IN T[illegible] UNITED STATES DISTRICT COURT FOR
THE DISTRICT OF THE VIRGIN ISLANDS

LAWRENCE CARTY, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	CIVIL ACTION NO. 94-78
	)	
ALEXANDER A. FARRELLY, et al.,	)	
	)	
Defendants.	)	

SETTLEMENT AGREEMENT

INTRODUCTION

The parties, having negotiated and reached agreement for the settlement of this class action, do hereby submit this Settlement Agreement to the Court for its review and approval, in full settlement of all claims and without admission of fault, binding upon the parties and their successors according to the terms set forth therein, unless further modified by the Court. This Settlement Agreement is intended by the parties to be enforceable by the Court to the same extent as a court order.

In entering into this Settlement Agreement, the parties acknowledge that the safety and security of prisoners and staff are a matter of mutual concern. The parties further acknowledge that certain conditions and eventualities are within the contemplation of the parties. These include the possibility that the St. Thomas Criminal Justice Complex, and the Virgin Islands jail and prison system may experience a substantial increase or decrease in its population; that the rate of crime or conviction within the U.S. Virgin Islands may continue at its current rate of increase or decrease substantially; that the incidence of parole may increase

EXHIBIT A

or decrease substantially; that the cost of construction of new facilities or renovation of existing facilities may increase or decrease substantially; that substantial difficulty may or may not be encountered by the Virgin Islands Bureau of Corrections in attracting and employing security and non-security staff; and that substantial construction delays may or may not occur with respect to the renovation of existing units or the construction of new facilities, units or additions thereto. A condition or eventuality within the contemplation of the parties shall not be grounds for seeking an equitable modification under F.R.C.P. 60(b)(5) or for contesting a motion to enforce this agreement.

Unless other dates are specified herein, the date for implementation of the following provisions is January 1, 1996.

DEFINITIONS

"Defendants" shall mean the Governor and the Attorney General of the U.S. Virgin Islands, the Director of the Bureau of Corrections (BOC), and the Warden and Assistant Warden of the St. Thomas Criminal Justice Complex (CJC).

"Defendants' Counsel" shall mean the Attorney General for the U.S. Virgin Islands or her designee.

"Double-celling" shall mean the placement of two (2) prisoners in a cell.

"Plaintiffs" shall mean pretrial detainees and sentenced prisoners housed at the St. Thomas Criminal Justice Complex (CJC).

"Plaintiffs' Counsel" shall mean Benjamin Currence, Mark Lopez, Marjorie Rifkin, and other lawyers and their assistants

employed by the National Prison Project of the American Civil Liberties Union Foundation, 1875 Connecticut Avenue, N.W., Ste. 410, Washington, D.C. 20009.

"Substantial Compliance" shall mean that the defendants have generally fulfilled the provisions of this Agreement governing the delivery of medical, dental and mental health services; environmental health, fire safety conditions and practices; and addressing overcrowding, management, security and inmate activity issues.

I. POPULATION

The defendants agree to the following limitations on the population at CJC:

1. The population limit at CJC shall be 97.
2. No sentenced prisoners serving a sentence in excess of one (1) year shall be confined at CJC.
3. No cell shall confine more than two (2) inmates.
4. Five (5) cells shall be established as single cells for special management inmates i.e., medical, mental health, segregation. If all special management prisoners are transferred out of CJC, then the population cap shall be 100.
5. New admissions shall be confined in a separate housing cluster until they are medically evaluated.
6. Inmates shall not be housed in dayrooms, offices, or other spaces not specifically designed for housing.
7. Female inmates shall be housed separately from male

prisoners in their own cluster at CJC.

8. The population limits set forth in paragraphs (1) through (7) above shall become fully effective on April 1, 1995. In the interim, the defendants agree to open the Halfway House by January 1, 1995 and transfer a minimum of 30 inmates from CJC at that time. From January 1, 1995 forward, the CJC population will be permanently reduced by those 30 beds. Additionally, defendants agree to seek pretrial detention alternatives, reduce bails and to offer sentences of time served for prisoners charged with misdemeanors and nonviolent offenses. It is the parties' expectations that by January 1, 1995, the CJC population will be reduced by a total of 50-60 prisoners through these efforts.

II. SHELTER, PHYSICAL PLANT AND ENVIRONMENTAL HEALTH

The defendants agree to the following:

1. Repair the leaking roof by June 15, 1995.
2. Repair all sink units in the cells by April 15, 1995.
3. Repair all light fixtures in the facility by June 15, 1995.
4. Repair or replace all hot water heaters for inmate showers by April 15, 1995.
5. Provide water coolers in the clusters by December 1, 1994.
6. Replace all damaged or soiled mattresses by April 15,

1995.

7. Establish a mattress exchange program for new admissions by December 1, 1994.

8. Provide a storage area in each cell for inmates' personal belongings by May 15, 1995.

9. Establish a comprehensive institutional housekeeping plan by April 15, 1995. See Appendix A.

10. Establish a comprehensive kitchen maintenance and sanitation plan by January 1, 1995. Kitchen facilities will be inspected twice each year by the Virgin Islands Health Department.

11. Establish a comprehensive preventive maintenance plan for all mechanical systems and the physical plant by January 1, 1995.

12. Clean the drinking water system (cistern system). It will be cleaned by institutional staff with outside consultant staff supervision by April 15, 1995. In addition, an automatic chlorinating device will be installed and utilized at the point from which the water leaves the cistern and is distributed throughout the facility. The defendants also agree to comply with the conditions set out in the September 27, 1994 Department of Natural Resources letter from Ben Nazario to Alcedos Lettsome. See Appendix B.

13. Assign two (2) FTE maintenance staff qualified to perform plumbing, electrical, mechanical, ventilation and air

conditioning work by April 15, 1995.

14. Provide at a minimum the following food items: fruits and vegetables three times per week; milk daily, meat substitutes for religious and vegetarian diets and evening snacks by December 1, 1994.

15. Lighting in inmate rooms/cells shall be at least 20 footcandles at desk level and in personal grooming areas, as documented by an independent, qualified source.

16. Noise levels in inmate housing units shall not exceed 70 dBA (A Scale) in daytime and 45 dBA (A Scale) at night.

17. Circulation shall be at least 15 cubic feet of outside or recirculated filtered air per minute per occupant for cells/rooms, officer stations, and dining areas, as documented by an independent, qualified source.

18. Temperatures in indoor living and work areas shall be appropriate in the summer and winter comfort zones.

19. Food service operations shall be supervised by a full-time staff member who is experienced in food service management.

20. Policies and procedures shall be written, and practice instituted to specify the food service budgeting, purchasing, and accounting practices,

including but not limited to the following systems:

- food expenditure cost accounting designed to determine cost per meal per inmate
- estimation of food service requirements
- purchase of supplies at wholesale and other favorable prices and conditions, when possible, and in accordance with the Virgin Islands Code
- determination of and responsiveness to inmate eating preferences
- refrigeration of food, with specific storage periods

21. Policies and procedures shall be written, and practice instituted to require that accurate records are maintained of all meals served.

22. Documentation shall be maintained that the institution's dietary allowances are reviewed at least annually by a qualified nutritionist or dietician to ensure that they meet the nationally recommended allowances for basic nutrition. Menu evaluations shall be conducted at least quarterly by institution food service supervisory staff to verify adherence to the established basic daily servings.

23. Dietary allowances, as adjusted for age, sex,

and activity, shall meet or exceed the recommended dietary allowances published by the National Academy of Sciences. A qualified nutritionist or dietician is a person registered or eligible for registration by the American Dietetic Association or who has the documented equivalent in education, training, or experience, with evidence of relevant continuing education.

24. Policies and procedures shall be written, and practice instituted to require that food service staff plan menus in advance and substantially follow the plan and that the planning and preparation of all meals take into consideration food flavor, texture, temperature, appearance, and palatability.

25. Policy and procedure shall be written, and practice instituted to provide for adequate health protection for all inmates and staff in the institution, and inmates and other persons working in the food service, including the following:

26. All persons involved in the preparation of food shall receive a preassignment medical examination and periodic reexaminations to ensure freedom from diarrhea, skin infections,

and other illnesses transmissible by food or utensils; all examinations shall be conducted in accordance with local requirements.

27. When the institution's food services are provided by an outside agency or individual, the institution shall have written verification that the outside provider complies with the state and local regulations regarding food service.

28. All food handlers shall be instructed to wash their hands upon reporting to duty and after using toilet facilities.

29. Inmates and other persons working in food service shall be monitored each day for health and cleanliness by the supervisor of food services (or designee).

30. When required by statute, food products that are grown or produced within the system are inspected and approved by the appropriate government agency; there shall be a distribution system that ensures prompt delivery of foodstuffs to the institutional kitchen.

31. Policy and procedure shall be written, and practice instituted to require weekly inspections of all food service areas,

including dining and food preparation areas and equipment, by administrative, medical, or dietary personnel; these may include the person supervising food service operations or his/her designee. Refrigerator and water temperatures shall be checked daily by administrative, medical, or dietary personnel.

32. Meals shall be served at appropriate temperatures.

33. Policy and procedure shall be written, and practice instituted to provide for the issue of suitable clothing to all inmates. Clothing shall be properly fitted, climactically suitable, durable, and presentable.

34. A standard wardrobe shall be provided at the time of admission and should include as appropriate: shirts, blouses, dresses, trousers, skirts, undergarments, slips, socks and shoes.

35. Policy and procedures shall be written, and practice instituted to require that articles necessary for maintaining proper personal hygiene are provided to all inmates.

36. Each inmate shall be given at a minimum the following linens: two sheets, one towel, one pillow, one blanket and a mattress that shall be placed on a bed and not on the floor.

There shall be procedures for linen and towel exchange and personal laundry on a weekly basis, at a minimum.

37. As part of the admissions process, each inmate should be given soap, shampoo, a toothbrush, toothpaste or powder, a comb, and toilet paper. Shaving equipment should be made available upon request, and the special hygiene needs of females shall be met. An adequate floor stock of these hygiene items shall be maintained at all times to ensure that these items are reissued as needed.

38. There shall be a written plan for the control of vermin and pests that includes, at a minimum, monthly treatments and inspections by qualified persons.

39. Water for showers shall be thermostatically controlled to temperatures ranging from 100° Fahrenheit to 120° Fahrenheit to ensure the safety of inmates and to promote hygienic practices.

III. FIRE SAFETY

For the purposes of this section, the following requirements are set forth below:

1. The Main Control Center on the third floor should be the central station for all recommended fire alarm systems. That is, all fire alarm systems should automatically

retransmit to the Control Center.

2. All smoke detectors should be connected to the building fire alarm system.

3. Fire rated enclosures or separations should be 1 hour fire rated with openings protected with self closing or automatic closing fire doors. The exception is doors to cells which are not required to be self or automatic closing.

4. Smoke tight enclosures or separations can be of any materials that will resist the passage of smoke with openings protected with a self closing or automatic closing door that will resist the passage of smoke. The exceptions are the doors to cells which are not required to be self or automatic closing.

Requirements:

1. Provide a manual fire alarm system.

2. Provide smoke detectors in the day rooms. The existing battery powered smoke detectors in the day rooms are inadequate for this occupancy. Battery powered smoke detectors are only recognized for residential occupancies.

3. Provide a smoke barrier partition on the third floor to allow for the horizontal evacuation of the occupants on the third floor. The partition should divide the third floor into approximately two equally sized areas of refuge.

4. Cease the practice of storing the food carts in the exit access corridor adjacent to the kitchen by December 1, 1994.

5. a) Provide smoke detectors throughout the third floor to include in individual cells.

b) Provide heat detectors on the first and second floors and in the basement. In addition, heat detectors should be provided in the enclosed areas on the roof to include the storage areas, maintenance shops, mechanical rooms, laundry room, by January 1, 1995.

c) Provide a 1-hour fire-rated enclosure of the kitchen and adjacent storage area.

d) Provide a 1-hour fire-rated enclosure of all vertical openings to include utility shafts and stairways.

e) Provide a 1-hour fire-rated separation of each of the cluster housing areas to include the individual control rooms from the exit access corridors.

6. Immediately remove all the new foam plastic mattresses in the facility and replace with approved fire retardant treated mattresses by November 1, 1994.

7. Replace all existing damaged fire retardant mattresses by January 1, 1995.

8. Do not store mattresses in the housing units. If mattresses are to be stored in the building, they should

be stored in accordance with fire safety regulations by November 1, 1994.

10. A detailed emergency plan should be developed which is applicable to the St. Thomas Facility, to include training of staff and fire drills for staff by December 1, 1994 and inmates by February 15, 1995. See Appendix C.

11. A fire evacuation plan for the housing units shall be developed, training provided and drills performed.

12. Fire drills shall be conducted and critiqued. Drills shall be conducted once per quarter per shift for a total of 12 fire drills per year. Not all drills require the evacuation of the inmates.

13. Since the building currently cannot adequately protect the occupants inside the building during a fire, a plan shall be developed by December 15, 1994 detailing how to evacuate the inmates or provisions for inmates to "ride-out" the fire inside the building. The plan must take into consideration the type of fire protection systems in the building.

14. Proper receptacles shall be provided for cigarette smoking material by November 1, 1994.

15. The staff shall be trained in fire evacuation and fire emergency procedures by December 1, 1994.

16. The local fire department shall tour the facility so that they can become familiar with and adequately plan how to fight a fire in the building. The local fire department

shall periodically participate in the facility fire drills.

