retrieve reports of procedures done at his office.
3. The chronic care log should be created and it should include a field for whether the patient was seen as scheduled and if not seen, the reason for the patient not being seen must be identified. If that reason is absence of custody or of clinician the patient must be rescheduled.

MENTAL HEALTH FINDINGS: defer to Dr. Shansky's report

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This has been discussed under number v.

RECOMMENDATIONS: See number v.

MENTAL HEALTH FINDINGS: defer to Dr. Shansky's report

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We discussed this with the Medical Director and provided him a policy that has been approved in a DOJ process from another facility. He is to work with the HSA and draft both the policy and individual substance guidelines for both alcohol and substance intoxication and withdrawal.

RECOMMENDATIONS:

1. The Medical Director in working with the HSA should draft both a policy on intoxication and detoxification from substances including alcohol, opiates and benzodiazepines.

MENTAL HEALTH FINDINGS: defer to Dr. Shansky's report

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There has been only one full-time registered nurse; a second registered nurse started the day of our arrival. Therefore, it is not surprising that the infection control program has not yet been developed. The focus of an infection control program in a correctional setting should be based on tuberculosis screening as well as response to suspect cases, the monitoring and management of acute skin infections and the identification, monitoring and reporting of sexually transmitted diseases. The intake process, which includes a TB skin test, should include documentation of the results in the record and this should be done timely. Each day the person who records the results should pull the records and document them directly in the chart.

RECOMMENDATION:

1. Discuss with the monitoring staff the requirements of an infection control nurse.

MENTAL HEALTH FINDINGS: defer to Dr. Shansky's report

RECOMMENDATIONS: defer to Dr. Shansky's report

i. Adequate suicide prevention, including:

(i) the immediate referral of any prisoner with suicide or serious mental health needs to an appropriate mental health professional;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: Due to time constraints during this site visit the monitor was unable to review officers' logs in an effort to identify anyone placed on observation by security but unknown to the mental health service. There are, however, many examples of behavioral checklists completed and submitted in timely fashion to mental health when an officer identifies unusual or concerning behaviors.

A chart reviewed upon referral by Ms. Brett, USDOJ, was of an inmate seen for intake in late July, 2014 who was noted to be uncooperative. His medical intake three days later was negative for mental health issues and no referrals were generated. Mid-August, 2014 there is a notification that he was refusing meals and medications because he had found a roach in his oatmeal and believed that the jail was trying to poison him. At that time a licensed practical nurse asked the officer to fill out a behavioral checklist rather than generate one herself. Four days prior to that encounter the inmate had been seen for self-inflicted lacerations of his arms at the hospital emergency department. The inmate was released from jail on August 22, 2014. This case highlights several issues:

1. the reluctance by medical staff to initiate an emergency referral to psychiatry
2. improper management due to a lack of follow-up regarding his emergency department visit and
3. the report to the nurse that he was avoiding food which should have generated a medical referral for, at a minimum, weights, vital signs, and counseling

These issues need to be corrected.

RECOMMENDATIONS:

1. The service is encouraged to create an electronic suicide watch log that would contain information useful in future quality improvement projects. Recommended data fields would include at a minimum:
   a. the inmates name
   b. BOC#
   c. date of referral, if one is made
   d. date and time placed on suicide watch

e. an indication of what level of suicide watch the inmate was initially placed on
f. date and time a suicide watch level is changed
g. date and time the inmate is removed from suicide watch
h. date of completion of the post-24-hour risk assessment
i. date of completion of the post one week risk assessment
j. date of completion of any other post-suicide watch risk assessment

2. Any evidence of food avoidance should prompt a medical evaluation and possible initiation of a hunger strike protocol, if warranted.
3. A hunger strike policy should be developed.
4. Information concerning any recent self-inflicted laceration should generate an urgent referral by any staff person observing or receiving the report of this type of behavior to mental health.

(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: No records were identified for review that would enable monitoring of this provision during this visit.

RECOMMENDATIONS: Complete and implement suicide policies and protocols upon approval.

(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: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: At the current time a suicide risk assessment instrument is not developed and in use.

RECOMMENDATIONS:

1. An Internet search for a suicide risk assessment tool will provide links to multiple websites. Staff can review the assessment tools located on the Internet and determine if any would be pertinent to the facility as is or with modifications. The SAMSHA website has links to several free instruments including the Columbia suicide risk assessment tool which has Internet training available. It is important, however, that suicide detection assessment tools used are validated for jail settings and the specific population being assessed.

2. Screening Tools Assessing Risk of Suicide and Self-Harm in Adult Offenders: A Systematic Review at: http://ijo.sagepub.com/content/early 2010/03/11/ 0306624X09359757. abstract

   This systematic review assessed the validity of screening instruments to identify the risk of suicide and self-harm behavior in offenders. A search of 11 electronic databases and grey literature resulted in the inclusion of five studies. The five studies revealed four screening instruments, including the

Suicide Checklist, the Suicide Probability Scale, Suicide Concerns for Offenders in Prison Environment (SCOPE), and the Suicide Potential Scale. Two instruments, SCOPE and Suicide Potential Scale, shared promising levels of sensitivity and specificity. The reporting of information was generally varied across items on the Standards for the Reporting of Diagnostic accuracy (STARD). Research is needed to assess the predictive validity of tools for offender populations in the identification of those at risk, particularly those in probation and community settings.

3. Develop for approval valid suicide screening and assessment tools for initial and follow-up screening purposes.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: For the fifth consecutive assessment, the A-Dorm officer reported having no cut-down tool. Additionally, the officer working in detention housing unit was not able to locate a cut-down tool; the tool was later found and presented by another officer. It seems obvious that recommendations pertaining to quality control that ensures the presence of cut-down tools as required is not being followed. The presence of this tool is vital to ensure that if suicide is attempted by an inmate, staff have the tools at their disposal to potentially save the inmate's life.

RECOMMENDATIONS:

1. Cut-down tools must be readily available in all housing units and all officers must be able to rapidly locate and obtain those tools when needed. The tools should be stored in exactly the same location in each housing unit. This will help to ensure consistent and reliable access by staff
2. Cut down tools should be available in all housing areas, and areas where inmates could have an opportunity to harm themselves, i.e. kitchen, medical building, etc.
3. All staff required to use this tool should be well-trained and emergency drills demonstrating proficient use of the tool should be conducted on a regular basis.
4. Supervisors should regularly inventory and audit tool location and make immediate provisions to replace missing or non-functioning tools when found.

(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: The Territory conducted Suicide Prevention and Mental Health training in September involving many staff. Instructor qualifications, curriculum, lesson plans, course hand-outs, and pre/post tests were provided to this Monitor for review. Course instructors appeared well qualified and the training materials were well organized and professionally developed but are considered very basic and somewhat inaccurate. For example, the "Facts about Suicide" Power Point slide used in this training reports that "*Jail suicide is 9 times higher than in the general pop[ulation]."* This comparative prevalence information is inconsistent with national research. According to the U.S. Bureau of Justice Statistics, the 2012

per 100,000 inmate suicide rate for jails and prisons was 40 and 16 respectively. By comparison, the American Association of Sociology reported the national suicide at 12.9 – a rate difference of 3.1 higher for jail inmates and 1.24 higher for prison inmates. It is very important that the suicide prevention training program present accurate and current facts.

Although this training does not meet the requirements of this Provision for several reasons explained below, the training nonetheless seems important and valuable.

This training failed to meet the requirements of this Provision for the following reasons:

1. Lesson plans did not include scenario-based instructional methods;
2. Lesson plans did not include any related policies, procedures, or forms related to suicide detection, intervention, housing, management, aftercare;
3. Lesson plans did not include use of cut-down tools;
4. Demonstration of proficiency was not determined or it was not reported to this Monitor;
5. All required staff did not complete the training;
6. Training information was not corrections-specific;
7. Training did not include current research or "best-practices" in correctional suicide detection, intervention, management, aftercare.

