UNITED STATES DISTRICT COURT
DIVISION OF ST. THOMAS AND ST. JOHN

Carty v Mapp
Civil No. 94-78

SECOND REPORT OF KATHRYN A. BURNS, MD, MPH
ON COMPLIANCE WITH MENTAL HEALTH PROVISIONS OF THE SETTLEMENT AGREEMENT
July 2015

I have completed a second site visit and assessment of the mental health services offered to inmates at the Criminal Justice Complex (CJC), St. Thomas, United States Virgin Islands. I did not visit the CJC Annex this trip because mental health care is delivered primarily at CJC and inmates with serious mental illness are housed at CJC rather than the Annex for the most part. The site visit was conducted on April 20 and April 21, 2015. I prepared a draft report of the visit and provided it to the parties for review and comment. This report has incorporated their feedback and edits where appropriate.

Although the baseline and April site visits were separated in time by eleven months, there was little difference in the findings: No medical or mental health care policies or procedures had been adopted, although some draft policies were provided to me for review. [1] Intake screening is conducted by correctional staff rather than health care staff, regardless of whether health care staff are on duty at the time of booking. The mental health social worker, Ms. Warren does a psychosocial and mental health assessment upon referral but psychiatric assessment/treatment continues to be delayed. Inmates with serious mental illness do not have access to higher levels of mental health care. Mental health staffing levels have actually decreased: the second part-time psychiatrist (Dr. Napier) left the island and the contract psychologist no longer provides any routine services. The psychology intern who worked with the psychologist continues to co-facilitate group treatment with Ms. Warren weekly.

[1] In addition to the draft policies I was provided, defendants' response to my draft report stated the Bureau of Corrections had begun developing a number of medical and mental health policies, procedures and forms as of June 15, 2015. However, none of these most recent drafts have been provided to me and so I cannot comment further on them.

EXHIBIT A

Insufficient staffing levels of both treatment and custody staff continue endangering the lives and safety of inmates and staff. There is no appropriate safe housing for mentally ill inmates or those requiring placement on suicide precautions. Actual therapeutic treatment space for individual and group interventions is lacking.

The defendants did not adopt the recommendations from my first report that advised focus on policies and procedures to address high risk practices and situations such as the intake screening process, suicide prevention (including the creation of safety cells, risk assessment, monitoring, documentation and communication), seclusion and restraint. Instead, the defendants' status report indicated that all mental health provisions were given a Priority Level A rating. Specific details were not provided but at the time of the April visit, none of the items I suggested as immediately critical had been completed nor did I find any other mental health items completed. Ms. Warren did conduct some basic training for detention staff on signs and symptoms of mental illness and suicide in corrections but without the ability to reference a policy, it is difficult to ascertain the utility and relevance of such training. I did not review staff training records during the visit and do not know whether all officers and all shifts had the training. (Ms. Warren was also called upon to train staff at St. Croix, further compromising inmate access to mental health care at CJC since she is the only full time mental health worker there.) In spite of the training, incident reports and logbooks continue to reflect the use of use physical force, steel restraints and lock down for persons with serious mental illness – almost always without consultation from mental health to de-escalate situations and often without notifying mental health staff even after the fact to determine whether a treatment intervention would be helpful. One of the two inmates previously reported as being in the jail after a finding of not guilty by reason of insanity remains in the jail. He refuses medication and has been held in lockdown status in his cell nearly continuously for months. (The other inmate has been released to a treatment facility.)

Areas of improvement were minimal in comparison to the magnitude of the tasks necessary to comply with the terms of the Settlement Agreement and more importantly, for inmate health and safety. There was more documentation of individual treatment contacts with Ms. Warren and group notes in the mental health files as compared to the baseline review. Nursing documentation in the Medication Administration Records (MARs) also appeared to have improved.

I have used the same format for this report as in the baseline report. Findings are correlated with specific items in the Agreement. I found no areas of compliance or even partial compliance with any of the requirements of the Agreement relative to the provision of mental health care to inmates in spite of the modest improvements in documentation noted above and the mental health training sessions.