17. Although it is not a good fire safety practice to chain and lock doors in the means of egress, it is not the intent of these requirements to interfere with the security needs of the facility. When on a periodic basis the chains and locks are needed for security, all staff members shall be made aware of this and a sufficient number of the staff should be provided with keys to unlock the doors in case of an emergency. The doors should not be chained and locked on a regular basis.

18. The defendants shall not store combustibles or other material in the exits.

19. Repair all broken or damaged electrical lighting fixtures by June 1, 1995.

20. Flammable liquids in the maintenance and storage areas shall be stored in approved flammable liquid storage cabinets.

21. The fire load in all offices shall be reduced by November 1, 1994.

IV. MEDICAL CARE

A. STAFFING AND TABLE OF ORGANIZATION

1. The defendants agree to retain a Health Care Coordinator who is responsible for making recommendations for the development of medical policies and procedures which, when adopted, will be largely in compliance with the

National Commission on Correctional Health Care Guidelines as they currently exist except as otherwise provided in this Agreement. These policies and procedures shall include, but not be limited to, such issues as quality assurance, programs for chronic care, special-needs inmates, admission to and administration of the infirmary at St. Croix, and a peer review of the practitioners who are contracting with the United States Virgin Islands. The Health Care Coordinator shall be responsible for implementing the medical policies and procedures in conjunction with the Registered Nurse at CJC. Day-to-day supervision and management shall be provided by the Registered Nurse at CJC by December 1, 1994.

2. A full-time Registered Nurse will function as the on-site supervisor of medical services and will report directly to the Nurse Supervisor. He/she will be responsible for development, implementation and monitoring of health care policies and procedures and monitoring and requisitioning of supplies and equipment. The full-time Registered Nurse shall be in place at the facility by December 1, 1994, and certification by the Director of the Bureau of Corrections that the nurse is in place shall be submitted to the Plaintiffs' counsel.

3. Nursing personnel in addition to the Registered Nurse will be present at CJC from at least 9:00am until 8:00pm

on weekdays and for four (4) hours each weekend day by January 1, 1995. Certification by the Director of the Bureau of Corrections, including the schedules of all nursing personnel, will be submitted to the Plaintiffs' counsel no later than January 1, 1995.

4. A physician will be present at CJC at least two hours each weekday to provide new admission evaluations, sick call and medical follow-up care, by December 1, 1994. The physician's schedule, showing compliance with this provision will be submitted to the Plaintiffs' counsel no later than December 1, 1994.

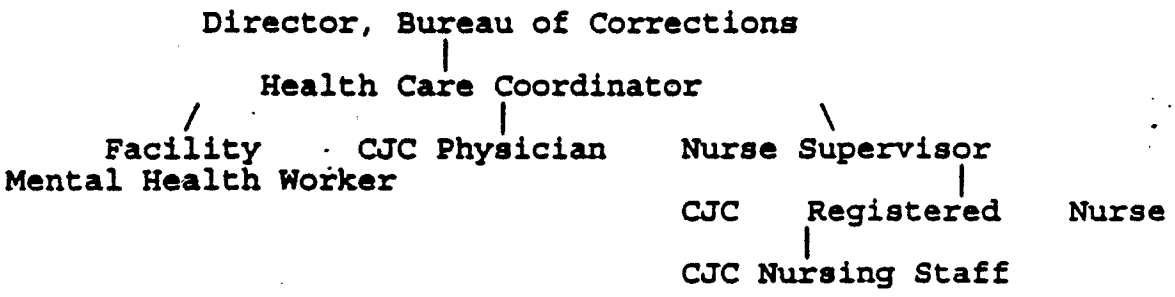
It will be the responsibility of the Health Care Coordinator to assure that adequate physician coverage is provided.

5. A physician will be on-call by telephone at all times when there is no physician on-site at the facility by November 1, 1994. This may be the physician who regularly visits the facility or other local physician(s) contracted with for 24-hour coverage. The Health Care Coordinator will be responsible for assuring that 24-hour coverage is provided. A schedule showing this coverage will be submitted to Plaintiffs' counsel no later than November 1, 1994.

6. A Master's-level Mental Health Worker will provide mental health services by January 1, 1995. His/her responsibility will include initial evaluation of all

inmates with mental health problems, development of mental health treatment plans, monitoring psychiatric medications in consultation with the physician, insuring mental health follow-up, and individual and group counseling. The Mental Health Worker will be in place by January 1, 1995. The Director of the Bureau of Corrections will certify that a Mental Health Worker is in place. The duties of the mental health worker are more fully set forth in section V. below.

7. Table of Organization:



A roster of health care personnel as indicated on the table of organization and a record of hours actually worked will be kept by the Nurse Supervisor. This record will be submitted to the Plaintiffs' counsel on a quarterly basis, beginning January 1, 1995.

B. EMERGENCY CARE

1. Adequate equipment will be maintained on-site for management of medical emergencies. This equipment will include the following:

stretcher (1)
ambu bag (1)
ammonia ampules (5)
alcohol sponges (10)

flashlight (1)
back board (1)
splints (2)
cervical collar (1)
sphygmomanometer (1)
stethoscope (1)
eye stream (dacriose, 1 bottle)
glucose tablets (6) or glucola (1 bottle)
nitroglycerin tablets (1 bottle)
betadine solution (1 bottle)
band aids (1 box)
4 x 4 gauze bandage (10)
5 x 9 gauze bandage (2)
3-inch ace bandage (1)
4-inch ace bandage (1)
triangular bandage (sling)
4-inch flexible gauze bandage (1)
3 x 9 Vaseline gauze (2)
sterile gloves (2)
1-inch tape (1 roll)
2-inch tape (1 roll)

A list of emergency equipment will be maintained by the Registered Nurse. The equipment will be inspected daily for completeness and condition and said inspection will be noted on the list with the initials of the staff member doing the inspection. Records of the inspections will be given to the Health Care Coordinator on a monthly basis. The Health Care Coordinator will ensure that replacement equipment is obtained as necessary. The emergency equipment list, including all the equipment noted above, and the system of checking equipment will be implemented by April 1, 1995. Certification by the Health Care Coordinator that the equipment and the system are in place will be submitted to the Plaintiffs' counsel no later than April 1, 1995.

2. A log will be maintained indicating time of all emergency hospital referrals, time leaving CJC and time of arrival at the hospital by December 1, 1995. Certification by the Warden that this log is being

maintained will be submitted to the Plaintiffs' counsel no later than December 1, 1995. The log will be submitted to the Plaintiffs' counsel on a quarterly basis.

C. Cardiopulmonary Resuscitation (CPR)

(1) Training will be provided for all medical staff by April 1, 1995. Certification by the Health Care Coordinator of completion of the initial training will be submitted to the Plaintiffs' counsel no later than April 1, 1995. All medical staff will maintain current CPR certification. The Registered Nurse will be responsible for ensuring that all medical personnel maintain current CPR training. A list of medical personnel and their CPR status will be submitted to the Plaintiffs' counsel on a quarterly basis.

(2) CPR training will be available to correctional officers. At least two officers with CPR certification will be present at all times at CJC by April 15, 1989. Certification by the Warden that at least two CPR-certified officers are on duty at all times will be submitted to the Plaintiffs' counsel no later than April 15, 1995. A list of officers with CPR certification and hours worked will be submitted to the Plaintiffs' counsel on a quarterly basis.

D. CHRONIC CARE

1. Written policy, procedure, and practice shall make available chronic and convalescent care to inmates of the facility.

E. SUBSTANCE ABUSE TREATMENT

1. Written policy and procedure shall guide the clinical management of chemically dependent inmates and include the following requirements:

- diagnosis of chemical dependency by a physician
- determination by a physician as to whether an individual requires nonpharmacologically or pharmacologically supported care
- individualized treatment plans developed and implemented by a multidisciplinary team
- referrals to specified community resources upon release when appropriate

2. Written policy, procedure, and practice shall provide for substance abuse programs for inmates with drug and alcohol addiction problems. These programs should include the following:

- staff trained in drug and alcoholic treatment to design and supervise the program
- coordination with community substance abuse programs
- efforts to motivate addicts to seek help
- realistic goals for the rehabilitation of inmates with substance abuse problems

a variety of approaches to provide flexibility to meet the varying needs of different addicts

F. MEDICATIONS

1. New admissions requiring medication will be transported to the hospital for medical evaluation and prescriptions if no medical personnel are on call or on-site at CJC. Certification by the Warden that this system is in place will be submitted to the Plaintiffs' counsel no later than December 1, 1994. The Warden will be responsible for ensuring that new inmates are promptly transported to the hospital for medical evaluations and prescriptions as necessary.

2. By December 1, 1994, prescriptions for inmate medications will be taken to the pharmacy and the filled prescriptions returned to CJC within twenty four (24) hours of the writing of the prescriptions, unless it is medically indicated that they be dispensed sooner. Certification by the Warden that this is being done will be submitted to the Plaintiffs' counsel no later than December 1, 1994. A log of prescriptions and time required for obtaining medications will be maintained and submitted to the Plaintiffs'

counsel on a quarterly basis.

3. Medications will be given from a filled prescription only to the patient for whom it was prescribed by December 1, 1994. Prescription medications will not be re-used for other patients. Certification of compliance with this provision, including that all non-current prescription medications have been discarded, will be submitted to the Plaintiffs' counsel no later than December 1, 1994. The Nurse Supervisor will be responsible for ensuring on-going compliance with this provision and will inventory prescription medications to discard those no longer in use on a weekly basis.

4. Controlled substances will be maintained in a locked narcotic cabinet and will be counted and logged by nursing staff whenever dispensed and on a daily basis by December 1, 1994. Certification by the Warden that a locked cabinet is present and in use and by the Nurse Supervisor that the system of counting and logging controlled substances is in place will be submitted to the Court no later than December 1, 1994. A copy of the narcotics control log will be submitted to

the Plaintiffs' counsel on a quarterly basis.

5. All medications will be routinely checked by nursing staff for expiration dates and expired drugs discarded. Certification by the Health Care Coordinator that this is being done will be submitted to the Plaintiffs' counsel by December 1, 1994. The Registered Nurse will inspect all medications monthly and will note the presence of any expired drugs. The results of these inspections will be submitted to the Plaintiffs' counsel on a quarterly basis.

G. INTAKE EVALUATIONS

1. By December 1, 1994, a brief health screening question list will be administered at admission and prior to housing by a nurse. If an admission occurs in the absence of nursing coverage, a correction officer who has been instructed in its use by medical staff shall conduct this evaluation. The prisoner shall be evaluated the next day by the nursing staff. Questions on the screening list will include current illnesses, medications, and suicidal ideation or history. The form will be submitted to medical staff for use in

inmates' medical intake evaluations and will be retained in inmates' medical records. The form will be in use by December 1, 1994. Certification by the Warden that this system is in place shall be submitted to the Plaintiffs' counsel no later than December 1, 1994.

2. A medical intake evaluation, utilizing a standardized history and physical examination form substantially the same as the form provided as Appendix D, will be performed by the facility physician on all new admissions within four (4) days of admission. This system will be in place by December 1, 1994. Certification by the Health Care Coordinator that the system is in place will be submitted to the Plaintiffs' counsel no later than December 1, 1994.

3. Laboratory tests will be performed on all new admissions within seven (7) days of admission and consist of the following:

   a. tuberculin skin test (PPD) in accordance with CDC guidelines attached hereto as Appendix E.

   b. urinalysis (dipstick)

   c. syphilis blood test (RPR)

   d. complete blood count (CBC)

e. PAP Smear (women)

f. urine pregnancy test (women)

g. additional tests deemed clinically necessary by physician

These tests shall be implemented by December 1, 1994. Certification by the Health Care Coordinator that the practice has been implemented shall be submitted to the Plaintiffs' counsel no later than December 1, 1994.

4. By December 1, 1994, defendants shall conduct PPD testing on all CJC prisoners, employees and agents of defendants who have direct contact with prisoners, unless such employee or agent has had a negative test result recorded within the last twelve months or has a previously recorded positive PPD. Persons who test ≥ 5mm will be treated in accordance with CDC guidelines.

5. The defendants shall implement prompt and consistent testing, reading and recording of PPD tests for newly arriving prisoners, including the administration of PPD tests as soon as practicable at the time of entry into the system.

H. SICK CALL

1. Sick call will be freely accessible on a regularly scheduled, daily basis and will be conducted by qualified medical staff (MD or RN) in an appropriate physical space containing a medical examination table, adequate lighting, and running

water. Equipment required for physical evaluation will be available, including:

flashlight

otoscope/ophthalmoscope

sphygmomanometer

tongue depressors

reflex hammer

examining gloves

The sick call system, with adequate equipment and physical space, will be in place by December 1, 1994. Inmates' sick call request slips will be submitted daily and collected from boxes in all clusters twice daily by medical staff. Medical staff shall record the date(s) of treatment on sick call slips and place slips in the inmates' medical charts. Certification by the Health Care Coordinator that the system is in place, including a schedule of sick call times, a list of the equipment available, and a description and location of the physical space provided, will be submitted to the Plaintiffs' counsel no later than December 1, 1994.

I. FOLLOW-UP CARE

1. Patients requiring follow-up for chronic diseases or other reasons will be scheduled for the purpose in a follow-up log substantially the same as that provided in Appendix F. A disposition

on each patient scheduled will be entered into the log. A list of patients with chronic conditions will be maintained by medical staff to insure that such patients are not lost to follow-up. This system will be in place by December 1, 1994. Certification by the Health Care Coordinator that the system has been implemented will be submitted to the Plaintiffs' counsel no later than December 1, 1994. The Registered Nurse will be responsible for monitoring the follow-up system and ensuring compliance with this section of the plan. A copy of the follow-up logs and chronic disease list will be forwarded to the Plaintiffs' counsel on a quarterly basis.