RECOMMENDATIONS: In addition to the previous recommendations reiterate below, all suicide prevention training must:

1. Comply with the elements of this Provision as stated above;
2. Be corrections-specific;
3. Base lesson plans on current research with regard to:

    a. Inmate populations and characteristics relevant to suicide risks
    b. Prevalence of suicides and suicidal behavior in correctional settings
    c. Conditions and circumstances relevant to risk of suicide
    d. Locations in facilities
    e. Effects of solitary confinement
    f. Methods of suicide in correctional settings
    g. Instruments and items used to attempt/commit suicide
    h. Safe housing

Staff Training

The essential component to any suicide prevention program is properly trained staff, who form the backbone of any correctional facility. Very few suicides are actually prevented by mental health, medical or other professional staff because suicides are usually attempted in housing units, and often during late evening hours or on weekends when they are generally outside the purview of program staff. These incidents, therefore, must be thwarted by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about suicidal inmates. Correctional staff are often the only personnel available 24 hours a day; thus, they form the front line of defense in preventing suicides.

All correctional, medical, and mental health personnel, as well as any staff who have regular contact with inmates, should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. The initial training should include administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, guiding principles to suicide prevention, inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the facility's suicide prevention policy, and liability issues associated with inmate suicide. The two-hour refresher training should include a review of administrator/staff attitudes about suicide and how negative attitudes impede suicide prevention efforts, predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, and review of any changes to the facility's suicide prevention plan. The annual training should also include general discussion of any recent suicides and/or suicide attempts in the facility. In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, "mock drills" should be incorporated into both initial and refresher training for all staff.

Identification/Referral/Evaluation

Intake screening and ongoing assessment of all inmates is critical to a correctional facility's suicide prevention efforts. It should not be viewed as a single event, but as an ongoing process because inmates can become suicidal at any point during their confinement, including the initial admission into the facility; after adjudication when the inmate is returned to the facility from court; following receipt of bad news or after suffering any type of humiliation or rejection; confinement in isolation or segregation; and following prolonged a stay in the facility. In addition, although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide. Research consistently reports that approximately two-thirds of all suicide victims communicate their intent some time before death, and that any individual with a history of one or more suicide attempts is at a much greater risk for suicide than those who have never made an attempt.

Intake screening for suicide risk may be contained within the medical screening form or as a separate form. The screening process should include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that the inmate is currently at risk. Specifically, inquiry should determine the following:

- Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates inmate is a medical, mental health or suicide risk now?
- Have you ever attempted suicide?

- Have you ever considered suicide?
- Are you now or have you ever been treated for mental health or emotional problems?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Are you thinking of hurting and/or killing yourself?

Although an inmate's verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate's denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise. The process should also include referral procedures to mental health and/or medical personnel for a more thorough and complete assessment.

The intake screening process should be viewed as similar to taking your temperature, it can identify a current fever, but not a future cold. Therefore, following the intake screening process, should any staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for suicide, a procedure should be in place that requires staff to take immediate action to ensure that the individual is constantly observed until appropriate medical, mental health, and/or supervisory assistance is obtained.

Finally, given the strong association between inmate suicide and isolation/special management (e.g., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by medical or mental health staff upon admission to the placement.

The screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in inmates. This process, coupled with staff training, will only be successful if an effective method of communication is in place at the facility.

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. There are essentially three levels of communication in preventing inmate suicides: between the arresting/transporting officer and correctional staff; between and among facility staff (including correctional, medical and mental health personnel); and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. At Level 1, what an arrestee says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting officers should pay close attention to the arrestee during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information

regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

At Level 2, effective management of suicidal inmates is based on communication among correctional personnel and other professional staff in the facility. Because inmates can become suicidal at any point during confinement, correctional staff must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility's shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of all inmates on suicide precautions. Multidisciplinary team meetings (to include correctional, medical and mental health personnel) should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

At Level 3, facility staff must use various communication skills with the suicidal inmate, including active listening, staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

Poor communication between and among correctional, medical, and mental health personnel, as well as outside entities (e.g., arresting or referral agencies, family members) is a common factor found in the reviews of many custodial suicides. Communication problems are often caused by lack of respect, personality conflicts and boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

Housing

In determining the most appropriate housing location for a suicidal inmates, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate since the use of isolation escalates the sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, and straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In

addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Levels of Observation/Management

In regard to suicide attempts in correctional facilities, the promptness of the response is often driven by the level of supervision afforded the inmate. Medical evidence suggests that brain damage from strangulation caused by a suicide attempt can occur within 4 minutes, and death often within 5 to 6 minutes. Two levels of supervision are generally recommended for suicidal inmates: close observation and constant observation.

Close Observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. Staff should observe such an inmate in a protrusion-free cell at staggered intervals not to exceed every 10 minutes (e.g., 5, 10, 7 minutes).

Constant Observation is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis. In some jurisdictions, an intermediate level of supervision is utilized with observation at staggered intervals that do not exceed every 5 minutes.

Other aids (e.g., closed-circuit television, cell mates) can be used as a supplement to, but never as a substitute for, these observation levels.

In addition, mental health staff should assess and interact with (not just observe) the suicidal inmate on a daily basis. The daily assessment should focus on the current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., "What are your current feelings and thoughts?" "Have your feelings and thoughts changed over the past 24 hours?" "What are some of the things you have done or can do to change these thought and feelings?" etc.)

An individualized treatment plan (to include follow-up services) should be developed for each inmate on suicide precautions. The plan should be developed by qualified mental health staff in conjunction with not only the inmate, but medical and correctional personnel. The treatment plan should describe signs, symptoms, and the circumstances under which the risk for suicide is likely to recur, how recurrence of suicidal thoughts can be avoided, and actions the inmate and staff will take if suicidal ideation reoccurs.

Finally, due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide

precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is not any nationally-acceptable schedule for follow-up, a suggested assessment schedule following discharge from suicide precautions might be: 24 hours, 72 hours, 1 week, and periodically until release from custody.

Intervention

Following a suicide attempt, the degree and promptness of the staff's intervention often foretells whether the victim will survive. National correctional standards and practices generally acknowledge that a facility's policy regarding intervention should be threefold. First, all staff who come into contact with the inmate should be trained in standard first aid procedures and CPR. Second, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit's emergency response bag (that should include a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool). Third, correctional staff should never presume that the victim is dead, but rather should initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all equipment utilized in responding to an emergency within the facility is in working order on a daily basis.

Finally, although not all suicide attempts require emergency medical intervention, all suicide attempts should result in immediate intervention and assessment by mental health staff.

Reporting

In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command. Following the incident, the victim's family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim before the incident should be required to submit a statement including their full knowledge of the inmate and incident.

Follow-Up/Mortality-Morbidity Review

An inmate suicide is extremely stressful for both staff and other inmates. Staff may also feel ostracized by fellow personnel and administration officials. Following a suicide, misplaced guilt is sometimes displayed by a correctional officer who wonders: "What if I had made my cell check earlier?" Inmates are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and inmates are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, and mental health personnel), provides affected staff and inmates an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of

dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Every completed suicide, as well as serious suicide attempt (i.e., requiring medical treatment and/or hospitalization), should be examined through a mortality-morbidity review process. If resources permit, clinical review through a psychological autopsy is also recommended. Ideally, the mortality-morbidity review should be coordinated by an outside agency to ensure impartiality. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include a critical inquiry of: 1) the circumstances surrounding the incident; 2) facility procedures relevant to the incident; 3) all relevant training received by involved staff; 4) pertinent medical and mental health services/reports involving the victim; 5) possible precipitating factors leading to the suicide or serious suicide attempt; and 6) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: See f.iv.