Sources of Information:

I visited the CJC April 20-21, 2015. Prior to the visit, I re-reviewed the Settlement Agreement and requested the following documents from defendants in order to prepare for the visit with updated information. (Note - This is essentially the same list of documents requested prior to the baseline visit in May 2014 and will continue to be requested routinely in preparation for a site visit.)

1. All medical and mental health policies and procedures including:
    a. Receiving Screening/Intake
    b. Mental Health Screening and Assessment
    c. Medication administration, including daily administration times
    d. Health care requests/referrals including any logs tracking this information
    e. Mental health classification
    f. Suicide Prevention including any risk assessment instruments, observation forms and logs tracking the number and duration of watches
    g. Disciplinary policy
    h. Mental health treatment planning

i. Psychotropic medication
j. Therapeutic seclusion and restraint policy and procedures including any observation logs, assessment instruments and logs tracking the number of episodes requiring seclusion or restraint and the duration of the episode(s)
k. Discharge/Release policy and procedure
l. Any policy that describes the provision of mental health care to inmates in segregation
m. Quality Improvement
n. Management information system
o. Specialized mental health housing unit

2. Staff training materials related to intake screening, suicide prevention, signs and symptoms of mental illness and responding to medical and mental health crises
3. Complete psychotropic medication formulary
4. Staffing plan and current table of organization including whether positions are filled or vacant; CVs of all mental health staff including verification of current licensure.
5. Program descriptions for mental health care provided, psychiatric services and any specialized mental health housing.
6. Basic population information about the facility (average number of inmates at the facility and length of stay; number of intakes and releases per month for last 12 months)
7. Number of inmates on mental health caseload, number of inmates prescribed psychotropic medication
8. Mental health crisis care information: suicide or crisis watch logs for past year including transfers to inpatient psychiatric care
9. Inmate deaths for the past 2 years including date of death, cause and manner of death (suicide, homicide, accident or natural)
10. Any contracts of memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities such as inpatient hospitalization
11. Any and all mental health care staff meeting minutes that address mental health care operations and coordination of care; and any written communication to the Director or Associate Director regarding mental health care as a result of these meetings.

Documents received in response included intake forms and flow sheet (1.a.); Mental Health Services Intake Screening - undated (1.b.); Mental Health Service policy (same number as Intake

Screening and also covers mental health screening, assessment, suicide watch, medical, medications, release planning, records, physical plant, training and ends with screening and referral); Suicide Prevention Policy and Procedure dated 2009 (1.f.); written training materials covering signs and symptoms of mental illness and suicide prevention (2); medication formulary dated 2014 (3); a list of mental health services and psychological tests (5); list of inmates on the mental health caseload and those prescribed medication (7); suicide watch observation logs (8); inmate death (9) and some meeting minutes (11). Relevant documents will be discussed in the report sections that follow, but as noted, defendants informed me that the draft policies they provided in response to the document request are no longer relevant since they began developing policies and procedures in June and so earlier comments on items 1.a. and 1.b. have been omitted/revised since the draft report was shared with the parties. It is important to note that the defendants reported they began developing the policies in June 2015. No timelines for completion, adoption, implementation or staff training were provided. The full list of items under development may be found in Appendix B. The majority of them have some relevance or application to mental health care and as they are developed, I am available to review, comment and assist in the intervals between site visits.[2] I have also included comments/recommendations regarding items/requirements for policies in specific sections of this report.

No contracts or memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities including hospitalization were provided. No staffing plan or table of organization was provided though staffing information was available during interviews on site.

During the site visit, I toured the housing units called Cluster 1 (the "mental health" housing unit for male inmates), Cluster 6 (segregation unit) and the inmate "library" which is currently also used for mental health treatment groups. I reviewed classification records, mental health records, medical records, medication administration records, some housing unit logbooks and portions of the main control log. I interviewed mental heath director/social worker Ms. Warren and ten inmates of the 37 inmates reported as being on the mental health caseload. I attempted to meet with Dr. Lu, the psychiatrist, but he was not available to me; he left the facility on the first day without meeting with me and was not at the jail on the second day of my site visit. I subsequently reviewed some incident reports and other information pertaining to the inmate suicide that occurred in December 2014.