J. MEDICALLY INDICATED DIET

1. Medically indicated diets will be ordered by medical staff, who will submit a requisition form substantially the same as that provided at Appendix G, to the kitchen manager. The kitchen manager will insure that inmates on medically indicated diets receive the proper diets. This system will be in place by

December 1, 1994. Certification by the Warden that the system has been implemented will be submitted to the Plaintiffs' counsel no later than December 1, 1994.

2. Guidelines for preparation of medically indicated diets will be developed in consultation with a dietician and will be present in the kitchen by December 1, 1994. Certification by the Warden that the guidelines are posted will be submitted to the Plaintiffs' counsel no later than December 1, 1994. The kitchen manager will be responsible for consulting with the dietician as necessary and periodically updating the posted guidelines.

3. Medical staff will maintain a list of patients receiving medically indicated diets by December 1, 1994. The list of patients will be reviewed by the Registered Nurse for continued need and for completeness on a monthly basis. A copy of the list will be submitted to the Plaintiffs' counsel no later than December 1, 1994.

K. HOSPITAL APPOINTMENTS

1. A record will be kept of all appointments requested at the hospital (clinics, dental, laboratory, x-ray), date of appointment, whether visit occurred, and disposition by

December 1, 1994. Clinic referral forms and the clinic log book will be substantially the same as those provided in Appendix H. Certification by the Health Care Coordinator that the system is in place will be submitted to the Plaintiffs' counsel by December 1, 1994. A report listing all hospital referrals and their disposition will be submitted to the Plaintiffs' counsel on a quarterly basis.

L. MEDICAL REFERENCES

Up-to-date medical references will be available at CJC, including Physicians' Desk Reference, Conn's Current Therapy, and Lippincott Manual of Nursing Practice by January 1, 1995. Certification by the Health Care Coordinator that the references are available will be submitted to the Plaintiffs' counsel no later than January 1, 1995. The Registered Nurse will monitor the availability and currentness of the references and will report to the Nurse Supervisor when replacement is necessary. The Health Care Coordinator will ensure that such replacements are made.

M. MISCELLANEOUS MEDICAL ISSUES

1. After ninety days of detention, the defendants shall provide eyeglasses to those inmates who need them.

2. After sixty days of detention, the defendants shall provide routine dental services to prisoners. If restorative services are indicated, they shall be provided.

3. Emergency dental care shall be provided to all prisoners regardless of length of stay.

4. The defendants shall adopt quality assurance practices, including bi-weekly meetings between the Health Care Coordinator and CJC medical staff by January 1, 1995.

5. By November 1, 1994, inmates in need of infirmary care shall be transferred to the Infirmary at Golden Grove.

N. MEDICAL CHARTS

1. The defendants shall adopt standardized charting practices by December 1, 1994. The prisoners' health record files shall contain the following items:

-completed admission screening form

-health appraisal data forms

-all findings, diagnoses, treatments, dispositions

-record of prescribed medications and their administration

-laboratory, x-ray, and diagnostic studies

-signature and title of documenter

-consent and refusal forms

-release of information forms

-place, date and time of health encounters

-health service reports, e.g., dental, mental health, and consultations

-treatment plan, including nursing care plan

-progress reports

-discharge summary of hospitalization and other termination summaries.

2. The method of recording entries in the prisoners' records, the form and the format of records, and the procedures for their maintenance and safekeeping shall be approved by an appropriate health authority.

3. All findings, including notations concerning mental health, dental, and consultative services shall be recorded at the time of service delivery or no later than 14 days from the time of discharge or termination of treatment. The receiving screening form shall become a part of the record at the time of the first health encounter.

4. Prisoners suffering from infectious diseases and in need of medical isolation shall be transferred to St. Thomas Hospital for appropriate treatment.

V. MENTAL HEALTH

1. Mental health referrals, evaluations, and follow-up will be managed by the Mental Health Worker. A mental health checklist and referral form substantially the same as those provided in Appendices I and J will be used. The Mental Health Worker and referral system

will be in place by January 1, 1995. Certification that the referral system is in place will be submitted to the Plaintiffs' counsel no later than January 1, 1995.

2. Referrals shall be made to the local hospital in emergency situations or to the Community Mental Health (CMH) Center. All prisoners referred for non-emergency care shall be evaluated by CMH or CJC staff within five (5) days, unless a shorter period is medically indicated.

3. Upon return to CJC from a mental health evaluation, any reports or recommendations will be reviewed by the Mental Health Worker and medical staff and appropriate housing and follow-up will be arranged. This system of review, housing, and follow-up will be in place by January 1, 1995. Certification by the Health Care Coordinator that this has been implemented will be submitted to the Plaintiffs' counsel no later than January 1, 1995.

4. A housing area at CJC will be designated for inmates requiring mental observation by November 1, 1994. In this area, suicide watch and close mental health follow-up will be available. Certification by the Warden that a mental health housing area has been provided will be submitted to the Plaintiffs' counsel no later than November 1, 1994.

5. The defendants shall establish mental health cells for prisoners in need of restraints, seclusion, or observation by December 1, 1994.

6. Hospital beds for inmates requiring hospitalization shall be made available at the St. Thomas Hospital by November 1, 1994.

VI. CORRECTIONS AND SECURITY

A. Operations

1. By April 1, 1995, the defendants shall establish policies and procedures governing the operations of CJC. This manual shall contain all procedures for institutional security and control, with detailed instructions for implementing these procedures. The manual shall be available to all staff and reviewed at least annually and updated if necessary.

2. The defendants shall establish an objective-based classification program in conformity with the guidelines issued by the National Institute of Corrections by April 1, 1995.

3. Housing officers shall conduct fifteen-minute checks of the housing units and maintain a log by November 1, 1994.

4. Disciplinary and protective custody

segregation cells shall be established. Prisoners in need of long-term segregation shall be transferred to Golden Grove by April 1, 1995.

5. Defendants shall immediately discontinue the practice of instituting long-term facility-wide lockdowns of prisoners in excess of 72 hours, unless emergency circumstances exist. For the purposes of this agreement, emergency is defined as a circumstance caused by a significant security breach affecting the entire facility, or riot, fire, hurricane or similar event not caused intentionally by the defendants. If the defendants intend to extend a lockdown beyond 72 hours for emergency reasons, the BOC Director shall notify plaintiffs' counsel immediately and certify the justification for extending the lockdown. Within 72 hours thereafter, the BOC Director shall forward a plan to plaintiffs' counsel to end the lockdown. A record of all lockdown periods, regardless of length, shall be maintained at CJC and made available to plaintiffs' counsel upon reasonable notice. If the lockdown exceeds 72 hours and the plaintiffs' dispute the justification offered by the defendants or believe the conditions are

unconstitutional, plaintiffs can seek appropriate relief from the Court.

B. Activities

1. Outdoor recreation shall be provided not less than three hours daily, seven days a week by April 1, 1995. In the interim, prisoners will be provided 1.5 hours of outdoor recreation daily.

2. By November 1, 1994, inmates shall not be confined to their cells more than twelve hours daily. The cell doors shall remain open during out-of-cell periods. The parties understand that this twelve hours represents the maximum amount of in-cell time on a regular daily basis, and takes into consideration unusual circumstances such as power outages or staff shortages.

3. By May 1, 1995, the defendants shall establish a comprehensive library system;

4. Substance abuse services shall be provided by April 1, 1995;

5. Jobs shall be made available for sentenced and long-term detainees by April 1, 1995.

C. Excessive Force

By April 1, 1995, Defendants shall do the following:

1. Defendants shall develop a policy and procedures that strictly prohibit the use of force except in clearly defined appropriate circumstances;
2. All use of force incidents shall be visually supervised by the Shift Commander where feasible, and reported immediately;
3. A use of force report(s) shall be prepared by the staff involved;
4. Medical personnel shall be notified immediately when there is a use of force incident or when prisoners are placed in restraints. The personnel shall immediately examine the inmate and prepare an injury report;
5. For a period of one year from the entry of this agreement, all use of force incidents shall be videotaped and recorded where feasible;
6. All use of force reports, incident reports, injury reports, and videotapes shall be collected and forwarded to the Assistant Warden for review. They shall

be preserved in a orderly manner and made available to plaintiffs' counsel for review on a periodic basis;

7. Any allegations of physical abuse shall be referred to the DOJ and plaintiffs' counsel for investigation.

D. Training Requirements

Orientation

1. As of April 1, 1995, policies and procedures shall be written that all new full-time employees shall receive four (4) hours of orientation training before undertaking their assignments. Orientation training shall include at a minimum the following: orientation to the purpose, goals, policies and procedures of the institution and parent agency; working conditions and regulations; employees' rights and responsibilities; and an overview of the correctional field. Depending on the employee(s) and the particular job requirements, orientation training may include preparatory instruction related to the particular job.

Correctional Officers

2. As of April 1, 1995, policies and procedures shall be written and practice shall provide that all new correctional officers receive an additional 120 hours of training during their first

year of employment and an additional 40 hours of training each subsequent year of employment. At a minimum, this training shall cover the following areas:

- security procedures
- supervision of inmates
- signs of suicide risk
- suicide precautions
- use of force regulations
- report writing
- inmate rules and regulations
- rights and responsibilities of inmates
- fire and emergency procedures
- safety procedures
- firearms training
- key control
- interpersonal relations
- social/cultural life styles of the inmate population
- communication skills
- first aid

VII. AMERICANS WITH DISABILITIES ACT

Defendants shall comply with the Americans With Disabilities Act (ADA) by January 1, 1995.

VIII. RELIGIOUS FREEDOM

Defendants shall provide the following by January 1, 1995:

A. Defendants shall provide meat substitutes for prisoners who observe religious diets.

B. Defendants shall allow prisoners to groom themselves in accordance with religious beliefs unless a medical risk exists in a specific case as defined by a physician.

C. Defendants shall offer congregate religious services.

D. Defendants shall allow prisoners to have items necessary to practice their religious beliefs, including, but not limited to, kufi skull caps and prayer rugs, unless a security risk exists in a specific case.

IX. LEGAL ACCESS

A. By January 1, 1995, policies and procedures shall be written, and practice instituted to ensure the right of inmates to have access to courts. The right of access to the courts shall provide at a minimum that inmates have the right to present any issue, including the following: challenging the legality of their conviction or confinement; seeking redress for illegal conditions or treatment while under correctional control; pursuing remedies in connection with civil legal problems and asserting against correctional or other government authority any other rights protected by constitutional or statutory provision or common law. Inmates seeking judicial relief shall not be subjected to reprisals or penalties because of the decision to seek such relief.

B. By January 1, 1995, policies and procedures shall be

written and practice instituted to ensure and facilitate inmate access to counsel and assist inmates in making confidential contact with attorneys and their authorized representatives; such contact includes, but is not limited to, unmonitored telephone communications, uncensored correspondence, and contact visits.

C. By January 1, 1995, institutional authorities shall assist inmates in making confidential contact with attorneys and their authorized representatives; these representatives may include law students, special investigators, lay counsel, or other persons who have a legitimate connection with the legal issue being pursued. Provision shall be made for visits during normal institutional hours, uncensored correspondence, telephone communications, and additional hours outside of the routine schedule requested because of special circumstances.

D. By April 1, 1995, policies and procedures shall be written, and practice shall provide for the rights of inmates to have access to an appropriate law library and to paper, typewriters and other supplies and services related to legal matters. The law library shall include at a minimum relevant and up-to-date constitutional, statutory, and case law materials, applicable court rules, and practice treatises.

When an inmate is unable to make meaningful use of the law library on his or her own, the additional assistance necessary for effective access is provided.

X. MAIL, TELEPHONE AND VISITATION

Defendants shall do the following by January 1, 1995:

A. Policies and procedures shall be written to govern inmate correspondence; they shall be available to all staff and inmates, and reviewed annually and updated as needed.

B. Policies and procedures shall be written and institutional practice implemented to provide that indigent inmates, as defined in policy, receive a specified postage allowance to maintain community ties. An inmate without financial resources shall be provided the means to send a reasonable number of letters per month. Community ties include family, personal friends, but not privileged communication to attorneys, public officials and courts.

C. Policies and procedures shall be written and implemented to govern inmates' access to publications. Any restrictions on access to publications shall be directly related to maintenance of facility order and security.

D. Policies and procedures shall be written and instituted to provide that inmate mail, both incoming and outgoing personal, but not privileged legal mail, may be opened and inspected for contraband.

E. Defendants shall develop and institute written policies and

procedures to provide for inmates' access to telephones. Telephone facilities shall permit reasonable and equitable access to all inmates and permit a reasonable amount of privacy. Procedures shall specify the hours during which the telephone is available, the maximum length of calls, and any limitation on calls.

F. Defendants shall develop and implement written policies and procedures that provide that the number of visitors an inmate may receive and the length of visits may be limited only by the facility's schedule, space, and personal constraints or when there are substantial reasons to justify such limitations.

XI. MISCELLANEOUS

Halfway House: It is not the parties' intention that the services provided in this Agreement for the benefit of CJC prisoners shall be diminished in any respect by the opening of the Halfway House or other facilities.

Expansion of CJC

Any expansion of CJC into the first or second floors of the building shall be subject to the terms of this Agreement, except that staffing levels shall be increased proportionately.

MONITORING AND COMPLIANCE

The following provisions shall be in effect immediately upon the execution of this Agreement:

A. The BOC shall post and maintain one (1) copy of this Agreement in the CJC law library and in the

dayroom of each housing cluster.