RECOMMENDATIONS: Annual disaster drills should include scenarios with response to a mental health emergency/suicide and be documented in a file maintained by the training supervisor.

Previous Recommendations Remain Appropriate:

1. Immediately develop and implement comprehensive pre and in-service suicide prevention training that is 1) evidence based, 2) policy and procedure driven, 3) includes valid and reliable knowledge and application competency evaluation methods. Such training would naturally include detection, recognition, assessment, and intervention topics and materials.
2. Implement policies, procedures, and protocols that govern and control staff response regarding inmate behavioral and/or verbal indications of suicide risk. Governing documents must require initial and ongoing involvement of medical and mental health staff in the response to suicide prevention actions.
3. Suicide prevention is considered a life safety issue that requires, at minimum, quarterly suicide prevention drills involving correctional, medical, and mental health staff to ensure 1) training and response efficacy, 2) effectiveness of policy and procedure, and 3) compliance with the Agreement.

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: GGACF remains without a suicide resistant cell. Construction is well underway to create a new dental suite, medical observation cell, and two mental health observation/suicide prevention rooms. This new area will have the nursing station

directly outside the window of the identified suicide prevention room. In addition, there will be a security officer's desk steps away.

Suicide resistant gowns and blankets have been purchased and are on site. Soft four-point restraints are also on site but as yet there is no restraint bed available. Staff will need to ensure that there are no ligature points in the suicide prevention rooms. Retrofitting of those rooms should occur prior to the placement of any inmates in those cells.

RECOMMENDATIONS: Continue with the current modifications to the medical treatment building.

The appropriate forms documenting the clinicians orders for security implementation should be developed and then vetted through the process in the settlement agreement

Previous Recommendations Remain Appropriate:

1. Appropriate bedding, clothing, food and utensils, property, and pallet should be specified by the mental health clinician when supervising officer placing an inmate on suicide watch.
2. Retrofit cells designated suicide precautions to be suicide proof.
3. Renovation of an intake cell may be the only immediate alternative. If this environment is utilized, then the facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates.
4. The following guidelines should be considered when establishing suicide-resistant housing environments:[1]

The safe housing of suicidal inmates is an important component to a correctional facility's comprehensive suicide prevention policy. Although impossible to create a "suicide-proof" cell environment within any correctional facility, given the fact that almost all inmate suicides occur by hanging, it is certainly reasonable to ensure that all cells utilized to house potentially suicidal inmates are free of all obvious protrusions. And while it is more common for ligatures to be affixed to air vents and window bars (or grates), *all* cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures have been used as anchoring devices in hanging attempts. As such, to ensure that inmates placed on suicide precautions are housed in "suicide-resistant" cells, facility officials are strongly encouraged to address the following architectural and environmental issues:

1. Cell doors should have large-vision panels of Lexan (or low-abrasion polycarbonate) to allow for unobstructed view of the entire cell interior at all times. These windows should <u>*never*</u> be covered (even for reasons of privacy, discipline, etc.) If door sliders are not used, door interiors should not have handles/knobs; rather they should have recessed door pulls. Any door containing a food pass should be closed and locked. Interior door hinges should bevel down so as not to permit being used as an anchoring device. Door frames should be rounded and smooth on the top edges. The frame should be grouted into the wall with as little edge exposed as possible.

[1] http://www.ncianet.org/services/suicide-prevention-in-custody/publications/checklist-for-the-suicide-resistant-design-of-correctional-facilities/

In older, antiquated facilities with cell fronts, walls and/or cell doors made of steel bars, Lexan paneling (or low-abrasion polycarbonate) or security screening (that has holes that are ideally 1/8 inches wide and no more than 3/16 inches wide or 16-mesh per square inch) should be installed from the ***interior*** of the cell.

Solid cell fronts must be modified to include large-vision Lexan panels or security screens with small mesh;

2. Vents, ducts, grilles, and light fixtures should be protrusion-free and covered with screening that has holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

3. Wall-mounted corded telephones should ***not*** be placed inside cells. Telephone cords of varying length have been utilized in hanging attempts;

4. Cells should ***not*** contain any clothing hooks. The traditional, pull-down or collapsible hook can be easily jammed and/or its side supports utilized as an anchor;

5. A stainless steel combo toilet-sink (with concealed plumbing and outside control valve) should be used. The fixture should ***not*** contain an anti-squirt slit, toothbrush holder, toilet paper rod, and/or towel bar;

6. Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath. If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

7. Electricity should be turned off from wall outlets outside of the cell;

8. Light fixtures should be recessed into the ceiling and tamper-proof. Some fixtures can be securely anchored into ceiling or wall corners when remodeling prohibits recessed lighting. All fixtures should be caulked or grouted with tamper-resistant security grade caulking or grout. Ample light for reading (at least 20 foot-candles at desk level) should be provided. Low-wattage night light bulbs should be used (except in special, high-risk housing units where sufficient lighting 24 hours per day should be provided to allow closed-circuit television (CCTV) cameras to identify movements and forms).
   An alternative is to install an infrared filter over the ceiling light to produce total darkness, allowing inmates to sleep at night. Various cameras are then able to have total observation as if it were daylight. This filter should be used only at night because sensitivity can otherwise develop and produce aftereffects;

9. CCTV monitoring does ***not*** prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should ***only*** supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around

the housing should be caulked or grouted. Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color. CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including *all* four corners of the room. Camera lens should have the capacity for both night and low light level vision;

10. Cells should have a smoke detector mounted flush in the ceiling, with an audible alarm at the control desk. Some cells have a security screening mesh to protect the smoke detector from vandalism. The protective coverings should be high enough to be outside the reach of an inmate and far enough away from the toilet so that the fixture could not be used as a ladder to access the smoke detector and screen. Ceiling height for new construction should be 10 feet to make such a reasonable accommodation. Existing facilities with lower ceilings should carefully select the protective device to make sure it cannot be tampered with, or have mesh openings large enough to thread a noose through. Water sprinkler heads should not be exposed. Some have protective cones; others are flush with the ceiling and drop down when set off; some are the breakaway type;

11. Cells should have an audio monitoring intercom for listening to calls of distress (*only* as a supplement to physical observation by staff). While the inmate is on suicide precautions, intercoms should be turned up high (as hanging victims can often be heard to be gurgling, gasping for air, their body hitting the wall/floor, etc.);

12. Cells utilized for suicide precautions should be located as close as possible to a control desk to allow for additional audio and visual monitoring;

13. If modesty walls or shields are utilized, they should have triangular, rounded or sloping tops to prevent anchoring. The walls should allow visibility of both the head and feet;

14. Some inmates hang themselves under desks, benches, tables or stools/pull-out seats. Potential suicide-resistant remedies are: (a) Extending the bed slab for use as a seat; (b) Cylinder-shaped concrete seat anchored to floor, with rounded edges; (c) Triangular corner desk top anchored to the two walls; and (d) Rectangular desk top, with triangular end plates, anchored to the wall. Towel racks should also be removed from any desk area;

15. All shelf tops and exposed hinges should have solid, triangular end-plates which preclude a ligature being applied;

16. Cells should have security windows with an outside view. The ability to identify time of day via sunlight helps re-establish perception and natural thinking, while minimizing disorientation. If cell windows contain security bars that are not completely flush with window panel (thus allowing a gap between the glass and bar for use as an anchoring device), they should be covered with Lexan (or low-abrasion polycarbonate) paneling to prevent access to the bars, or the gap, should be closed with caulking, glazing tape, etc.
    If window screening or grating is used, covering should have holes that are ideally 1/8 inches wide, and no more than 3/16 inches wide or 16-mesh per square inch;