[2] There had been some discussion about my drafting an administrative directive regarding suicide prevention for the facility but I was told that the BOC policy was nearly complete at the time of my site visit, so I did not draft a directive.

Report Format:

As with the baseline report, this one is also focused primarily on mental health requirements articulated in the Settlement Agreement, Section V. Medical and Mental Health Care and particularly Section V.2.x. Mental Health Care and Treatment. I have again grouped the mental health care requirements into the following larger categories for purposes of reporting.

- Intake screening
- Mental health assessment
- Medication management
- Access to off site consultation and specialty care, including inpatient and emergency care
- Suicide prevention
- Staffing
- Segregation
- Mental health levels of care, access to inpatient or intermediate care, psychotropic medications and special procedures (seclusion and restraint)

There are a number of over-arching provisions more broadly related to the provision of appropriate mental health care as well such as inmate safety and supervision (Agreement Section IV) and the provision of timely medical and mental health care consistent with community standards (Section V.1 and V.2.e.) contained in the Settlement Agreement as well. Findings related to some of the specific requirement areas are also relevant to these larger concepts/requirements. (The example provided in the first report was that of a suicide prevention program requiring a relevant policy and procedure; mental health staffing to assess risk and provide treatment; enough correctional staff to identify inmates at risk of suicide, closely monitor inmates placed on suicide watch and provide emergency intervention in the event of a suicide attempt; safe housing and appropriate property management; proper prescription and administration of medications; access to psychiatric inpatient care if suicide risk is not abated by treatment measures employed at the jail; training for correctional

staff on signs of suicide, mental illness, emergency intervention and practice drills.) As previously, I will attempt to indicate when there are broader implications for larger, over-arching Agreement provisions in the specific sections where relevant.

Record reviews and interview information of individual patients are summarized in Appendix A that accompanies this report.

Mental Health components of Settlement Agreement

Intake Screening	
Settlement Agreement Sections: V.2.a.	Not compliant

The Settlement Agreement requires that screening be conducted by qualified medical and mental health professionals and that all inmates with a positive screen receive timely and appropriate care, including transfer to a hospital when indicated. If nursing staff is not available for the intake screening, a specially trained corrections officer shall administer an initial needs survey.

A Mental Health Intake Screening policy was provided (undated but identified as Policy Number MH-01) to me originally but I was told that it is no longer relevant or applicable given the development of policies listed in Appendix B. The BOC should take this opportunity to ensure that the new policy is consistent with the requirements of the Agreement: nursing staff (rather than correctional officers) must conduct the screening during regular hours; correctional staff who do the screening in off-hours require special training for the task. (The policy that I was given indicated that medical, mental health or correctional staff could conduct screening.) The intake policy should also specify timeframes to address identified needs including mental health assessments of routine and emergency referrals, medication continuity, suicide prevention and the mechanism to ensure immediate transfers to a hospital when necessary.

As observed in the files reviewed, correctional staff continue to complete the intake screening at all times. Medical nurses see the newly arrived inmate the same day or the following day depending on the time of arrival. (Nurses are at the facility 8 AM - 6 PM daily.) The "Intake Health Services" form utilized by the medical nurses does not contain sufficient mental health information to adequately screen for mental health needs or suicide risk. (This form was produced in response to the document request item 1.a.) Referrals are generated to the mental health social worker, Ms. Warren. Referrals are primarily inmates who have previously been at the facility with known mental health needs and/or inmates arriving with prescription psychotropic medications.