B. On 72 hours' notice to defendants, plaintiffs' counsel and their assistants shall have the right to meet freely and privately with individual prisoners at CJC in a contact visit area.

C. Defendants shall grant plaintiffs' counsel access to tour CJC to evaluate defendants' compliance with this Agreement. Plaintiffs' counsel shall provide ten (10) days' notice to defendants in advance of these tours.

D. For the purpose of monitoring this Settlement Agreement, the BOC agrees to permit meetings between plaintiffs' counsel and groups of CJC prisoners at a time on a monthly basis at the CJC. This provision will in no way interfere with the right of plaintiffs' counsel to meet with their clients on an individual basis.

E. Upon request by plaintiffs' counsel, BOC shall grant plaintiffs' counsel, their assistants and consultants access to any documents that may demonstrate compliance or lack of compliance with the terms of this Agreement.

F. As of the effective date of this agreement, the defendants will begin providing the following periodic reports related to compliance with this agreement to plaintiffs' counsel:

- quarterly population reports indicating the number of sentenced prisoners and pretrial detainees held in

each cluster, the number of inmates held in: new admissions housing area(s), protective custody, infirmary, or medical isolation units.

- quarterly medical reports indicating: the number of physical exams conducted, PPD tests administered, referrals to St. Thomas Hospital for emergency care and specialty clinics.
- quarterly prisoners' medical grievances indicating: the number of grievances filed on various medical care issues.
- quality assurance reports (as generated)
- quarterly statistics and narrative summaries of incidents involving assaults by prisoners and by staff, indicating the outcome of each incident.
- quarterly reports on use of force by CJC staff.
- quarterly food services reports (by Virgin Islands Division of Public Health)
- quarterly water quality reports (by BOC and Virgin Islands Departments of Planning and Natural Resources and Health)
- bi-monthly status reports on recruitment and hiring for positions covered by this agreement
- sanitation reports (as generated by the Department of Health and Internal BOC Audit)
- semi-annual law library inventories.

During each monitoring visit, defendants shall make available to

plaintiffs' counsel, their assistants and consultants, records and reports relevant to any of the matters described in this Agreement. These records shall also be available for review by consultants or experts working with plaintiffs' counsel. Among the documents to be produced are:

- medical records of treatment provided to plaintiffs maintained by CJC staff and by St. Thomas Hospital;
- records of mental health care provided to plaintiffs at CJC or community mental health facilities;
- records of the death of any plaintiffs, either at CJC or at St. Thomas Hospital or local hospice facilities;
- copies of sick call request slips submitted by prisoners and daily lists of prisoners seen by medical staff;
- incident reports involving plaintiffs;
- use of force reports;
- staff disciplinary reports and referrals to outside agencies;
- logbooks and documents reflecting new admissions to CJC; the number of prisoners attending daily recreation sessions and law library.

Plaintiffs' counsel shall have the authority to retain consultants to evaluate compliance with the terms of this Agreement in the technical areas of medical, dental and psychiatric care, environmental, fire and life safety, when they reasonably believe such assistance is necessary to assess compliance under the terms of this Agreement. Defendants will bear the cost of the reasonable fees and expenses of these consultants in the event that plaintiffs' counsel are required to initiate enforcement proceedings.

All provisions of this decree which are not accompanied by an implementation date shall be implemented as soon as practicable and no

later than January 1, 1996.

Counsel for the plaintiff class will bring any complaints of non-compliance to the attention of defendants' counsel prior to initiating any court action. The parties will attempt in good faith to resolve all such disputes between themselves in the first instance.

Defendants' counsel will notify counsel for the plaintiff class of any proposed modification of the rights and privileges accorded plaintiffs by this decree prior to seeking formal court approval for any such modifications. The parties will attempt in good faith to resolve all disputes concerning such modifications between themselves in the first instance.

If defendants are unable to implement fully the terms of this Agreement, despite their best efforts, plaintiffs are free to seek such other and further relief from the Court as may be necessary to bring about elimination of the conditions which this decree seeks to remedy. The defendants shall petition the Court for relief under F.R.C.P. 60(b)(5) for changed circumstances that may arise that are outside the contemplation of the parties as set forth in this Agreement.

JURISDICTION

This Court shall retain jurisdiction over this matter to insure compliance with the foregoing provisions until such time as all provisions of this decree have been fully implemented and the court has made a finding of substantial compliance.

ATTORNEYS' FEES

The parties agree to attempt to negotiate attorneys' fees and

costs. Should the parties be unable to reach a settlement as to attorneys' fees and costs within 60 days of final approval of this decree, the matter shall be submitted to the Court for its determination; provided, however, that this time period may be extended by stipulation of the parties if approved by the Court.

Respectfully submitted,

Benjamin A. Currence, P.C.
No. 12 Norre Gade, Second Floor
P.O. Box 6143
St. Thomas, U.S.V.I. 00804-6143
(809) 775-3434

Mark J. Lopez, Esq.
Marjorie Rifkin, Esq.
National Prison Project of
the ACLU Foundation
1875 Connecticut Avenue NW
Suite 410
Washington, DC 20009
(202) 234-4830

Attorneys for Plaintiffs

Dated: October 12, 1994

Rosalie S. Ballentine, Esq.
Attorney General

BY: _____
S. Elwood York, Esq.
Principal Assistant Attorney General
as Attorney for Defendants
Virgin Islands Department of Justice
48B-50C Kronprindsens Gade
St. Thomas, USVI 00802
(809) 774-5666

Dated: October 12, 1994

_____
Kurt Walcott, Warden
Virgin Islands Bureau of Corrections
3008 Orange Grove
St. Croix, VI 00820

Dated: October 12, 1994

It is hereby ORDERED that the foregoing Settlement Agreement is approved and etnered as the judgment of this Court on this ____ day of October, 1994.

_____
Honorable Stanley S. Brotman
United States District Judge

APPENDIX A

APPENDIX A

HOUSEKEEPING PLAN/SANITATION

PURPOSE

To ensure effective housekeeping practices through the conduct of regular inspections thus requiring desired standards of sanitation.

GENERAL

This procedure provides a vehicle for the regular monitoring of environmental health programs especially related to housekeeping practices and sanitary conditions.

PROCEDURES

I. A staff member designated by the Warden will serve as coordinator of the sanitation inspection program designed to ensure:

A. All areas are clean and orderly
B. Lighting and ventilation equipment function
C. No fire, safety, or health hazards exist
D. All equipment, tools, and security devices perform properly
E. In living areas, inspections shall include verification of appropriate supervision of inmate workers and potentially hazardous materials
F. All plumbing equipment including toilet, bathing, washing, and laundry facilities operate properly
G. A review of previous reports is conducted

II. Inspections

Inspections will be done weekly by appointed staff. Staff will be appointed for this within 15 days of entry of the plan. Those staff members who are appointed shall be familiar with expected sanitation and safety practices of the area they are inspecting. After the inspection, the inspecting staff member shall fill out the inspection report (see attachment), will review the results of the inspection and write down any needed work to be done in order to comply with any indicated deficiencies, and will sign off on the report and then send it to the Warden for review.

Any deficiencies that are noted on the inspection should be corrected as soon as possible. All deficiencies that create serious safety or health problems for inmates or staff will be corrected immediately.

III. Area Housekeeping Plans

Plans will require the following:

A. A cleaning schedule for the area
B. Specific assignments for inmates assigned to sanitary duties
C. A time schedule for duty completion
D. Specific instructions for the cleaning of:

1. Floors and doors
2. Inmate quarters
3. Inmate personal property
4. Walls and windows
5. Toilet and shower facilities
6. Equipment
7. Storage areas

E. Waste disposal procedures which provide for proper collection, storage and disposal of all liquid and solid waste accumulation for the area
F. Instructions for the acquisition, utilization, and storage of cleaning supplies and equipment.

IV. Plan Approval

The area housekeeping plans will be forwarded to the Virgin Islands Health Department for review and approval. A copy of the approved plan for each area shall be distributed and maintained in the area and in the Warden's office.

V. Sanitation of Cells and Rooms

Each inmate is required to maintain sanitary living area conditions as follows:

A. Each inmate shall be responsible for the cleanliness of his cell or living area including walls, floors, sink, toilet, windows, and other property within the cell room or living area.

B. Cleaning materials and articles for cleaning shall be issued by the area supervisor to the inmates. The inmate is responsible for the proper usage and care of these articles.

C. No curtains, screens, paper, cellophane, or cardboard, etc, shall be hung in the cell or on the cell doors since this constitutes a fire hazard.

D. the designated staff person shall inspect cells and living areas daily and report any infractions of these orders to his/her immediate supervisor.

E. The supervisor shall, as needed, issue the inmate an unsatisfactory cell condition warning (written or oral) and, in case of continued non-compliance, issue a misconduct report.

VI. Monthly Inspections

A monthly inspection will be conducted by the institutional Coordinator of Sanitation. He/she will submit a report to the Warden for review. The report shall be sent to the affected areas for review and response. All discrepancies shall be examined and corrected within 30 days of receipt. If items take longer, a Plan of Action will be submitted.

VII. Semi-annual Independent Audit

The Virgin Islands Health Department will conduct a semi-annual sanitation and health inspection. These reports will be reviewed by the Warden and the Director of the Bureau of Corrections. All discrepancies shall be examined and corrected within 30 days of receipt. If the items take longer, a Plan of Action will be submitted.

VIII. Training of Inspectors

The inspecting officers doing weekly inspections for the institution shall be knowledgeable in sanitation and safety practices. Institutional inspectors shall be knowledgeable of daily sanitation and safety needs.

The Virgin Islands Health Department will conduct training sessions for these officers and for the institutional Coordinator of Sanitation.

AREA INSPECTED:_____ AREA SUPERVISOR:_____ DATE:___

DATE INSPECTED:_____ FACILITY ADMINISTRATOR REVIEW:_____

INSPECTED BY:_____ DATE REVIEWED:_____

CIRCLE APPROPRIATE DESIGNATION: S=Satisfactory U=Unsatisfactory
N/A=Not applicable

1. GROUNDS (Exterior) Free of debris, grass areas Sport equipment, condition of sidewalks, stairs, and walls.	S	U	N/A	7. ELECTRICAL Grounding of equipment, exposed wiring covered. Condition of junction boxes, switches, and fittings. Power cord not frayed. Guarding of equipment.	S	U	N/A	
2. BUILDINGS (Interior) Floors, walls, ceilings, and stairs clean, repaired. Windows washed and repaired. Control flammables, toxics, caustics. Containers properly labeled	S	U	N/A	8. PROTECTIVE EQUIPMENT Eye and face protection. Gloves available. Noise protection.	S	U	N/A	
3. ROOMS Clean, in good condition, beds made, proper bedding, and mattress covers. Ventilation clear and open. Waste control: Food and snacks in room approved and controlled. Minimum of flammable materials.	S	U	N/A	9. FLAMMABLE AND COMBUSTIBLE LIQUIDS Proper and safe storage and dispensing. Adequate ventilation in storage and when dispensing liquids. Grounding of containers with flammable and combustible materials.	S	U	N/A	
4. SHOWER FACILITIES Floors, walls, and ceilings clean and in good condition. Shower operating.	S	U	N/A	10. FIRE SAFETY Fire protection equipment: extinguisher regularly checked, evacuation plan up to date, first aid equipment, fire hoses, heat and smoke detectors, emergency lights.	S	U	N/A	
5. TOILET FACILITIES Soap, towels, and covered waste basket provided. Facilities clean and in good condition. Toilet operating.	S	U	N/A	11. REFUSE Adequate amount of containers available, conveniently located, cleaned regularly.	S	U	N/A	
6. HYGIENE Clothing cleaned, properly stored, and in good condition. Bedding clean.	S	U	N/A	12. FOOD SERVICE Proper food temperature maintained. Serving area, equipment, and utensils clean. Cross contamination prevented. Food handlers hair restraint, free of infections or respiratory illnesses.	S	U	N/A	

INSPECTOR'S EXPLANATIONS:

AREA SUPERVISOR'S COMMENTS:

APPENDIX B

GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES

DEPARTMENT OF PLANNING AND NATURAL RESOURCES
NISKY SHOPPING CENTER
SUITE 45
CHARLOTTE AMALIE, ST. THOMAS, V.I. 00802

September 27, 1994

Mr. Alcedos Lettsome
Chief, Bureau of Corrections
Alexander A. Farrelly Criminal Justice Complex
St. Thomas, VI 00802

Dear Mr. Lettsome:

In accordance with the Virgin Islands Rules and Regulations, Title 19, Chapter 51, Subsection 1303, the Alexander A. Farrelly Criminal Justice Complex is classified as a community public water system (CPWS) because it has at least fifteen (15) service connections and/or regularly serves at least twenty-five (25) persons year round. Furthermore, the facility uses water from a cistern that is supplied by two (2) sources, roof catchment and the VI Water and Power Authority (WAPA). Because these sources are mixed in the cistern, the facility cannot be considered part of WAPA's public water system. As a CPWS, you are required to provide for the routine monitoring of your drinking water quality as dictated by the Virgin Islands Safe Drinking Water Rules and Regulations and the Federal Safe Drinking Water Act and Amendments.

The Department of Planning and Natural Resources (DPNR's) records indicate that up to the present date your public water system has not complied with any of the drinking water monitoring requirements of either the Federal or the Virgin Islands Safe Drinking Water Act.

You are hearby notified to immediately come into compliance with all of the Rules and Regulations of the Safe Drinking Water Act. The following is a summary of what is required:

1) Routine monthly monitoring of Total/Fecal Coliforms under §1303-41 of the VI Rules and Regulations.