17. The mattress should be fire retardant and not produce toxic smoke. The seam should be tear-resistant so that it cannot be used as a ligature;

18. Given the fact that the risk of self-harm utilizing a laundry bag string outweighs its usefulness for holding dirty clothes off the floor, laundry bag strings should be removed from the cell;

19. Mirrors should be of brushed, polished metal, attached with tamper-proof screws;

20. Padding of cell walls is prohibited in many states. Check with your fire marshal. If permitted, padded walls must be of fire-retardant materials that are not combustible and do not produce toxic gasses; and,

21. Ceiling and wall joints should be sealed with neoprene rubber gasket or sealed with tamper-resistant security grade caulking or grout for preventing the attachment of an anchoring device through the joints.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: At the current time there are no inmate records for review of constant supervision pertaining to suicide prevention. However, there is one man who assaulted a female officer in the segregation unit. He has a long-standing chronic serious mental illness. The medical staff and security removed him from segregation and have modified an office in the clinic into a medical observation room. This man is currently living in this room under the constant supervision of an officer until such time as a better accommodation is available. This has resulted in one fewer mental health interviewing rooms available in the clinic. It is also an inappropriate long term housing solution as the office has not been adequately retrofitted. It is my understanding that the BOC is attempting to locate a facility on the mainland capable of managing a seriously mentally ill inmate with physical and classification limitations.

RECOMMENDATIONS: GGACF should develop a suicide prevention observation log form that allows for officers' entries of their staggered 15 minute checks.

Previous Recommendations Remain Appropriate:

1. Suggest a separate inmate log be developed for inmates placed on watch that can be filed in the medical record or by security. This log could indicate property allowed and whether the inmate is on constant or staggered 15-minute watches.
2. The facility needs a policy that reflects the current capabilities and provides the greatest amount of supervision required to safely monitor someone on suicide watch.
3. Renovation of an intake cell may be the only immediate alternative. If this environment is utilized, then the facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates.

4. Suggest a separate inmate log be developed for inmates placed on watch that can be filed in the medical record or by security. This log could indicate property allowed and whether the inmate is on constant or staggered 15-minute watches.

(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 - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: There are currently no clinical cases to review for compliance to this provision.

RECOMMENDATIONS: The suicide prevention policy directing this process is currently under review.

Previous Recommendations Remain Appropriate:

1. The facility needs a policy that reflects the current capabilities and provides the greatest amount of supervision required to safely monitor someone on suicide watch.
2. It is recommended that the facility develop a form listing each level of observation that would also specify what property the inmate is allowed to have in their possession as well as indicating which staff member has ordered the watch and property restrictions. Consultation with the monitoring team may be a useful assistance.
3. The facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates if they continue to be housed in the reception area.
4. The facility needs a policy that reflects the current capabilities and provides the greatest amount of supervision required to safely monitor someone on suicide watch.
5. Renovation of an intake cell may be the only immediate alternative.
6. If this environment is utilized then the facility needs to carefully monitor how readily medical and mental health staff can maintain daily contact with the inmates.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We have identified the need for more regular clinician hours. We have been informed that the Medical Director will be available three days per week and a fill-in physician will be available three days per week on the weeks that the Medical Director is not available. The second contract must be obtained and the Medical Director position must be solidified by also resolving the licensed pharmacist issues. The Territory also must resolve payment issues in order

to retain qualified staff – we understand that the Medical Director has not been paid consistently for his services, and non-payment may result in the Medical Director's resignation.

Also, there are to be four registered nurses, one of which positions will be split between two half-time nurses, each working the weekends. There will also be a third LPN who will complement the two existing LPNs. There must also be hired a permanent medical records technician. These are by our determination the medical staffing needs at present.

RECOMMENDATIONS:

1. Fill the two RN positions who are each identified as half time, thus completing the fourth full-time RN position.
2. Solidify both the Medical Director hours and the fill-in clinician hours so that there are regularly scheduled visits for a clinician including sick call follow up, offsite service follow up and where necessary, chronic care visits and initial health appraisal visits along with urgent care visits.
3. Fill the vacant licensed pharmacist position or contract.
4. Fill the LPN position.
5. Fill the permanent medical records clerical position.

MENTAL HEALTH FINDINGS: Current staffing allows for a part-time psychiatrist and one full-time qualified mental health professional. The latter position is currently unfilled. No formal staffing analysis has been provided for review. However, at the current time since the facility lacks a mental health programming vision, it would be difficult for them to develop a staffing plan to meet the unknown needs.

RECOMMENDATIONS:

1. As previously discussed, leadership will begin to develop an initial plan for presentation at the next site visit of what their desired mental health program will look like. Based on that outline and my prior recommendations the preliminary staffing needs analysis can then be performed and reviewed by the monitoring team.
2. It is my opinion that the current psychiatric (psychiatrist) staffing for this site is quite sufficient. However the supporting staff position is insufficient to meet the needs of the inmate population and will be elaborated in the following sections.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: Without a doubt, staffing must increase to meet the needs of the inmate population. In the meantime, the Territory can take some steps to alleviate the burdens on current staff. For example, the exam rooms in the housing units must be cleaned, sanitized and appropriately equipped, thus potentially reducing some needs for medical transport onsite to the clinic. On the other hand, an officer does need to accompany the medication nurse both mornings and evenings, seven days per week. In addition, there should be a second officer working with the

current officer in the clinic area which will soon also include an infirmary area and two officers will manage that population.

RECOMMENDATIONS:

1. Fill a correctional officer position to work with the medication nurses mornings and evenings to accompany the nurse and work as a team with that nurse.
2. Provide a second correctional officer for the clinic/infirmary area.
3. There should be a medical van and offsite service medical transporters.
4. The exam rooms in the housing unit should be cleaned and sanitized and appropriately equipped in order to reduce the onsite escort needs.

MENTAL HEALTH FINDINGS: Correctional officer staffing levels remain inadequate to ensure compliance with this Provision. Required training curricula does not sufficiently address all subject matter required.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate:

1. Develop staffing policies and procedures that reflect facility and population needs.
2. Develop staffing documents that allow for accurate and timely tracking of staffing levels, shift and duty assignments, work locations, and shortages.
3. Ensure staff members are properly trained in all aspects of their respective duty assignments working with special needs and mentally ill inmates.
4. Provide Monitor with accurate, complete, and up-to-date staffing schedules as described above.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There is a QI policy. We are emphasizing that by utilizing the logs and improving them as recommended, the HSA could begin monitoring the following services:

1. Intake processing for completeness and timeliness
2. Sick call for timeliness
3. Urgent care for completeness and timeliness, including offsite emergency room reports
4. Scheduled offsite services for completeness and timeliness, including offsite service report
5. Chronic care visits for timeliness
6. Dental services for timeliness
7. Sick call for timeliness

RECOMMENDATIONS: Follow the above list of nine elements to begin the quality improvement program.

MENTAL HEALTH FINDINGS: No such protocol has been received by this monitor for assessment.

RECOMMENDATIONS: Please provide copies of the required protocol for review.

m. Adequate dental care;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There is an oral care policy which is close to final form but we have recommended some revisions. We have also learned that there continues to be a problem with access to the dentist due to escort problems as well as availability of the dentist in terms of his arrival per schedule at the facility. Until the policy has been finalized this area will remain in noncompliance. The dentist needs to insure his availability and custody staff needs to insure that they are bringing the patients to him. On the day of our visit when he was there all of the patients were seen, but from the records this was clearly an exception and not the rule. There must be a dental log including the reasons why patients are not seen; when the reason is absence of dentist or absence of custody, these patients must be rescheduled.