The policy under development not withstanding, at the time of my visit in April, there were no changes to the findings in my baseline report: "The current practice is not compliant with the Agreement and is not set forth in policy. Correctional officers, with no specialized training, are doing all of the initial screening, even when nurses are on duty. Furthermore, the current instrument is too narrow and misses cases of inmates with serious mental health needs at the front door." Continuing from the first report: "Patients with schizophrenia and other psychiatric illnesses are at elevated risk of suicide and may present an increased risk of harm to others as well when they are psychotic. Rapid identification is vitally important so that treatment may begin or continue as soon as possible. Clinical studies have also demonstrated that the longer that treatment is delayed (such as in this case), the longer it takes for it to work and degree of improvement eventually achieved is less than it would have been had treatment been timely. The intake screening instrument must be revised to reflect important areas of mental health inquiry so that serious mental health needs are not missed and treatment delayed. Screening instruments are intended to cast a broad net to "catch" both known (obvious) cases as well as persons displaying more subtle signs of difficulties. Thereafter, a mental health professional can further assess and refer the inmate to the appropriate level of mental health care, including psychiatric hospitalization when necessary.

There are multiple deficiencies that must be addressed to come into compliance with the Agreement: policy and procedure, revised instrument; nursing to conduct screening during regular hours, special training for officers to do the initial screening when nurses are not present; mechanism to ensure immediate continuation of prescription medications, and timely referral to and assessment by a psychiatrist. Policy, procedure and actual practice are also required demonstrating that acutely ill and unstable inmates are transferred emergently for hospitalization when necessary. No such policy or procedure was provided nor was there any evidence that acutely ill inmates have access to emergency care and psychiatric hospitalization."

Case examples in the Appendix that illustrate the problems with the current intake screening process include cases 1, 6, 7, 9 and 11. These cases demonstrate psychiatric assessments delayed for weeks or months with subsequent worsening of inmates' mental conditions as well as examples of inmates that should have been diverted to psychiatric hospitalization at the front door of the jail for immediate and intensive treatment.

Mental health assessments – as follow-up from positive intake screening, conducted by qualified mental health professional within 3 days of admission	
Settlement Agreement Sections: V2b	Not compliant

The Mental Health Service policy (undated, also numbered MH-01) provided to me indicated a "complete mental health assessment" and "psycho-social evaluation" is completed by a "mental health worker" when "it is determined that further mental health or substance abuse intervention is warranted." This policy is not consistent with the terms of the Agreement. As previously noted, the social worker, Ms. Warren, does a psychosocial and initial assessment, but she is not a qualified mental health professional as defined by the Agreement. (Qualified mental health professional is defined as a psychiatrist or psychiatric nurse practitioner.) Ms. Warren's assessments are documented in an inmate-

specific mental health file (which is maintained separately from the inmate's medical file.)[3] Ms. Warren refers inmates to Dr. Lu, the psychiatrist, for further assessment and medication management. The psychiatric assessments are frequently quite delayed and impact inmate access to treatment. Without treatment, psychiatric symptoms worsen and increase the risk of suicide, the potential for harm to others and vulnerability in the inmate population. Additionally, as stated above, delays in treatment have been shown to delay the rate of improvement and negatively impact the degree of improvement. (The response to treatment is not as robust as it would have been had treatment been more immediate.) The Agreement requires a mental health assessment by a psychiatrist or nurse practitioner within three days of admission for these reasons.

The following cases in Appendix A illustrate delayed mental health assessments: 1, 2, 4, 5, 8, 9, 10, 11, 12 and 13. (Psychiatrist assessment delayed by several days, to weeks to as many as several months.)

Medication management - continuity, administration & management of medications that address a number of factors including continuity, timely responses to medication orders and labs, professional medication administration procedures, monitoring for effectiveness and side effects, discharge medications; timely access to a psychiatrist and psychiatric review of medications; and the Agreement's general provisions for timely and appropriate care, including psychiatric care.	
Settlement Agreement Sections: V2f sections i-vi; V2x section iv; V2e; V1	Not compliant

There is *no* medication or psychotropic medication policy currently in effect. A policy is required by the Agreement to address continuity, administration and management of medications. Defendants indicated that policies entitled Medication Services and Psychotropic Medication are among those under development in response to my draft report.

[3] Maintaining separate mental health and medical files can create problems with health care and mental health staff being able to access and review medication orders and other health-related information. This can be overcome if the records are stored in the same place so that all health providers with a need to know can access both records. However, at CJC, the medical records are kept in the medical area and the mental health files are maintained by Ms. Warren.