2) Routine daily turbidity sampling under §1303-42 of the VI

Rules and Regulations.

3) Lead and Copper sampling under 40 Code of Federal Regulations (CFR) Ch. 1 Subpart I: The initial monitoring period for sampling for your system began on July 1, 1993. You are required to sample at least ten (10) sites within your system during the initial compliance period (six (6) months). A second set of ten (10) samples will be required in the subsequent sampling period (subsequent six (6) months). Future sampling frequency will be based on the results of the first two (2) rounds of sampling.

4) Inorganic contaminant sampling in accordance with §1303-43 of the VI Rules and Regulations and 40 CFR Ch. 1 Subpart C §141.23. You are required to sample annually for all inorganic contaminants listed in §1303-21 at the entry point to your distribution system in the compliance period that began on January 1, 1993 and ends on December 31, 1995. The five (5) inorganic contaminants promulgated under the Phase V Rule (antimony, beryllium, cyanide, nickel, and thallium) have to be sampled annually between January 1, 1996 and December 31, 1998. Repeat monitoring requirements depend on the analytical results of the first round of sampling.

5) Volatile Organic Contaminant (VOC) sampling in accordance to §1303-44C of the VI Rules and Regulations for eight (8) contaminants (Phase I Rule) listed in §1303-28 should have been completed in the initial compliance period beginning on January 1, 1991. This sampling must be conducted at the point of entry to the distribution system every three (3) months for one (1) year. Frequency of subsequent sampling will be determined by DPNR based on these initial results. In accordance to 40 CFR Ch 1. Subpart C §141.24, sampling for an additional ten (10) contaminants listed in §141.61(a)(9)-(18) (Phase II Rule) must be completed by December 31, 1995, and sampling for an additional three (3) contaminants listed in §141.61(a)(19)-(21) (Phase V Rule) must be completed December 31, 1998. Initial sampling for these VOCs must occur in four (4) consecutive quarters for one (1) year. The results of this sampling will determine the frequency of future sampling.

6) Regulated Synthetic Organic Contaminant (SOC) sampling in accordance with 40 CFR. Chap 1 §141.24 must be completed by December 31, 1995 for 18 SOCs listed in §141.61(c)(1)-(18)(Phase II Rule) and by December 31, 1998 for an

additional 15 SOCs listed in §141.61(c)(19)-(33) (Phase V Rule). The sampling must occur in four (4) consecutive quarters during the initial year of sampling. Future sampling frequency will be based on the results of this initial round of sampling.

7) Unregulated VOCs and SOCs must be sampled in accordance with 40 CFR Ch. 1 Subpart E §141.40. Sampling should be performed quarterly for the period of one (1) year every five (5) years.

7) Radionuclide sampling in accordance to §1303-45 and §1303-46 of the VI Rules and Regulations. Quarterly samples must be taken during the initial year of sampling. Compliance will be based on a composite of this quarterly sampling. Future monitoring will occur once every four (4) years unless otherwise determined by DPNR.

8) Daily chlorine residual sampling is recommended by DPNR for all CPWS.

Enclosed is a copy of the Virgin Islands Drinking Water Regulations to assist you in this task. A copy of the Code of Federal Regulations (40 CFR) is available for your review at the DPNR office at Suite 231, Nisky Center, St. Thomas. Failure to initiate monitoring for Total Coliforms under and turbidity under within thirty (30) days of this letter will result in future enforcement actions from DPNR. Failure to initiate lead and copper sampling within forty-five (45) days of this letter will result in future enforcement actions by the Environmental Protection Agency (EPA). Sampling of inorganics and organics that should have occurred prior to 1995 must be completed within sixty (60) days of this letter. Enforcement actions may include the imposition of fines up to $5,000 per day for each day you continue to be in violation.

If you have any questions, please call Ira Hobson of my staff at 774-3320.

Sincerely yours,

Leon G. Reed

for Benjamin I. Nazario
Director, DEP

Enclosure

cc: Honorable Rosalie Ballantine, Attorney General
Honorable Anthon Christian, Police Commissioner
Honorable Verne Hodge, Presiding Territorial Court Judge
Mr. Steve Monsanto, Director of Operations Department of Justice
Mrs. Alda Garfield, Deputy Commissioner of Police

APPENDIX C

APPENDIX C

EMERGENCY PLAN

PURPOSE

To describe institution fire procedures, identify equipment available, and to require monitoring of both fire prevention procedures and emergency equipment. To describe the emergency plans for bomb threats and riots.

GENERAL

Inmates, employees, and visitors are provided with a safe environment through the effective use of fire safety procedures and equipment. The most important aspect of an effective fire protection plan is fire prevention. Correctional employees constantly shall be cognizant of fire hazards such as altered outlets, overloaded electrical units, expended fire extinguishers, and improper trash storage. An institutional fire cannot only cause tremendous financial loss, but also threaten lives when the fire occurs in a housing unit. It is essential therefore that all employees make fire prevention a basic part of their daily activities.

All employees shall be attentive to maintaining good housekeeping standards to augment fire safety. This shall include:

A. Proper storage of combustible materials
B. Preventing hazardous electrical situations
C. Participating in fire drills
D. Instructing inmates in fire safety procedures
E. Reporting fire hazards to the Safety Officer
F. Checking fire control equipment regularly.

PROCEDURES

I. Fire Prevention and Safety

A. The following will be required at the facility:

1. Specifications for the selection and purchase of furnishings to indicate the minimum acceptable requirements for fire and safety performance of materials

2. Non-combustible receptacles for smoking materials readily accessible in living quarters and throughout the institution

3. All exits distinctly and permanently marked,

continuously visible and kept clear and maintained in usable condition

4. An emergency generator maintained to provide essential lights, power, and communication during emergencies. The power generator shall be tested at least every two (2) weeks and other emergency equipment shall be tested at least once each quarter

5. All personnel shall be trained in the operation of written emergency plans prior to entry on duty. Employees shall review said emergency plans on a yearly basis.

B. Physical Plant/Material/Equipment Requirements

1. Furnishings: Use of furniture with polyurethane padding and cubicle dividers of plywood or plastic is prohibited. However, wood furniture and cubicle dividers clad with laminate meeting Class A interior finish rating is acceptable.

   a. Floor Coverings: Upkeep and excessive wear are prime considerations in evaluating type and choice of floor covering. However, all carpeting and resilient carpeting must meet Class B rating.

   b. Curtains, Drapes, and blinds: All curtains, drapes, and adjustable blinds shall be of Class A rating.

2. Exits: All living units shall have at least two (2) exits positioned no more than 100 feet to safety. No dead end shall be longer than fifty (50) feet.

   a. All exits are to display exit signs. Diagrams of exit routes must be displayed on unit bulletin boards or walls.

   b. No living quarter doors shall have more than one (1) lock; it shall be of the prison-type locking device.

3. Emergency Lighting: All housing units shall have emergency lighting from the emergency generator to provide sufficient illumination to egress areas during emergencies.

4. Extinguishers: Fire extinguishers will be placed throughout the institution. Extinguishers shall be conspicuously located and mounted where they are readily available. Extinguishers shall not be obstructed or obscured from view. Portable extinguishers shall be maintained in a fully charged and operable condition, and stored in the designated place when not being used. Maintenance shall be performed as follows:

All extinguishers will be checked monthly according to the Preventive Maintenance schedule. All extinguishers out of date, which is yearly, will be removed and replaced with a current extinguisher. The out of date extinguisher will be replenished if needed and hydrostatically tested. Daily checks of gauges will be made by area duty staff.

5. Emergency Keys: Emergency keys are marked as emergency keys on institutional staff key rings in order to be able to unlock emergency doors. Emergency key rings are located at Central Control. These rings contain the necessary keys to open up emergency doors within the institution.

C. Inspections

1. The Virgin Islands Fire Protection service will inspect the institution yearly in order to determine compliance with fire and safety codes. An inspection report will be submitted to the Warden, who in turn will correct any deficiencies found by the Inspector. The response by the Warden shall be sent back to the Inspector within thirty (30) days after receiving such a report.

2. The institutional Safety Officer will conduct inspections of the institution at least monthly. A report of his/her findings will be submitted to the Warden.

The Warden will send out the report to the respective areas that are mentioned on the report. Each area supervisor will have two (2) weeks from the receipt of the report to respond back to the Warden about what will be done to correct any deficiencies.

3. There will be weekly safety checks by selected institutional staff. They will submit a weekly

report to the Warden for his review. Any discrepancies will be sent back to the appropriate work/unit supervisors so that they may take steps to alleviate any problems.

4. The Virgin Islands Fire Protection Service will train institutional staff to do the required weekly and monthly inspections.

D. Fire Drills and Evacuation

1. Institutional Philosophy: Preservation of inmate, public, and staff life are the most important elements of the fire prevention and evacuation plan. The staff's first responsibility in cases of fire is to get everyone evacuated to safety. If the fire is of such a nature that a staff member can handle it by extinguishers, then the employee should handle it. It will be a staff member's judgement call. If the fire is of such a nature that he does not know what to do, evacuate the area and let trained fire fighters from the Fire Department handle it. Staff are not expected to be heroes, but they are expected to follow the evacuation procedures properly.

2. Fire Drills: Fire drills shall be conducted quarterly at the direction of the Safety Officer. The Warden shall be informed of a pending announcement of a fire drill.

a. Fire drills shall be conducted at least once each quarter.

b. The Safety Officer shall schedule the drills and notify the Warden of the scheduling. Prior notification of the drill shall be limited so as to increase drill effectiveness.

c. The Safety Officer shall monitor the drill and report to the Warden in writing.

d. Inmates shall be evacuated from their housing units and work areas according to the posted evacuation maps.

e. An Officer will be dispatched to the parking lot in order to offer possible assistance to the Fire Department personnel and apparatus.

f. The yard officer shall report to the Control Center in order to issue keys and/or equipment as needed.

g. Traffic through the entrance and gates shall be cleared immediately to facilitate fire apparatus access.

h. When the all clear signal is determined by the Safety Officer, immediately following the fire drill, a unit count shall be conducted if ordered by the Warden.

i. The drill shall not be complete until all inmates and staff assigned to the area are identified.

j. When count is clear, all personnel and inmates shall return to their regularly assigned areas.

3. Evacuation Instructions: Evacuation instructions for each individual work area and housing units are on the posted evacuation maps that are posted in each area.

4. Security: The possibility of an escape attempt is increased during a drill or an emergency. Therefore, the officer in charge must insure that a sufficient number of security staff are posted on the perimeter fence during an emergency or drill especially when inmates are being evacuated from their units. The officer in charge shall activate a roving patrol that shall monitor the institution perimeter as well as repel possible interference by outside spectators.

E. Emergency Fire Procedures and General Instructions

1. Notify the Control Room immediately by radio, telephone or by pulling the fire alarm station nearest the emergency if one is available.

If possible, call the Control Room to report the fire emergency with exact description of the situation including location of fire, size of fire and smoke color.

Smoke color indicates the following:

a. yellow: Indicative of toxic gases, evacuate immediately. DO NOT attempt to extinguish.

b. grey brown wisps: Indicative of flashover. STAY CLEAR. Evacuate immediately.

c. grey black: Indicative of primary stage fire. Extinguish if possible AFTER immediate area is evacuated. DO NOT attempt to extinguish in thick smoke.

2. Do not disturb the fire site.

If emergency extinguishing equipment is used, use short blasts at the flame base. Do not disturb the powder by prodding or fanning. Use additional extinguishing powders if necessary.

3. Turn off all electrical switches.

4. Close all windows and doors.

5. Protect the fire scene until an investigation can be conducted. The institution investigator or designee shall be in attendance during the investigation. The Virgin Islands Fire Protection Service shall be provided an institutional fire report within twenty-four (24) hours after the fire.

F. Fire Related Duties for Control Center

When notified of a fire, by a panel alarm or through another type of communication, the Control Center officer shall initiate the following procedure:

1. Immediately call the Fire Department through the local emergency number providing all available fire related information and the exact location of the fire

2. Notify the affected areas, if necessary, to begin evacuation procedures. This notification shall consist of either telephonic instructions to the supervisor, when possible, or instructions via the radio.

3. Advise all radio units of the emergency situation, directing available personnel to proceed to the affected area, and alerting the outside perimeter posts to maintain high security levels.

4. Begin notification of personnel on the emergency

notification roster, i.e., Warden, Assistant Warden, etc.

5. Alert the Medical Department personnel if on site.

6. Maintain an accurate record of notifications of and times pertaining to the emergency.

7. Make all emergency keys in the key cabinet available to appropriate staff immediately upon notification of the emergency.

G. Fire Related Duties of Physical Plant Staff and Medical Staff

1. Maintenance personnel shall be notified and placed on standby alert in order to perform any necessary emergency repair work.

2. Medical personnel shall be placed on standby alert in order to treat possible injuries.

H. Authority and Responsibility During a Fire

1. During a fire emergency the highest ranking officer on duty shall have absolute and total authority for decisions made affecting the institution, the emergency, and security of the premises. Once the Warden or his/her designee arrives, command will be transferred after briefing.

2. Upon the arrival of the Fire Department, the Senior Fire Officer of the Fire Department shall be delegated sufficient authority to control and extinguish the fire.

I. Distribution and Posting of Fire Plan

1. A copy of the floor plan showing exit routes shall be posted in a conspicuous place in each area of the institution. The floor plan shall have directional arrows that reflect the exits and escape routes, the location of the fire extinguisher, and emergency equipment.