RECOMMENDATIONS:

1. The HSA should track both the availability of the dentist as well as the availability of custody escorts as part of the QI program.
2. The dental program should report to the QI program the numbers of scheduled patients and the numbers who arrive and the reason for non-arrival for each of the patients who did not arrive.
3. The above information should be reported to the QI program monthly.
4. The dental program should track the number of extractions and restorations performed each month and we will be able to review that data upon return.
5. Develop adequate dental care policies, procedures, and protocols.

MENTAL HEALTH FINDINGS: defer to Medical Findings.

RECOMMENDATIONS: defer to Medical Findings.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We provided the Territory with a policy from another institution in another jurisdiction which has been approved through the DOJ review. There have been no deaths since our last visit and we are waiting completion of the mortality review policy.

RECOMMENDATIONS:

1. Utilizing the policy we provided, redraft the mortality review policy.
2. This is a restatement of a prior recommendation: arrange for reports from offsite clinic encounters to be made available at the prison for patients seen for offsite infectious disease or gyne problems or any other problems be obtained by the offsite service coordinator.
3. Consider utilizing the services of an offsite service clinician to perform a death review on all deaths of patients incarcerated in Department of Corrections.

MENTAL HEALTH FINDINGS: No change since previous visit. There have been no deaths or suicide attempts reported for the mental health caseload since the time of our last visit. However, there has been a case that should be reviewed of an inmate with a serious mental illness who decompensated over several months' time, ended up in segregation without any disciplinary reports and then struck an officer.

RECOMMENDATIONS: Recommend a morbidity review for the case of the inmate housed in the MTB by the facility prior to our next audit. Please submit the reports and supporting documents (incident reports, etc.) generated by that review to the monitor's team for review.

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 - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We do have a draft segregation round policy. We have discussed issues regarding both the medical and mental health rounds and this draft is to be revised for our approval.

RECOMMENDATION: Previous Recommendation Remains Appropriate:

1. Draft the policy and procedure for segregation rounds for our review.

MENTAL HEALTH FINDINGS: Mental health rounds in segregation units are not occurring. In addition the women in X unit continued to report that medication pass still occurs at the outside gate to the housing unit and nurses rarely enter the unit (exceptions reported are mostly due to inclement weather). Inmates frequently have medical and mental health issues that are not reported to staff via a sick call request. Oftentimes this is a direct result of a mental illness that may cause the individual to be withdrawn or paranoid. It is essential that medical and mental health staff have direct visualization of these individuals in order to identify potential infectious diseases, undiagnosed medical illnesses, and signs of the onset of or reactivation of the mental illness. An example of this is a seriously mentally ill inmate in segregation seen by this auditor who had a highly infected right eye. When asked about this he informed this reviewer that he was placing menthol in his eye because it itched. This information was relayed to the medical director so proper health education could be provided to the inmate and so medical staff could conduct a physical examination of the inmate's eye for signs of injury.

RECOMMENDATIONS: In-service training to medical and mental health staff should be provided regarding the purposes of these rounds in identifying inmates with active medical and mental health issues, especially when housed in segregated units.

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 - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: At the current time this provision is unmet. Inmates with serious mental illnesses remain in segregation. One inmate in particular is in a corner cell with no inmate in the cell next to his. Therefore, this man with a serious mental illness is at a level of confinement that approximates isolation.

The psychiatrist reported that she receives no notification when an inmate on the mental health caseload is placed in segregation.

RECOMMENDATIONS:

1. Inmates in segregated units with a serious mental illness should be entitled to a minimum of 10 hours per week of unstructured out of cell time. Security will need to develop a plan and a means of tracking the number of hours each of these inmates is allowed to be out of cell.
2. GGACF needs to develop a plan for identifying seriously mentally ill inmates in segregation units. Treatment needs should be determined by the mental health staff and a plan for implementing the required programming in the segregation unit. Those inmates who are observed to have difficulties tolerating the segregation environment due to their mental illness should be removed and placed in appropriate housing with treatment programming available to address their mental health condition.
3. Medical should be notified of any inmate placed in segregation and when staff is on site, a pre-segregation review should be completed.

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 - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: At the current time there is no process in place by which the mental health provider reviews or consults with the disciplinary hearing officer regarding potential disciplinary sanctions for those inmates with a mental illness. The psychiatrist has never been contacted by the hearing officer for her input. This is a potentially dangerous practice that will result in the placement of seriously mentally ill individuals in isolation, or subject them to improper discipline, in contravention of the Settlement Agreement and best practices.

RECOMMENDATIONS:

1. GGACF should develop a process incorporated in the disciplinary policy that describes the protocol for communication between the hearing officer and a qualified mental health professional whenever an inmate on the mental health caseload is facing disciplinary sanctions.
2. A notification form should be developed that would request written input by the behavioral health staff to the hearing officer. It is recommended that a copy of that completed form be retained by the health services administrator or mental health director. This quality improvement data can be reviewed to determine if disciplinary sanctions are mitigated as a result of the input by the health staff.
3. Mental health input into the disciplinary process, and a clear plan for pre-segregation mental health and medical assessments should be implemented. Because the service does not offer 24 hour nursing and mental health staffing, segregation assessments should be performed during the next business day following placement. The purpose of these assessments is to look for risk factors that would necessitate restricting placement in segregation because of a clinical determination that the medical or mental health condition is likely not to improve in that housing location when compared to other placements, such as a specialized mental health unit.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This area was also discussed in letter (c); however, additionally construction has gone forward on the infirmary space, including two dental operatories, a pharmacy area and areas for both mental health suicide observation and acute and chronic medical housing. These areas are close to being finished. They then have to be appropriately equipped and this remains an ongoing need. Also in (c) we discussed the need to refurbish, clean and sanitize the exam rooms in the housing units other than lockdown and appropriately equip them. The Territory is to be commended for progress in the work in the infirmary area.

RECOMMENDATIONS:

1. Complete the infirmary renovations.
2. Appropriately equip the infirmary area, including two dental operatories.
3. Insure that there is at least one more officer available in the clinic/infirmary area.
4. Complete per our recommendations the infirmary policy.

MENTAL HEALTH FINDINGS: In the past there had been two private offices in the medical treatment building designated as mental health offices. Currently one is occupied full-time by an inmate patient and the other is being used for medical records. As a result, the psychiatrist is using the former director of nursing's office to see patients. Should a qualified mental health professional be located and hired, there is currently no office designated for that person to provide treatment services.

RECOMMENDATIONS: It would be helpful if there was a general current and future plan presented to the monitors regarding clinical space for both medical and mental health staff once a full complement of staff are on board.

Previous Recommendations Remain Appropriate:

1. The facility needs to explore what barriers may exist to providing frequent and adequate services to inmates in special housing in sound private settings.
2. Send the Monitor the plans as soon as a draft has been developed.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: As mentioned in prior sections, visits to psychiatry are timely. However, current staffing is inadequate to provide the types of services necessary for the mental health care and treatment to be considered adequate by national standards. GGACF is currently only providing psychiatrist services. Due to staffing shortages there are no ongoing programs for individual counseling. In the absence of a mental health professional other than the psychiatrist, comprehensive treatment planning is not occurring; nor is treatment other than visits to the psychiatrist who does include her treatment plan in that section of her progress note.

RECOMMENDATIONS: Continue all efforts to hire qualified mental health professionals to comply with this Agreement and provide adequate levels of mental health staff to ensure provision of qualified, consistent assessment and treatment.