Record reviews indicated previously identified problems persisted: there were breaks in continuity of medication management (orders not written timely); inmates were not monitored closely for side effects or response to prescribed medications; inmates were not seen in response to new or worsening symptoms; medication orders and changes without documentation of a face-to-face examination; and orders for injectable medications, including long-acting injectable medication without inmate consent and/or appropriate legal or clinically appropriate administrative authorization. Psychotropic medication continuity is extremely important and when there are breaks in continuity or medications aren't ordered timely, psychiatric symptoms return. These include suicidal thoughts and behaviors, aggression, impulsivity and other symptoms that create a risk of self-harm, harm to others and management problems in the jail.

In contrast to the initial site visit, Dr. Lu appeared to have begun to use more of the newer antipsychotic medications in addition to the older medications. However, there was still no evidence of monitoring inmates regularly for the development of either metabolic syndrome (a potential side effect of the newer medications) or movement disorders (common side effects of the older medications.)

Dr. Lu now appears to re-write medication orders at monthly intervals. However, when he changes medications or doses, it remains unclear in terms of intent since he does not discontinue previous orders and they do not have a "Stop" date. (In other words, it is ambiguous whether the earlier order is to be continued in addition to the new order or whether only the new order is in effect.)

A complete medication formulary was produced in response to the second request. It does not contain specific psychotropic medications for the treatment of psychosis, depression or mood stabilization. However, Dr. Lu previously explained that he is able to prescribe whatever medication he believes necessary for treatment of serious mental illnesses – it does not need to be listed on the formulary. Nursing staff corroborated his statement; nurses simply order whatever medication is

prescribed by Dr. Lu from the pharmacy and it is available for administration. Nursing staff were unaware of any restrictions with respect to psychotropic medications.

The medication administration records (MARs) documentation had improved since the baseline visit. The records were monthly and each medication was written on a separate line. (I did not check the injection medication log this visit so do not know whether or not there had been improvements.)

Case reviews that illustrate the areas of serious problems with the medication practices include all but case 8 in Appendix A. The other 14 cases are highly problematic and include delays in assessment and medication orders; failure to monitor (follow-up examinations, laboratory studies, etc.); involuntary medication administration ordered without legal authority to do so; failure to petition for permission to medicate involuntarily in other instances and no evidence of informed consent.

Off site specialty care and consultation, emergency care and systems to track and monitor inmates with mental health and medical needs	
Settlement Agreement Sections: V2g;V2i section i-vii;V2j; V2p; V2q	Not compliant

There was no change from baseline report with respect to these sections:

"No policy or training curriculum for staff in recognizing and responding to emergencies were provided. No protocol for periodic assessment of the facility's compliance with policies and procedures regarding the identification, handling and care of detainees and prisoners with serious medical and mental health conditions was provided. These items are required by the Agreement.

No contracts or memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities such as inpatient hospitalization were provided. No system to classify, track or monitor inmates' mental health needs was in effect.

> Documentation of response to mental health crises was inconsistent; sometimes progress notes were present in the mental health file indicating that treatment staff were notified of a crisis and responded while in other situations, there was a notation in the housing unit log that an inmate was placed on lock-down for self-injurious or other crisis behavior but no corresponding referral to mental health or treatment intervention. Inmates experiencing mental health crises are not receiving treatment to address or eliminate the crises. This creates an increased risk of harm, including self-injury, inmate on inmate or staff injury and staff on inmate injury when untrained correctional officers using physical force to place inmates in lockdown status or steel restraints…"

Appendix A includes case examples demonstrating the need for inmates with serious mental illness to receive emergency treatment including hospitalization. In one case, a psychotic inmate struck a peer in misperceived self-defense. He remains psychotic and an imminent and serious danger to others. He has not been referred for hospitalization and is not housed on Cluster 1 for his own safety to prevent the possibility of retaliation. Efforts at treatment have not been intensified. (Case 1) Two other inmates were on watch status for mental health crises 10/27/14-11/7/14 but neither were taken to an emergency room or hospitalized. (One of them, case 15, committed suicide the following month.) Another inmate, who remains psychotic, manic and out of control has sustained multiple injuries as a consequence of officers attempting to manage his behavior through the use of physical force. (Case 4) Still another has been locked down in his cell without treatment since May 2014. (Case 5) All of these cases and others demonstrate the serious harm resulting from failure to hospitalize acutely ill inmates. (See also cases 2, 3, 6, 7, 8, 9 and 11 in Appendix A.)