2. The institution's Safety Officer will ensure that these floor plans and instructions are up-to-date and accurate.

J. Fire Plan Review

This plan is to be certified by the Virgin Island Fire Protection Service. It is to be reviewed annually and updated, if necessary, by the Warden. If it is updated it will be reissued to the Virgin Island Protection Service.

II. Bomb Threats

The procedures to be followed in the event of a bomb (scare) threat are fairly basic and the most important action is evacuation without causing a panic which could result in damage to personnel and property.

A. Dealing With the Caller

1. Once the threat has been received, try to keep the caller on the line by asking questions which might help to establish whether the call is genuine or a crank call.

Example: 1. Where is the bomb placed?

2. When is it set to go off?

3. Why did you place the bomb?

4. What does it look like?

5. Who are you? (attempt to identify caller)

2. Listen for background noises on the phone which might give a clue to the location of the caller.

3. Notify the proper Bureau of Correction personnel, starting with the Warden.

B. Evacuation/Immediate Action Plan

1. Persons in the area will be evacuated similar to the fire evacuation plan, moving to the safest zone while maintaining custody and control and avoiding panic.

2. Due to the fact that any officer or other staff personnel who works in a given area should be familiar with the area and can readily identify any object that is unfamiliar or does not belong there, each person should search his own area and anyone not associated with the search should be evacuated from the area.

3. Most "Time Bombs" are activated by the use of an alarm clock, thus searchers should listen for a ticking sound.

4. In the event that a foreign object is located which resembles an explosive device the searcher should:

   a. DO NOT TOUCH, make sure the area has been evacuated and call for the proper authority or the Explosive Device Technician.

   b. If the object is questionable e.g., briefcase, purse, box, etc., try to ascertain who might have left it where it was found. If no one identifies the object, have it checked out. Remember, it is better to be slow but sure, than hasty and sorry.

5. After the area has been cleared as safe, a head count of inmates should be made, especially if a false alarm was declared. The threat might have been made to divert attention to cover an escape.

III. Riots/Disturbances

A. Preventive Steps

A riot is any concerted act of five or more inmates that is designed to cause property damage or personal injury. The following procedures can help to detect, prevent or control such acts:

1. Constant alertness by staff personnel for the introduction of contraband which may be used as weapons or tools for escapes.

2. Careful observation for possible weakness in, or tampering with security facilities e.g. gates, windows, locks, bars, vents, etc.

3. Regular shakedowns for the detection of contraband.

4. Frequent counts to maintain accountability of all prisoners at all times.

5. Frequent review of riot control procedures and regular training of riot control teams.

6. Frequent check of emergency communications and emergency equipment.

B. Indicators of Impending Riots

1. An unusual accumulation of commissary products (edible) and tobacco stored in housing units.

2. Large amounts of weapons and other dangerous contraband necessitating more frequent shakedowns.

3. Segregation of large groups of prisoners engaged in secret conversations.

4. Increased violations of institutional rules and regulations.

5. Increased number of fights within and/or between groups.

6. Obvious amount of tools and kitchen utensils being stolen.

7. Unusual silence and tension throughout the institution.

8. Inmates refusing to work or carry out orders.

9. Increase in number of complaints or requests for change of housing assignment.

10. Segregation in the dining room with inmates refusing to eat.

C. Reaction to Danger Signs

1. Notify the Tour Commander of indications of an impending riot.

2. Try to interrogate inmates in the area for possible information about the cause of these signs / or

3. Try to get information from a Trustee or other valid source of information which may reveal a potential occurrence.

4. Investigate complaints and, if found to be legitimate, take steps to get them settled.

5. Immediately report any information of an impending disturbance to the Tour Commander so that action can be taken to prevent it from happening.

6. Keep all lines of communication between superior officers and the control room open limiting phone calls to the length absolutely necessary.

D. Responsibilities in the Event of a Riot/Disturbance

1. Warden and Assistant Warden:

a. Responsible for putting emergency plan into effect.

b. Responsible for alerting all off duty personnel.

2. Supervisors:

a. During 12-8 and 4-12 tours on duty staff will be responsible for putting the emergency plan into effect.

b. Tour Commander will mobilize the staff by:

i. Summoning all available personnel to the control room area by best code or alarm applicable, insuring that all correction officers on all posts except entrance gates and doors will respond.

ii. Give instructions, and assisted by control room officer and/or other riot team personnel, distribute necessary equipment.

3. Control Room Officer:

a. When a disturbance develops in inmate living areas which cannot be handled by the personnel on duty in that area, the control room officer will be immediately notified by telephone, messenger, or radio.

b. Will be designated by the Tour Commander to make the following notifications.

i. The Director

ii. Police headquarters by direct (hot line) phone. In the event that telephone communication is impossible, use available radio

personnel to request transmittal of message to police headquarters.

iii. Hospital superintendent requesting emergency equipment and personnel be put on standby.

E. Evacuation/Immediate Action Plan

1. The officer who witnesses the start of the disturbance will immediately notify the Control Room Officer. He will then attempt to:

a. Lock off all doors that might help to isolate the rioters from other prisoners, officers or visitors.

b. He will secure his area and attempt to remove himself and all non-participants who wish to be removed from the area.

c. He will then appraise the Tour Commander of the situation.

2. All staff personnel will be notified by the best available code or signal other than by announcement over the General Paging System.

3. Added security will be posted on the perimeter and in the towers.

4. The following areas will be considered "Key Areas" and shall be properly secured.

i. Support Building

ii. Vocational Training Building

iii. Treatment Building

iv. Administrative Building

v. Manhole (Electrical Ducts)

5. Non-participating inmates will be removed to the most secure area available with appropriate supervision. All other visitors and non-essential staff personnel should be removed to the outside of the institution.

F. Mobilization of Staff

1. The Tour Commander shall summon all available personnel, including those who are off duty or on pass status.

2. All possible resources for prompt action in providing maximum protection to life and property and maintaining security of the institution will be mobilized.

3. Riot Control Teams will rendezvous in the designated area. The Riot Control Team will consist of:

   a. Eleven (11) officers each squad

   b. One (1) Supervisor, one (1) Senior Correction Officer each squad.

4. Squad Leaders will issue necessary equipment and will be responsible for briefing of squads during the course of action.

5. One squad will enter the institution from the control room area and the other through the rear gate mounted in vehicles. Both will rendezvous by the chapel and by order of the Squad Leaders will assume the appropriate riot control formation.

6. The Squad Leaders will identify the instigator(s) of the riot, determine the necessary formation and attempt to isolate the leaders/rioters.

7. After isolating the instigators and rioters the squads will then secure the area.

8. The Warden will notify the Fire Department if necessary.

9. The Director will notify the Governor and request activation of the National Guard if necessary.

G. Post Riot/Disturbance Procedures

1. Check for and administer first-aid to the injured. Obtain required medical aid.

2. Conduct head count of all prisoners.

3. Assess and begin repair of damages.

4. All personnel involved will complete a report to the Tour Commander describing injuries, damages and other pertinent information.

APPENDIX C

EMERGENCY KEYS

PURPOSE

To require that keys for exits from inmate living areas are properly marked for easy identification by touch and can be issued quickly as necessary.

GENERAL

This procedure is intended to expedite staff and inmate evacuation of locked areas in an emergency.

PROCEDURES

I. The emergency keys to open all exit doors from inmate living areas will be maintained in the institution's control center and will be readily available for issuance by the control center officer.

II. Each housing unit will have its own such emergency key ring containing its exit door keys. Such key rings will be clearly labeled with tags delineating the specific housing unit.

III. Each of the exit doors in each housing unit will be clearly designated as Door 1, Door 2, Door 3, etc. in a consistent pattern (e.g. from left to right when facing the unit from inside the compound) which shall be known by all staff.

IV. The emergency keys for these doors shall have one, two, three, etc. notches cut in their handles correlating to the number of the door which they fit.

V. A similar pattern of notching the key handles will be employed for the exit door keys carried by the housing unit officers inside the units.

VI. Rings of emergency keys to open all exit doors for all other buildings in the facility will be readily available for issuance by the control center officer. Such keys shall be clearly labeled.

VII. The emergency keys in the control center will be tested monthly by the Chief of Security or his designee. Problems with worn keys or malfunctioning locks will be reported immediately and corrected.

VIII. A written record of the issuance of all emergency keys will be made by the control center officer.

DATE OF FIRE DRILL: _____ TIME DRILL STARTED: _____

AREA(S) EVACUATED: _____

SPECIAL CIRCUMSTANCES OR SCENARIO OF DRILL: _____

EVACUATION ROUTE USED: _____

TIME LAST PERSON LEFT EVACUATED AREA: _____ DID EMPLOYEE(S) AND OFFENDERS EVACUATE AREA IN AN ORDERLY FASHION?

____YES ____NO COMMENTS: _____

WERE ALL DOORS IN EVACUATED AREA SHUT? ____YES ____NO COMMENTS: _____

WAS A CHECK MADE OR COUNT TAKEN TO INSURE THAT ALL EMPLOYEES OR OFFENDERS WERE EVACUATED? ____YES ____NO COMMENTS: _____

TIME EMPLOYEES AND OFFENDERS RETURNED TO EVACUATED AREA: _____

COMMENTS: _____

SIGNATURE OF EVALUATOR(S): _____

APPENDIX D

INTAKE HISTORY and PHYSICAL EXAMINATION

DATE: _____ TIME: _____ ☐ AM ☐ PM INSTITUTION _____

Have you been here before? _____ When? _____ How long do you expect to be here? _____ CT Date _____

QUESTION	NO	YES	GIVE DETAILS ON POSITIVE RESPONSES
1. HAVE YOU SEEN A DOCTOR IN THE PAST MONTH?			
2. HAVE YOU BEEN IN THE HOSPITAL RECENTLY OR HAD AN OPERATION?			
3. HAVE YOU BEEN INJURED RECENTLY OR HAVE AN INJURY NOW?			
4. HAVE YOU BEEN TREATED FOR SYPHILIS, GONORRHEA OR OTHER VD? WHEN? WHERE?			
5. DO YOU HAVE LICE OR CRABS NOW?			
6. DO YOU HAVE A HISTORY OF: ASTHMA			
EPILEPSY/SEIZURES			
HYPERTENSION			
HEART TROUBLE			
T.B.			
DIABETES			
HEPATITIS			
7. FAMILY HISTORY OF HEART DISEASE, DIABETES, T.B. OR OTHER DISEASE?			
8. ARE YOU TAKING ANY MEDICATIONS?			
9. ARE YOU ALLERGIC TO ANY MEDICATIONS OR OTHER SUBSTANCES?			
10. HAVE YOU EVER HAD A SKIN TEST FOR TB? WHEN? RESULTS?			
11. HAVE YOU BEEN TREATED OR HOSPITALIZED FOR NERVOUS/MENTAL PROBLEMS?			
12. HAVE YOU TRIED TO HURT OR KILL YOURSELF? THOUGHT OF IT? EXPLAIN?			
13. DO YOU HAVE ANY OTHER HEALTH PROBLEMS? DESCRIBE.			

14. DO YOU USE ALCOHOL OR DRUGS HABITUALLY? If yes, how much, how long and when last used. Withdrawl?

DRUGS USED	YES	NO
Alcohol		
Barbiturates		
Heroin		
Methadone		
Cigarettes		
Other		

15. ARE YOU ON METHADONE MAINTENANCE PROGRAM?
☐ Yes ☐ No
If Yes, Name of Program _____

FEMALE PATIENTS ONLY

Date of Last Period: _____
Birth Control: ☐ Yes ☐ No Type _____
Pregnant Now? _____
Pregnancies: _____ Children Born Alive: _____
Miscarriages or Abortions: _____
Pelvic or Tube Infection: _____ Dates: _____

SIGNATURE OF HISTORIAN:

PHS 13 (3/82)

CONSULTATION REQUEST

PATIENT'S NAME	D.O.B.	BK. CASE NO.
INSTITUTION	**HOUSE LOC.**	**HOSPITAL**
REFERRED TO	**CLINIC/WARD**	**CLINIC NO.**

EMERGENCY

LIFETHREATENING? (Immediate Transport) YES ☐ NO ☐

EMERGENCY (Within 2 hrs. Transport) YES ☐ NO ☐

TOUR COMMANDER _____

TIME _____

INDIVIDUAL CALLING _____

E.R. PHYSICIAN:

SUBJECTIVE DATA:

OBJECTIVE DATA:

ASSESSMENT:

REQUEST:

DATE _____ REFERRING PHYSICIAN _____ PHONE _____

CONSULTATION, FINDINGS, AND RECOMMENDATIONS:

DATE _____ PHYSICIAN _____

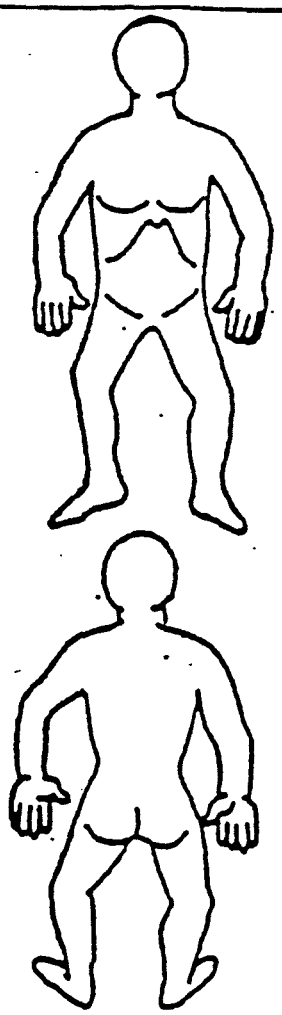
PULSE _____ /min. ☐ Irr ☐ Reg BP (right arm sitting) _____

TEMPERATURE (oral) _____ WEIGHT _____ HEIGHT _____

R / L / B /

VITAL SIGNS TAKEN BY:

SYSTEM	NL	ABNL	GIVE DETAILS OF ALL ABNORMALITIES
1. GENERAL APPEARANCE			
2. SKIN AND EXTREMITIES: Rash, Tracks, Scars, Lesions, Jaundice, Pallor, Abscesses, Edema			
3. HEAD TRAUMA: Inspection and Palpation. If Present, Check ENT & Fundi, Do Neuro.			
4. OTHER TRAUMA:			
5. EYES (PUPILS, CORNEA, CONJUNCTIVA, LIDS): Check Fundi if Diabetic or Hypertensive			
6. ENT – Deaf/Hearing Impaired			
7. MOUTH AND TEETH			
8. LUNGS AND RESPIRATORY EFFORT			
9. CARDIOVASCULAR: Include Check of Brachial and Femoral Pulses if Hypertensive			
10. ABDOMEN: Organomegaly, Bowel Sounds, Tenderness			
11. GAIT			
12. ALERTNESS AND ORIENTATION			
13. MOOD AND AFFECT			
14. RECTAL: If over Age 40 or with Symptoms			
15. EXTERNAL GENITALIA			
16. PELVIC: Cervical, Uterine, Adenexal			
17. BREAST EXAMINATION			
18. OTHER: Include Detailed Neurological if Indicated			



Is M.O. Indicated?
☐ Yes ☐ No

Is Inmate Suicidal?
☐ No
☐ Yes – Needs Psychiatric Attention

Is there a Possibility of Drug/Alcohol Withdrawal?
☐ Yes ☐ No

IMPRESSION – PLAN – DISPOSITION: List and Number Problems. Diagnoses and Place on Problem List. Write Assessment and Plans below, including Medication and Follow-up.