Previous Recommendations Remain Appropriate:

1. Continue to monitor the plans to implement the new forms, modifications to the tracking case list including housing area, past visit and date of return to clinic.
2. Consider developing quality improvement process to monitor outcomes from data collected via the treatment forms.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: The psychiatrist currently is in the clinic Monday through Thursday 11 AM to 5 PM. She reports being able to see anyone security can bring to her. She has noticed fewer days without a patrol officer (now maybe one day per week) which has greatly improved her access to the inmates on her clinical caseload. The psychiatrist remains enthusiastic and committed to supporting the service in any way she can. When off-site she is available to the facility 24 hours a day and frequently will see urgent cases in the emergency department on the days that she is in the hospital. In addition to her duties seeing inmates at the facility she also completes forensic evaluations requested by the courts.

The prior qualified mental health professional finally submitted her letter of resignation two weeks prior to the September site visit. That position has been posted and advertised and hopefully will be filled by the time of our next site visit. As a result of this critical staff shortage, services such as programming in A dorm (the housing area containing those with the most serious mental illnesses), outpatient counseling and initial psychological assessments, and rounds in segregation units by a mental health professional are not occurring.

Medical recently hired additional registered nurses and one nurse was going to be assigned to the psychiatrist. However, prior to leaving St. Croix, we learned that this nurse chose another job on the island and would, therefore, not be available to assist the psychiatrist.

RECOMMENDATIONS:

1. Successfully hire the authorized qualified mental health professional.
2. It is recommended the BOC consider creating at least one more qualified mental health professional position in order to, at a minimum:
   a. share coverage for the intake and assessment process,
   b. provide programming to seriously mentally ill inmates in both segregation units as well as A dorm and general population,
   c. provide weekly segregation mental health rounds,
   d. generate treatment and discharge plans,
   e. complete suicide watch follow-up.

   Then, additional staff positions, if needed, may be able to be filled with less specially trained personnel to provide structured activities such as recreational activities, life skills groups, patient education groups, etc. in programming units.

3. At the time of the next site visit, I am hopeful that the health services administrator, psychiatrist, and warden will have begun to brainstorm their own mission and vision of what an adequate mental health system and individualized treatment plan driven programming should entail at their facility. At a minimum, inmates in specialized mental health housing units (A Dorm) and those with a serious mental illness in segregation should be provided at least 10 hours per week of structured therapeutic activities as well as 10 hours of unstructured out of cell time (the latter pertains to segregated inmates). Inmates in the general population, particularly those with a serious mental illness, should have access to some group programming and individual counseling as needed.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: The psychiatrist has created a tracking form to monitor the date of the last psychiatric evaluation. In this field she actually tracks all appointments in the year 2014 for each individual. Most inmates were seen at least once every two months with a few being seen every three months. The psychotropic consent form being used and is quite

adequate. Medication side effects are being assessed at the time of outpatient visits. On chart review it was noticed that there is no quantitative tool in place for monitoring movement disorders such as the AIMS. To her credit, the psychiatrist does obtain vital signs including weight and girth to monitor for the development of metabolic syndrome.

RECOMMENDATIONS: Inmates on neuroleptic medication should receive an AIMS test at the time of initiation of neuroleptic medication and at least every six months.

(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; and …

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: See f. (iv)

RECOMMENDATIONS: See f. (iv)

RECOMMENDATIONS:

1. A detailed curriculum should be submitted for review to the monitoring team and approval by the Monitor.
2. Once obtained, training should be implemented with pre-and post-testing or other performance measures that have been approved by the Monitor.
3. GGACF should ensure the training officer or her records are available at the time of the next site visit for review by the monitoring team.
4. Develop, implement, and evaluate comprehensive training curricula to comply with Provision.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: Inmates with serious and persistent mental illnesses remain housed in segregation units, sometimes without disciplinary reports. As of yet, there are no housing units at the facility that would allow for the safe integration of these inmates into a psychiatric treatment unit. Currently the seriously mentally ill inmates in general population are primarily congregated in A Dorm. Although this housing unit is preferable to some of the other prison units primarily because it is airy and sunny; it remains an undesirable location. However, problems with this unit include, but are not limited to:

1. a narrow central corridor flanked by inmate cell,
2. a day room that is unobservable from the officer's station
3. no access to outside recreation.

4. the inmates' cells are also unobservable from the officer's station which is divided from the housing unit by a closed-door.
5. If the officer is in the dayroom, then there is no observation of the front door, nor the inmate's remaining in their cells.

RECOMMENDATIONS:

1. If programming is instituted in the current unit, an officer will need to be present to monitor the desk and inmates not attending the group. A second officer will need to be in the dayroom while the group activity is being conducted.
2. Inmates in this housing unit should have access to outside recreation.
3. Inmates taking certain psychotropic should also be cautioned as to an increased risk for photosensitivity and complications of disrupted heat regulation placing them at greater risk for heatstroke. Inmates from a mental health unit should have access to fresh water during times of outdoor recreation and shade.
4. Particularly for seriously mentally ill inmates on the prison's side where lengths of stay are longer, GGACF should determine what these inmates recreation and programming needs are in order to determine the configuration of appropriate housing.
5. It is likely that the facility will need to request capital improvement funds in order to meet the needs of this subclass.

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 previous assessment.

FINDINGS: The Territory provided this Monitor draft Fire Safety policies and procedures during the July onsite technical assistance visit. However, during this visit the Fire Safety consultant advised this Monitor that he had revised these policies and would thereafter provide them. The monitor has not yet received revised policy drafts despite making a written request.

The finalization of this policy is vital. Inadequate housing unit staffing levels and contraband control practices continue to enable inmate-caused fires in housing units. According to the Incident Log there were at least four (4) inmate-caused "fires and/or arsons" between 6/14 and 8/24; all of these reported incidents occurred in Detention units. Seven inmates were involved. Incident reports were only provided for two (2) of these events despite this Monitor's request for all such reports prior to this onsite visit.

Reports were provided for two (2) fire-related incidents occurring 7/16 and 8/24; both incident reports titled the incidents as "arsons".

The 7/16 arson occurred in unit 9A and involved an inmate starting a fire in his cell. The fire was extinguished and the inmate was moved to the Intake unit. The report fails to clearly articulate fire causes or ignition sources.

The 8/24 arson occurred in unit 9D and involved an inmate throwing a burning object at cell door #29 that "started a fire". An officer used a bottle of water to extinguish the fire. The inmate involved was locked in his cell. Again, the report fails to clearly articulate fire causes or ignition sources.

There were no other documents provided to this Monitor indicating further investigation of these events or whether a post fire-incident review was conducted by GGAF administration or the Fire Safety Consultant. As described above, incident reporting and investigations at GGACF are woefully inadequate. The Monitor is aware of no corrective action taken, disciplinary hearings conducted, contraband confiscated, or changes made as a result of these incidents.

These two incidents, alone, clearly demonstrate how dangerous incarceration and employment as a corrections officer at GGACF can be. The automatic fire detection and suppression system remains inoperable, inadequate staffing levels and contraband control leaves housing units deleteriously under controlled and monitored, inmates apparently have undetected and interrupted access to items to ignite fires, and inmates obviously have no inhibition about starting fires.

RECOMMENDATIONS: Previous recommendations remain appropriate. Additionally, the Monitor requests the reports for all drills and exercises conducted.

1. Finalize and implement fire safety policies once approved and according to the Monitor's schedule by 12/31/14.
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 must be clearly detailed in fire safety policies and procedures, and become a fundamental element of pre-and in-service training.

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: Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, cell and housing unit sprinklers are non-functional and regularly used by inmates to support personal clotheslines. 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.