Suicide prevention – calls for policy and procedures that include precautions, safety cells, monitoring, communication, treatment, follow-up	
Settlement Agreement Sections: V2l sections i-xii; IVB1d	Not compliant

The Suicide Prevention Policy and Procedure provided, dated 2009, was not consistent with the information provided in the training materials or documentation in the records. The Mental Health Services policy produced (undated) also contained suicide prevention information. I have been told that neither of these is in effect and a new Suicide Prevention policy is under development. The new policy must track the requirements spelled out in the Agreement (e.g., appropriate and timely assessment by adequately trained staff; a protocol for constant observation of suicidal inmates; application of a risk assessment instrument by a qualified mental health professional; suicide precaution orders and daily face-to-face assessment by a psychiatrist, etc.) The policy should also contain provisions for training, communication among facility staff and with the inmate, safe housing, observation, treatment, intervention in the event of a suicide and morbidity and mortality review.

Problems previously identified – failure to adequately screen and assess potentially suicidal inmates, house them safely, monitor them appropriately and transfer them to a higher level of care persist. Training materials presented to correctional staff by Ms. Warren regarding suicide prevention were provided but they do not correspond to any policy or procedure, because there is no single policy or procedure in effect. Even when Dr. Lu is involved in the assessment of inmates placed on watch, there is no increase in treatment intensity in response to mental health crisis or placement on suicide watch. He does not re-evaluate patients on watch status every day. There is still no adequate safe cell to house inmates placed on watch in CJC.

Serious problems with correctional officer monitoring of inmates persist. For example, a document titled “Bureau of Corrections Suicidal Attempts/Ideations” was produced. It indicated two inmates were on watch status from October 27, 2014 to November 7, 2014. The mental health file and medical files clearly indicate the placement on watch date and time as well as the discontinuation of the

watch status. However, the observation/monitoring logs completed by correctional staff were only provided for 10/27/14 and 10/28/14 even though the watch was not discontinued for another week. (There should have been a log for every day of the watch.) Additionally, housing unit logbooks indicate one of the inmates was permitted off the housing unit to go to the library during this supposed "watch" period as well - - - with no correctional monitoring. Even when monitoring was documented on October 27 and 28, monitoring intervals exceeded the 15-minute time frame specified by mental health staff. Observations were made only at intervals of an hour or longer in some instances. The same problems with documentation and improper monitoring were present on all watch logs reviewed. (Cases 10 and 15 in Appendix A.)

There had been no completed suicides in the two years preceding the inmate's death by suicide in December 2014. Although she was not officially on a watch at the time of her death, a review of the logs, incident reports, timelines and videos identifies a number of very serious problems at CJC with respect to suicide prevention. When she was discovered by a fellow inmate and correctional staff were summoned, there is no indication that any correctional officer retrieved the cut down tool from control when responding. Some officers attempted to untie the plastic bag that the inmate had fashioned into a noose and tied to the upper bunk in her cell. One of the officers did eventually cut it off of the bed though it is not clear what he used to cut it. There is no documentation that any of the correctional responders initiated first aid or CPR to the inmate while awaiting the arrival of outside EMS. The inmates was pronounced her dead at the scene when they arrived. (Matters of just a few minutes are absolutely critical in situations such as these and can make the difference between life and death.) Further, the videos from Cluster 7 reflect that correctional officer welfare rounds did not occur routinely as required. In fact, it appears that the inmate had not been seen by correctional staff for several hours prior to her discovery in the afternoon. Although the video recordings do not reflect rounds, the Cluster 7 logbook appears to reflect that welfare rounds/head counts were completed every hour of the night

and day. This is highly problematic and places inmates in grave danger. Other problems identified include issues with reporting and communication: the warden learned of this serious incident from his wife who received a phone call from a neighbor rather than hearing about it from his staff. No quality assurance/improvement reviews or mortality reports of the incident have been conducted and so no corrective action plan has been considered or implemented to address deficiencies.