LABORATORY (Check appropriate box for test performed)

☐ RPR Results? _____

☐ PPD Date Read _____ mm Induration _____

☐ CXR ☐ G.C. ☐ HCT ☐ PREG.

☐ LFT ☐ UA ☐ PAP ☐ OTHER

Examiner Date/Time

☐ PHS
☐ MHMC

Print Name

APPENDIX E

Received by the
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL
from MMWR, May 12, 1989, Vol. 38, No. 18, pp. 313-320, 325

Current Trends

Prevention and Control of Tuberculosis in Correctional Institutions: Recommendations of the Advisory Committee for the Elimination of Tuberculosis

These recommendations are designed to assist federal, state, and local correctional officials in controlling tuberculosis (TB) among inmates and staff of correctional facilities (e.g., prisons, jails, juvenile detention centers). This document addresses issues unique to correctional institutions; more general information about TB is available in the official American Thoracic Society (ATS)/CDC statements referenced in this document.

BACKGROUND

TB remains a problem in correctional institutions (*1–6*), where the environment is often conducive to airborne transmission of infection among inmates, staff, and visitors. In a survey of TB cases reported during 1984 and 1985 by 29 state health departments, the incidence of TB among inmates of correctional institutions was more than three times higher than that for nonincarcerated adults aged 15–64 years (CDC, unpublished data). Since 1985, 11 known TB outbreaks have been recognized in prisons in eight states (CDC, unpublished data). In addition, in some large correctional systems, the incidence of TB has increased dramatically. Among inmates of the New York State system, TB incidence increased from an annual average of 15.4 per 100,000 population during 1976–1978 to 106.5 per 100,000 in 1988 (*1*). In New Jersey during 1987, the incidence of TB among state inmates was 108.9 per 100,000—a rate 11 times that of the general population in New Jersey that year (New Jersey State Department of Health, unpublished data). In a survey of California Department of Corrections facilities, the TB incidence among inmates during 1987 was 80.3 per 100,000—a rate nearly six times that of California's general population for that year (California Department of Health Services, unpublished data).

Human immunodeficiency virus (HIV) infection among prisoners in a number of geographic areas heightens the need for TB control among inmates (*8,10*). According to a National Institute of Justice (NIJ) survey, as of October 1988, a cumulative total of 3138 confirmed acquired immunodeficiency syndrome (AIDS) cases had been reported among U.S. inmates since 1981—2047 cases by 44 of 51 state and federal systems and 1089 cases by 28 responding city and county jail systems. These

TB – Continued

reported AIDS cases represent a 60% increase since a similar survey was conducted in 1987. The incidence of AIDS among prisoners has been reported as markedly higher than that among the total U.S. population (*9*). During 1988, the incidence of AIDS in the U.S. population was 13.7 per 100,000 (*11*).* During the same year, the estimated aggregate incidence for state/federal correctional systems was 79 cases per 100,000.† Rates for individual systems ranged from 0 to 538. Although more than half the states have rates ≤ 25, eight state systems have rates ≥ 100. The aggregate rate for 28 responding city/county jail systems was 183 per 100,000. However, rates in city/county jails were described by NIJ as "extremely suspect" because of rapid turnover of population (*9*).

HIV infection in persons with latent tuberculous infection appears to create a very high risk for development of TB (*12–14*). One review of AIDS cases among inmates in selected New York correctional facilities found TB in 22 (6.9%) of 319 persons with AIDS (*3*).

Transmission of TB in correctional facilities presents a health problem for the institutions and may also be a problem for the community into which inmates are released. Each year, more than 8 million inmates are discharged from local jails (*15*) and more than 200,000 from state and federal prisons (*16*). Because the median age of inmates on release is relatively young – 27 years (*17*) – the total lifetime risk for TB in persons infected during incarceration is considerable.

GENERAL GUIDELINES

Control of TB is essential in correctional health care. Each correctional institution should designate an appropriately trained official responsible for operating a TB prevention and control program in the institution. A multi-institutional system should have a qualified official and unit to oversee TB-control activities throughout the system. These responsibilities should be specified in the official's job performance plan. The basic activities to be followed are surveillance, containment, and assessment.

Surveillance refers to identification and reporting of all TB cases in the system or institution and identification of all inmates and staff who are infected with TB (i.e., those with positive skin tests). New cases and newly infected persons must be quickly identified, and appropriate therapy begun.

Containment refers to ensuring that transmission of tuberculous infection does not occur. Appropriate diagnostic, treatment, prevention, and laboratory services must be available. Environmental factors conducive to the spread of TB, such as poor ventilation, should be corrected. Prison officials must ensure that persons undergoing treatment or preventive therapy be carefully monitored for compliance and drug toxicity and complete an appropriate course of treatment.

Assessment refers to prison officials' responsibility for knowing whether the surveillance and containment activities are being carried out effectively.

---

*The incidence for the population at large was calculated as follows: (total number of cases reported to CDC in 1988 ÷ total population) x 100,000.

†Incidence for correctional inmates was approximated from a point prevalence as follows: (AIDS patients in the system at the time of the survey ÷ current inmate population of the system) x 100,000. Data on number of cases by year reported are not available for most correctional systems. The method used may underestimate the actual annual incidence in a correctional system.

TB — Continued

SURVEILLANCE

Diagnosis

The intracutaneous Mantoux tuberculin test (not multiple puncture tests) should be used to identify persons infected with tubercle bacilli. Generally, for correctional institution staff and inmates, a tuberculin skin-test reaction ≥10 mm induration is considered positive. However, a reaction of ≥5 mm is considered positive in persons who have had close recent contact with an infectious person and in persons who have an abnormal chest radiograph consistent with TB (*18*). In addition, infected persons who are immunosuppressed for any reason may show little or no reaction to the tuberculin test (*19*). Therefore, a tuberculin skin-test reaction in a person known to be infected with HIV should be considered positive if induration is ≥5 mm (*20*).

Skin testing of inmates and staff should be carried out at entry or on employment, respectively (*21*). Each skin test should be administered and read by appropriately trained personnel and recorded in mm induration in the personal medical record. All inmates and staff should participate, except those providing documentation of a previous positive reaction to the tuberculin test.

In jails with a rapid turnover of inmates, authorities may decide not to tuberculin test new detainees who are unlikely to remain in the system or in that facility for >7 days. However, provision must be made for appropriate diagnostic measures (e.g., sputum smear and culture and/or chest radiograph) for all persons who are symptomatic (18,20). (See Containment, below.)

In most correctional institutions, skin-test–negative inmates and employees having contact with inmates should have repeat skin tests at least annually. If data from previous screening and TB casefinding are available, the frequency for repeat skin testing should be determined based on the need for timely surveillance information. Observed risk of new tuberculous infection is the most useful evaluation criterion to consider. In institutions with a historically low risk of tuberculous infection (e.g., <0.5% of persons with skin-test conversions annually), an increase in AIDS cases or TB cases should be viewed as indicating a need for more frequent skin testing and intensified TB casefinding activities.

Persons with positive skin-test reactions and all persons with symptoms suggesting TB (e.g., cough, anorexia, weight loss, fever) should receive a chest radiograph within 72 hours of skin-test reading or identification of symptoms. Correctional health-care personnel should be aware of the often atypical signs and symptoms of TB in persons with HIV infection (*20*). Inmates with abnormal chest radiographs and/or symptoms compatible with TB should also have sputum smear and culture examinations. Sputum should be submitted for smear and culture examination from persons with pneumonia or bronchitis symptoms that fail to abate promptly after initiation of antibiotic treatment. Three specimens should be collected, preferably once daily on 3 consecutive days. In the absence of spontaneous production of sputum, aerosol induction in a properly ventilated area should be used to obtain specimens.

Tuberculin skin-test anergy may be a relatively late development in the progression from HIV infection to AIDS (*22*); consequently, inmates with known or suspected HIV infection (including those with nonreactive tuberculin tests) should receive a chest radiograph as part of initial screening, regardless of tuberculin skin-test status.

TB — Continued

Case Reporting

Whenever TB is suspected or confirmed among inmates or staff, this information should be immediately entered into the TB-control records at the institution and at the headquarters level, if in a multi-institutional system. The local or state health department should also be notified, as required by state and local laws or regulations.

Contact Investigation

Because TB is transmitted by the airborne route, persons at highest risk for acquiring infection are "close contacts" (e.g., persons who sleep, live, work, or otherwise share air with an infectious person through a common ventilation system). When a person with suspected or confirmed TB appears to be infectious (e.g., has pulmonary involvement on chest radiograph and cough, and/or positive sputum smear), close contacts must be skin tested unless they have a documented history of a positive tuberculin test (*21*). Close contacts with a positive tuberculin reaction or a history of a previous positive test and symptomatic persons, regardless of skin-test results, should receive immediate chest radiographs to detect evidence of pulmonary TB.

Depending on the ventilation in an institution, close contacts could include all cellmates, all inmates and staff on a tier, or all inmates and staff in a building. Health department staff should be consulted to determine who should be tested. When tuberculin converters are found among the close contacts, other persons with less contact may need to be examined. Every effort should be made by medical and nonmedical staff to ensure the confidentiality of persons with TB.

Close contacts with positive tuberculin reactions but without TB should be given at least 6 months' preventive therapy (see Preventive Therapy, below) unless medically contraindicated (*21*). Close contacts who do not have a positive tuberculin reaction and who are asymptomatic should have a repeat tuberculin test 10–12 weeks after contact has ended.

Contacts with known or suspected HIV infection should be considered for a 12-month course of preventive therapy, regardless of skin-test results, if evidence indicates that the source patient was infectious.

A patient with clinical TB may have negative sputum smears or cultures, especially if recently infected. Close contacts of such persons should also be examined to detect a source case and other newly infected inmates or staff.

CONTAINMENT

Isolation

Persons with suspected or confirmed TB who have pulmonary involvement on chest radiograph, cough, and/or a positive sputum smear should be immediately placed in respiratory isolation (e.g., housed in an area with separate ventilation to the outside, negative air pressure in relation to adjacent areas, and at least four to six room air exchanges per hour) (*23*). It may be necessary to move a patient to another facility or hospital with a respiratory isolation facility.

Respiratory isolation should continue until patients are on appropriate therapy and at least three consecutive daily negative sputum smears indicate that respiratory precautions may be removed. No special precautions are needed for handling patients' dishes, books, laundry, bedding, or other personal items.

Inadequate or interrupted treatment for TB can lead to drug-resistant TB and transmission of infection. Therefore, after effective medications have begun, it is of

TB — Continued

utmost importance to keep the patient on medication until completion of therapy, unless signs or symptoms of an adverse reaction appear. Arrangements must be made with the health department for continued medication and follow-up before an inmate with TB is released. Similar arrangements should be made before the release of inmates on preventive therapy.

Because crowding and poor ventilation are conducive to transmission of TB, improvements in housing conditions can help prevent outbreaks. Installing ultraviolet lights may be helpful in prisons where transmission of tuberculous infection has been a problem (*24*). Although the effectiveness of ultraviolet lights in decreasing TB transmission in such settings has not been confirmed by epidemiologic studies, ultraviolet lights have been used to reduce transmission of TB in hospitals and shelters for the homeless (*23,25*). When ultraviolet lights are used, proper installation and maintenance is essential (*24*).

Treatment

ATS/CDC recommendations should be followed for treatment and management of persons with confirmed or suspected TB (*20,26*). Each dose of medication should be administered by a designated ancillary medical staff person who watches the inmate swallow the pills. The medication may be given twice weekly (with appropriate change in dosage) after 1–2 months of daily medication (*26*). To ensure continuing compliance, if a patient is to be discharged before completion of therapy, the health department should be notified before the inmate is released.