An adequate supply 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. However, these devices are not always used to extinguish fires in housing units as demonstrated in a reported arson that occurred in August 24, 2014. During this event, the housing unit officer used a water bottle to extinguish a fire in a housing unit that was

caused by an inmate. The report does not articulate the accelerant used to create this fire but chose not to use the approved fire extinguisher to put out this fire. Although the officer showed quick action to prevent potential harm to other staff and inmates, it is very dangers to use water to extinguish a fire under certain circumstances and only approved fire extinguishers should be use. Furthermore, this report was not accompanied by any documentation discussing any follow-up actions, a review by the fire inspector, or counseling/retraining of the officer for failing to following policy.

On-site, GGACF staff indicated that sprinkler heads may be replaced in the "newer" buildings at some point in the next year, but the exact plans for this were not made available. 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. GGACF will never come into compliance with these provisions if that remains the case.

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. It is unclear when, if ever, full fire drills are conducted. This continues to put inmates at risk of injury or death, should a fire break out that cannot be suppressed by the hand-held fire extinguishers present in the officer control pods of housing units.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. Develop and implement a valid and reliable emergency key system as described above. Train and drill staff as discussed on system use.
3. Develop emergency key and locking mechanism inspection and reporting system as discussed above.
4. Implement competency-based staff training as discussed above.
5. Exercise fire safety program using onsite, scenario-based drills; include community responders in exercise planning and exercise events.
6. 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: 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.

RECOMMENDATIONS: Same as above.

1. Refer to previous recommendations for this provision.
2. Also refer to recommendations related to security provisions, contraband, and inmate manipulation of cell door locking systems.
3. Repair all remote cell locking notification technology.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated in the previous report, no records were provided to verify that all staff have been trained and tested on 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 operable. 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. Currently, the only means of adequately detecting and responding to fire emergencies is having an officer physically present at the scene of the emergency.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. 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 above.

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.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS:

1. 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.
2. 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.
3. Policy components involving medical and mental health staff should provide for their safety and security when involved in fire incident responses.
4. 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: Same as above. Additionally, there appeared to be some reduction in combustible clutter in inmate cells. Continue and monitor this practice.

RECOMMENDATIONS: Same as above.

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 was provided that demonstrates ongoing efforts of GGACF officials, maintenance supervisors, and the Fire Safety Consultant to assess, improve, and monitor facility sanitation and hygiene. Draft policies were provided to this Monitor for review prior to the Court ordering the monitoring team to write draft operational policies.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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).

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, not all housing unit emergency lights are functional and must be repaired or replaced.

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 decline in performance was found. Inmates housed in RSAT and Intake units again reported "constant" mosquito problems. An inspection of these cell areas again found broken and missing cell window screens that should be replaced.

RECOMMENDATIONS: Previous recommendations remain appropriate

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 – No substantive improvement from previous assessment.

FINDINGS: Inspection of housing units, cells, kitchen, and medical areas again show consistent presence of personal hygiene and cleaning supplies.

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.

This provision can advance to Substantial Compliance once related policies and procedures have been approved and implemented according to the Agreement.

f. Cleaning, handling, storing, and disposing of biohazardous materials;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No substantive change from previous assessment.

There is no formal sanitation plan or protocols covering compliance with this Provision nor a form training program for staff or inmates on this topic. Staff and inmates must be trained and demonstrate competence in handling biohazardous materials, provided and instructed on the

proper use of bio-protective clothing and supplies, and supervisors must closely monitor bi-hazard clean-ups. Remaining in Partial Compliance with this Provision can jeopardize the health of staff and inmates.

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 biowaste;
   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.
   G. 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.
   H. Develop a biohazardous control program that involves regular inspections of all potential contamination areas.
2. GGACF officials should consult an environmental specialist to assess these conditions and assist them in developing appropriate mitigation plans and policies.
3. 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: NONCOMPLIANCE

FINDINGS: Although a large supply of new mattresses were acquired, some inmates remain with filthy, tattered mattresses. Although none of these inmates complained about this conditions, clean and usable mattresses must be issued to every inmate.

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 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 who supervise inmates allowed to handle these chemicals must be properly trained in that role and those responsibilities. This has yet to occur.

RECOMMENDATIONS:

1. 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.
2. Ensure the cleaning chemical control plan is coordinated with medical staff for harmful exposure mitigation, response, and recovery protocols.
3. This provision can advance to Substantial Compliance once related policies and procedures 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, inmates continue to routinely wash personal and issued clothing in cell sinks and toilets, and dry these items in their cells using clotheslines anchored to fire sprinkler heads, walls, window frames, bunks, etc. This Monitor again observed soiled bed linens, no linens, tattered and dirty mattress, and mattresses with no covers in several occupied cells.

RECOMMENDATIONS:

1. Cease the practice of allowing inmates to wash personal and issued clothing in toilets and sinks.
2. Cease the practice of allowing inmates to dry clothing on make-shift clotheslines in their cells.
3. Routine and consistent replacement of damaged mattresses, mattress cleaning, cleaning of bedding.
4. Review, revise, develop, train, implement, and evaluate a comprehensive laundry management plan that governs total laundry operations.
5. Develop specific policies and procedures for handling, containing, and washing contaminated clothing, linens, and mattresses.

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 has 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: Territory officials report the initiation of a major project to repair and clean-up the kitchen area. The project is pending RFP approval.

Inspection of the kitchen found that utensils properly secured but the Territory still has not implemented a utensil check-in/out system to monitor tool inventory. Fire extinguishers were fully charged with current inspection certificates. Cooler temperatures were appropriate at about 38 degrees Fahrenheit. Inmate workers were engaged in cleaning activities under the supervision of an officer. No clutter was observed and the overall environment appeared organized.

Overall, there was little change from the previous assessment. This Provision could easily advance to Partial Compliance once policies are approved and implemented, and upon completion of the planned repair project.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, and evaluate food service program policies and procedures.
2. Ensure policies and procedures include, at minimum, the following elements:
   A. Meals that are nutritionally balanced, well-planned, and prepared and served in a manner that meets established health and safety codes;
   B. An adequate number of qualified food service employees and supervisors needed to monitor program quality and inmate worker supervision;
   C. Special menus that comply with various medical and religious needs and requirements;
   D. Maintain accurate accounting records;

E. That menus are reviewed at least annually by a qualified dietitian to ensure meals comply with nationally recommended allowance for basic nutrition;
F. Prohibitions of using food as a disciplinary measure;
G. Involvement of independent outside sources to verify food service facilities and equipment meet government safety codes;
H. Prescribes regular cleaning schedules including routine deep cleaning;
I. Provide written utensil control methods similar to those used by the tool shop;
J. Accident prevention program;
K. Personal and environmental sanitation requirements;
L. Food temperature monitoring and records keeping;
M. Adequate health protections for all staff and inmates including health screens and prohibitions against working in the kitchen when ill;
N. Requirements for daily monitoring of staff and inmate cleanliness practices, and that all bathrooms and wash basins are consistently supplied with antibacterial soap and hot water;
O. All areas and equipment related to food preparation, distribution, and storage require frequent inspection to ensure they are sanitary, operational, and safe;
P. Water temperature on final dishwasher rinse should be 180 degrees Fahrenheit; between 140 and 160 degrees Fahrenheit is appropriate if a sanitizer is used on the final rinse. The person conducting inspections should be a qualified food service inspector;
Q. Stored shelf goods are maintained at 45 degrees to 80 degrees Fahrenheit, refrigerated foods are 35 to 40 degrees Fahrenheit, and frozen foods at 0 degrees Fahrenheit or below, unless national or state codes specify otherwise;
R. Food temperatures for hot foods should range between 135-140 degrees Fahrenheit and cold foods at approximately 41 degrees Fahrenheit;
S. Supervisory food service staff should monitor food service operations to ensure that that cooking, cooling, and food temperatures and delivery meet established requirements;

3. GGACF officials should review food service requirements promulgated by the National Correctional Association and National Commission on Correctional Health Care.
4. Develop a food service training program that includes inmate and staff training records and ensure that all training is well-documented.
5. 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.

k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No improvement was again observed in the housing units during this assessment.

The lack of constant reliable access to drinkable water further prevents GGACF from ensuring that inmates live in a healthy environment. 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.

This problem was particularly acute in X dorm, per interviews with X Dorm prisoners and our observations. There is no sink or fountain available for providing drinking water, and the women reported that in lieu of drinking water, correctional staff deliver large buckets of ice from which the women chip chunks into individual cups and allow to melt overnight to provide water the next day. This practice is unsafe and falls far below constitutional standards.

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: The Monitor will develop and submit Training Policies consistent with this Provision as ordered by the Court, and has provided Territory officials several documents pertaining training curricula development. Training curricula was provided for the Mental Health/Suicide Prevention, and Locking training as previously discussed.

RECOMMENDATIONS:

1. Implement training policies and curricula once approved.

b. **Pre-service training for all new employees;**

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above.

RECOMMENDATIONS:

1. Provide the Monitor with all pre-service training curricula and lesson plans for all staff.

c. Periodic in-service training and retraining for all employees following their completion of pre-service training;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above. Training-related documents provided by Territory officials do not provide sufficient information and clarity to assess compliance.

RECOMMENDATIONS:

1. Provide Monitor with all in-service training curricula and lesson plans for all staff as requested.

d. Documentation and accountability measures to ensure that staff complete all required training as a condition of commencing/continuing employment.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Similar findings as discussed above.

RECOMMENDATIONS:

1. Provide the Monitor all training program curricula and completion of training reports.
2. Provide the Monitor with documentation on how compliance with this provision is being met.
3. Develop a basic spread sheet that allows the Monitor to clearly determine the following:
   - Total authorized staff per category (correctional, supervisory, civilian, contract, etc.)
   - YTD actual staffing levels per category, preferably by month
   - Number and percentage of current staff in each category who have completed required pre and in-service training, per month

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: As a result of the Territory's failure to meet deadlines in the revised Schedule, the Court ordered the Monitor to create and issue a revised Schedule. That schedule was completed by the Monitor as ordered and in collaboration with the parties, and is shown and described in this Report's Summary section.

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: As stated above.

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: By agreement of the parties, the Court ordered the Monitor to complete and submit to the parties all required policies and procedures no later than December 31, 2014. Several policies and procedures have since been submitted to the parties for review and approval.

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: Impact evaluations submitted continue to lack sufficient detail and metrics to quantitatively or qualitatively evaluate compliance achievement. This Monitor will continue to assist Territory officials to improve this required document.

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: The Monitor is charged by the Court to complete required policies and procedures as previously stated. Territory officials have neither submitted any compliance plans or requested modifications to any plans. In fact, the Territory has not submitted any plans whatsoever except for previous Schedules, which the Court ultimately directed this Monitor to complete.

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: Status reports submitted lack sufficient information and detail to assess compliance achievement. A review of various other documents suggest that much more compliance activity is underway but not being included in status reports. The Territory is encouraged to involve an interdisciplinary group to complete this report to ensure all areas of progress are included in the status report.

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 Monitor continues to experience long delays in receiving documentation regarding serious incidents.

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 Monitor provided a list of requested documents well before each onsite inspection. Once again, documents were not made available to the Monitor or USDOJ prior to arriving on site. This practice MUST change. All documents should be provided 10 days in advance of the visit for proper review prior to coming on-site. This will streamline monitoring efforts on site and save everyone considerable time. Moreover, during this visit, not all requested documents were provided on site, and multiple copies of some requested documents given.

Additionally, the Territory did not respond to the Monitor's request for additional documents following this assessment. It is impossible for the monitoring team to effective perform without needed cooperation from the Territory in the production of requested documents.

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 monitoring team experience no serious delays during this site visit. However, not all documents requested before and following this visit were provided. Monitoring effectiveness, completeness, and accuracy critically relies on timely and complete submission of requested documents.

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: As previously stated.

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.

Upon appointment to this case, this Monitor issued to the Territory and USDOJ written documents described how this Monitor would assess compliance with each Compliance Measure, how information would be gathered, what information would be requested prior to each onsite assessment, much of which would be used for routine reporting and ongoing monitoring. As stated previously, the Monitor and USDOJ continue experience difficulties consistently obtaining all requested records in a timely manner, albeit there has been some improvement on the part of the Territory, some requested records have not been provided at all.

Timely response to requests for records is critical to help ensure 1) timely and efficient monitoring of this Agreement, 2) the Court is provided timely, complete, and accurate information from the Monitor, and 3) consistent control and responsible management of monitoring resources, including the approved budget.

The Monitor, therefore, requests that all requests for records are provided timely and completely going forward. Additionally, this Monitor request the following records on a monthly basis for the purposes stated above:

1. Hand-written Incident Log
2. Hand-written Evidence (contraband) Collection Log
3. Excel Grievance Log
4. All Use of Force Review Reports
5. Monthly Disciplinary Committee Report / Discipline Log
6. Monthly Staffing Compliance Report (to be developed based on previously provided documents and communication)
7. Monthly Life and Fire Safety Inspection/Activity Report
8. Updates on capital improvements
9. Copies of all incident reports
10. YTD Prisoner Census Report (by housing unit)
11. Segregation (Special Housing) Census and Review Logs
12. Training Complete Logs
13. Any new forms created for administration or operational purposes
14. Other documents as determined need for routine monitoring

It is realized that providing these documents on a monthly basis will require the Territory to somewhat retool its resource management priorities and practices to some extent. This Monitor, therefore, extends assistance to the Territory to identify methods and processes for complying with this request and requirement.

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 the Baseline and subsequent visits and monitoring includes the following. Many of these documents were not provided at the Baseline and second visit as requested but more were provided during the second and third visits. Territory officials

stated that they intend to continue to generate and provide the requested documents. It is important to reiterate the need for the documents listed below. Considering the size of this list, and GGACF's limited staff and technical resources, the Monitor intends to assist the Territory in narrowing this list to the most salient items. Documents in bold below have either not been provided or have not been updated but are necessary for effective monitoring.

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) Medical and Mental Health Information:

27. A mock or blank chart containing all forms used, filed in appropriate order.
28. The infection control policies.
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.

It is important to note that the Territory made a reasonable effort to provide most of the information requested for this visit. However, log books and other reports were not ready for review on one the first day as they were during the previous visit. The balance of information listed above (in bold) is expected to be provided once it has been developed.

Territory officials and participants were exceptionally cooperative, involved, and supportive throughout this aspect of the monitoring process. The Territory's repeated desire to fully comply with the Agreement was evidenced by its active cooperation and involvement in the onsite visit. Similarly, United States Department of Justice representatives participating in the onsite assessment were equally cooperative and involved, which helped to maximize visit efficiency and productively. The presence of both Parties during the onsite visit assisted assessment focus and allowed for collaborative and timely resolution of important matters of mutual interest. Therefore, the Monitor and monitoring team respectfully requests that these representatives from both Parties continue participate at all future assessment visits.

The monitoring team used four primary reference points from which to assess compliance and progress with Agreement. These included: 1) the agreed 2012 Findings of Fact document, 2) documents, information, and data provided prior to, during, and following the onsite assessment, 3) the onsite visit, which included meetings, discussions, interviews, campus tours and inspections, and 4) the previous reports.

During this assessment, the monitoring team toured the campus, inmate housing units and cells, dayrooms and program spaces, intake/booking area, control rooms and officer posts, portions of the outer perimeter and fencing, and medical and mental health areas. We talked with BOC representatives and staff, and spoke with inmates.