Persons with positive smears or cultures at the beginning of therapy should be monitored by repeat sputum examinations for treatment response until they become smear-negative. Treatment failure is usually due to patient noncompliance with therapy but may be due to the presence of drug-resistant organisms.

All patients must be monitored by trained personnel for signs and symptoms of adverse reactions during chemotherapy (*20,26*). Expert medical consultation regarding monitoring and/or treatment of patients with complications (e.g., AIDS, drug resistance, adverse reactions, pregnancy, nonpulmonary TB) should be sought when necessary. Special emphasis should be placed on close supervision and care of TB patients infected with drug-resistant organisms.

Inmates with TB should be routinely offered testing with appropriate counseling for HIV infection. The presence of HIV infection necessitates longer treatment for TB and continued close observation for adverse drug reactions, treatment failure, and relapse (*20*).

Preventive Therapy

All inmates and staff with positive tuberculin reactions who have not previously completed an adequate course of preventive therapy should be considered for preventive therapy unless there are medical contraindications (*20,26*). Eligible inmates include those who will be incarcerated long enough to complete at least 1 month of continuous therapy; provisions should be made before release for the health department to oversee completion of at least 6 months of appropriate therapy (unless HIV infected; see below).

HIV-antibody testing should be offered to all known tuberculin-positive inmates. Tuberculin-positive persons with concurrent HIV infection appear to be at very high risk for TB and have highest priority for preventive therapy, regardless of age. Efforts should be made to encourage persons with known or suspected HIV infection to complete 12 months of therapy.

TB — Continued

Each dose of preventive therapy should be administered by a designated ancillary medical staff person who watches the patient swallow the pills. Since daily supervised therapy is often not feasible, twice-weekly supervised therapy is a satisfactory alternative.

Most experts believe twice-weekly intermittent preventive therapy (using isoniazid [INH] 900 mg) is effective, although it has not been studied in controlled clinical trials. Medication should *not* be given to an inmate without direct observation of drug ingestion.

All persons on preventive therapy must be monitored by trained personnel for signs and symptoms of adverse reactions during the entire treatment period (*26*). Some prison inmates will have underlying liver disease related to previous alcohol or narcotic abuse (*27–29*). Although chronic liver disease is not a contraindication to INH preventive therapy, such patients should be carefully monitored (*26*).

Persons for whom TB preventive therapy is recommended but who refuse or are unable to complete a recommended course should be counseled to seek prompt medical attention if they develop signs or symptoms compatible with TB. Routine periodic chest radiographs are generally not useful for detecting disease in the absence of symptoms; chest radiographs should be reserved for persons with symptoms, especially a persistent cough.

ASSESSMENT

Inmates are transferred frequently. Thus, record systems for tracking and assessing the status of persons with TB and tuberculous infection in the prison facilities are essential. These systems must be maintained by using current information on the location, treatment status, and degree of infectiousness of these persons. Prompt action must be taken to assure reinstitution of drug therapy should treatment lapse for any reason.

The record systems should also provide data needed to assess the overall effectiveness of TB-control efforts, and the following information should be reviewed at least every 6 months:

1. Tuberculous infection prevalence and tuberculin conversion rates for inmates and staff within each institution;
2. Case numbers and case rates;
3. Percentage of TB patients recommended for therapy who complete the prescribed 6-month course of directly observed therapy in 6–9 months (goal is ≥85%);
4. Percentage of patients with culture-positive sputum that converts to culture negative within 3 months of starting treatment (goal is ≥90%);
5. Percentage of persons placed on INH preventive therapy who complete at least 6 months of directly observed therapy (goal is ≥90%).

In multi-institutional systems, these data should be compiled for individual institutions and for the system as a whole, with results provided to corrections and health department officials.

ROLE OF THE HEALTH DEPARTMENT

Health departments should assist correctional institutions in developing and updating policies, procedures, and record systems for TB control. The health department should also provide access to expert TB medical consultation. A specific health department contact person should be designated to provide epidemiologic

TB — Continued

and management assistance to correctional facilities, and this responsibility should be an element in the designated person's job performance plan. This responsibility may require considerable initial onsite consultation and subsequent semiannual evaluation for correctional institutions.

Health department staff should assist in developing programs to train correctional institution staff (e.g., to perform, read, and record tuberculin skin tests; identify signs and symptoms of TB; initiate and observe therapy; monitor for side effects; collect diagnostic specimens; educate inmates; maintain record systems). Health or corrections departments may wish to grant certification to correctional staff completing this training.

Health departments should also provide consultation for contact examinations within correctional institutions and assure appropriate examinations for nonincarcerated contacts of persons with TB who are identified in these institutions.

In addition, health departments should cooperate with correctional staff in arranging continuing treatment for inmates released while receiving TB treatment or preventive therapy.

Health departments have a responsibility to maintain TB registries with updated medical information on all current TB cases within their jurisdictions, including those in correctional institutions. Records should be assessed quarterly, and necessary revisions in policies or procedures should be recommended. In addition, health departments should periodically assess the impact of correctional institution-acquired TB and tuberculous infection on the community as a whole.

Because inmates may have both TB and HIV infection, health department officials should assist correctional institutions in developing and implementing HIV prevention programs. Such programs include strategies to identify persons practicing high-risk behaviors, to counsel those infected with HIV, and to reduce high-risk behaviors among all inmates.

As circumstances change, these recommendations will be periodically revised. They are not intended to discourage new and innovative approaches for dealing with TB prevention and control in prisoners. The recommendations should be used instead to enhance the quality of medical care for persons in correctional institutions.

References

1. Braun MM, Truman BI, Maguire B, et al. Increasing incidence of tuberculosis in a prison inmate population: association with HIV infection. JAMA 1989;261:393–7.
2. Snider DE Jr, Hutton MD. Tuberculosis in correctional institutions [Editorial]. JAMA 1989; 261:436–7.
3. Braun MM, Truman BI, Morse DL, Maguire B, Broaddus R. Tuberculosis and the acquired immunodeficiency syndrome in prisoners [Letter]. JAMA 1987;257:1431–2.
4. Weiss R. TB troubles: tuberculosis is on the rise again. Sci News 1988;133:93–9.
5. Steed WW. Control of tuberculosis in institutions. Chest 1979;76[suppl]:797–800.
6. Steed WW. Undetected tuberculosis in prison: source of infection for community at large. JAMA 1978;240:2544–7.
7. King L, Geis G. Tuberculosis transmission in a large urban jail. JAMA 1977;237:791–2.
8. Abeles H, Feibes H, Mendez E, Girard JA. The large city prison—a reservoir of tuberculosis. Am Rev Respir Dis 1970;101:708–9.
9. Hammett TM. 1988 Update: AIDS in correctional facilities. Washington, DC: US Department of Justice, National Institute of Justice, 1989 [in press; documents no. NCJ-115522].
10. CDC. Acquired immunodeficiency syndrome in correctional facilities: a report of the National Institute of Justice and the American Correctional Association. MMWR 1988; 38:196–8.

TB — Continued

11. CDC. Update: acquired immunodeficiency syndrome—United States, 1981–1988. MMWR 1988;38:229–36.
12. CDC. Tuberculosis and AIDS—Connecticut. MMWR 1987;36:133–6.
13. Pitchenik AE, Burr J, Suarez M, Ferrel O, Gonzales G, Maes C. Human T-cell lymphocropic virus-III (HTLV-III) seropositivity and related disease among 71 consecutive patients in whom tuberculosis was diagnosed: a prospective study. Am Rev Respir Dis 1987;135:875–9.
14. Selwyn PA, Hartel D, Lewis VA. A prospective study of the risk of tuberculosis among intravenous drug users with human immunodeficiency virus infection. N Engl J Med 1989;320:545–50.
15. Bureau of Justice Statistics. Jail inmates 1988. Washington, DC: US Department of Justice, October 1987; document no. NCJ-107123. (Bureau of Justice Statistics bulletin).
16. Bureau of Justice Statistics. Correctional populations in the United States, 1988. Washington, DC: US Department of Justice, December 1987; document no. NCJ-103957.
17. Bureau of Justice Statistics. Prison admissions and releases, 1982. Washington, DC: US Department of Justice, July 1988; document no. NCJ-97998. (Bureau of Justice Statistics special report).
18. American Thoracic Society. Diagnostic standards and classification of tuberculosis and other mycobacterial diseases (14th edition). Am Rev Respir Dis 1981;123:343–61.
19. American Thoracic Society/CDC. The tuberculin skin test. Am Rev Respir Dis 1981; 124:356–63.
20. CDC. Tuberculosis and human immunodeficiency virus infection: recommendations of the Advisory Committee for the Elimination of Tuberculosis (ACET). MMWR 1988;38: 236–8,243–49.
21. American Thoracic Society/CDC. Control of tuberculosis. Am Rev Respir Dis 1982;125: 336–42.
22. Chaisson RE, Theuer CP, Schecter GF, Hopewell PC. HIV infection in patients with tuberculosis (Abstract). IV International Conference on AIDS. Book 2. Stockholm, June 12–16, 1988.
23. CDC. Guidelines for prevention of TB transmission in hospitals. Atlanta: US Department of Health and Human Services, Public Health Service, 1982; DHHS publication no. (CDC)82-8371.
24. Riley RL, Nardell EA. Clearing the air: the theory and practice of ultraviolet air disinfection. Am Rev Respir Dis (in press).
25. CDC. Tuberculosis control among homeless populations. MMWR 1987;36:257–60.
26. American Thoracic Society/CDC. Treatment of tuberculosis and tuberculosis infection in adults and children, 1986. Am Rev Respir Dis 1986;134:355–63.
27. Boyer TD. Cirrhosis of the liver. In: Wyngaarden JB, Smith LH Jr, eds. Cecil textbook of medicine. Philadelphia: WB Saunders, 1982:739–881.
28. Kreek MJ. Medical complications in methadone patients. Ann NY Acad Sci 1978;311:110–34.
29. Cherubin CE, Kane S, Weinberger DR, Wolfe E, McGinn T. Persistence of transaminase abnormalities in former drug addicts. Ann Intern Med 1972;76:385–8.

APPENDIX F

CLINIC FOLLOWUP APPOINTMENT BOOK

DATE _____

PAGE _____

NO	IDENTIFYING NUMBER	LOC.	NAME	REASON OR DIAGNOSIS	DISPOSITION		
					Seen	No show	COMME
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							
20							
21							
22							
23							
24							
25							

IK 7021

APPENDIX G

DIET REQUEST SLIP

DATE: _____

NAME: _____

BOOK AND CASE # _____

HOUSING AREA: _____

STARTING DATE: _____ END DATE: _____

DIET:

_____ CLEAR LIQUID

_____ LIQUID

_____ PUREED

_____ LOW FAT

_____ LOW SALT, SPECIFY NO. OF GRAMS _____

_____ DIABETIC, SPECIFY NO. OF CALORIES _____

_____ MERITENE, _____ CAN(S), (240cc), _____ TIMES A DAY.

_____ FOOD ALLERGIES: _____

SIGNATURE _____

APPENDIX H

7030

CLINIC LOG BOOK

DATE ____________ TOUR ____________ PAGE ____________

IDENTIFYING NUMBER	LOC	NAME	WIC	F/U	DIAGNOSIS	DISPOSITION										CLINICIAN			
						Rx	Tx.	Lx	XR	O	F/U	SC.	Inf.	RII	ER	RN	PA	MD	Fn

APPENDIX I

APPENDIX J

INMATE'S NAME | NUMBER | LOCATION | DATE

NAME/SHIELD OF REPORTING OFFICER | NAME/SHIELD OF SUPERVISOR NOTIFIED

BEHAVORIAL CHECKLIST

Listed below are some of the behavorial traits that may indicate a need for Mental referral. (Circle the appropirate item[s]).

1. Showing radical changes in behavior;
2. Expressing a desire to commit sucicide and/or attempting suicide;
3. Planning to inflict bodily harm, attempting or actually carrying out the act. (This may be expressed verbally or through written communication);
4. Unable to sleep, particularly at night, awakening at odd hours of the early morning and brooding;
5. Arranging personal belongings in order, after habitual disorder;
6. Any signs indicating a trip is being planned, e.g., packing personal belongings, discussing travel arrangements, etc., when such a trip is not feasible;
7. Giving away valued possessions, e.g., wearing apparel, books, pictures, cigarettes, commissary, etc.;
8. Continually refusing to lock-out during lock-out periods;
9. Hiding or attempting to hide, from the view of the correction officer/ observation aide;
10. Appearing to be talking to someone when, in fact, no one is present;
11. Frequent displays of shouting, crying and/or screaming;
12. Attempting to inflict self injury by banging parts of the body against the walls or fixtures;
13. Complaining of ailments, illness[es] and/or disease[s] that are non-existing;
14. Expressing a belief that there are plots or plans against personal safety; believing that someone or everyone is watching, talking, spying or acting suspiciously;
15. Having hallucinations/delusions (seeing objects or hearing voices that do not exist);
16. Unusual loss of memory;
17. Showing poor personal hygiene or appearance, doesn't shave, wash, or change clothes, etc.;
18. Exhibiting strong feelings of guilt;
19. Being depressed;
20. Constantly fighting and arguing with other inmates;
21. Being alarmed (frightened) or in a state of panic;
22. Any unusual action or behavior that should be brought to the attention of the Mental Health Staff.

OTHER: (explain)_____

SUPERVISING OFFICER'S ASSESSMENT AND RECOMMENDATION:_____

Supervisor's Name/Shield # _____ Date:_____

RESPONSE FROM MENTAL HEALTH SERVICES ON OTHER SIDE