As recommended in the baseline report, it is absolutely imperative that a comprehensive suicide prevention program be developed immediately to minimize the risk of completed suicide at CJC. Correctional staff must monitor inmate welfare at all times and be alert to changes in behavior that could signal potential suicide risk. The policy must also include and permit transfer to a higher level of care than that which can be provided in the jail when necessary.

Cases 10 and 15 in Appendix A illustrate the problems with the current suicide prevention practice.

Staffing – adequate professional staffing with periodic analysis and plans; adequate correctional staffing to support mental health mission	
Settlement Agreement Sections: V2m section ii,vii,viii; V2n; IVB1d	Not compliant

There are no positive changes in staffing levels to report. The second psychiatrist, Dr. Napier, left the island to return to his home in Canada. Dr. Lu is contracted to provide two hours of service daily Monday through Friday. His time is not verified. Main control logbook entries for one week in January, February and March were reviewed to calculate Dr. Lu's time on site and revealed the following:

Date	Time into jail	Time of exit
1/12/15	914A	945A
1/13/15	817A	1005A
1/14/15	824A	944A
1/15/15	823A	953A
1/16/15	Not recorded	1005A
2/23/15	828A	953A
2/24/15	824A	929A
2/25/15	919A	950A

2/26/15	853A	945A
2/27/15	832A	Not recorded
3/16/15	Not recorded	1012A
3/17/15	837A	Not recorded
3/18/15	858A	1006A
3/19/15	904A	Not recorded
3/20/15	848A	1007A

Although not every time is recorded in the main control logbook, it is the only verification of Dr. Lu's time that is available for review since it is not monitored in any fashion. The times that are recorded demonstrate that Dr. Lu is at the jail generally for an hour or 90 minutes daily rather than the two hours specified in his contract. This is not enough psychiatric time to provide an adequate level of care. In addition, documentation in the files demonstrates that Dr. Lu continues to perform forensic evaluations for the court during some portion of his time in the jail, further compromising the time available to take care of patients as well as posing serious ethical issues regarding his role.[4]

I have been provided no information that there is a relief psychiatrist when Dr. Lu is unavailable or documentation of 24-hour on-call coverage by a psychiatrist as required by the Agreement. There does not appear to be a relief psychiatrist. (In a note by Ms. Warren dated 12/18/14, she indicated a referral to psychiatry would be not be seen until 12/24/14 when Dr. Lu was scheduled to return. The inmate committed suicide 12/21/14.)

Ms. Warren, the mental health social worker is still at the jail and works full time. The psychologist (Thompson) no longer contracts with the jail although the psychology intern (Livingston) has continued to co-facilitate weekly group treatment with Ms. Warren. (They are currently providing two group sessions weekly for groups of 8-10 inmates.)

[4] I suggested that the Territory consider using videoconferencing with a psychological or psychiatric forensic expert for court reports to allow Dr. Lu to focus solely on his treatment role rather than mixing forensic and treating functions which compromises his time and relationships with inmates. The use of videoconferencing would also increase the potential pool of experts that could be used for forensic evaluations since they wouldn't have to be physically located on the island.

Staffing levels of correctional officers remains inadequate to support a mental health mission: suicide watches cannot be conducted appropriately; posts continue to be completely unmanned at times and at other times, officers are called off their posts to assist other officers in routine tasks such as meal distribution (leaving posts completely unmanned) to name just a few examples that highlight the inadequate correctional officer staffing levels. The review of videos relating to the time of the December suicide demonstrates that routine welfare rounds are not conducted as required leaving the inmates in grave danger.

As concluded in the initial report, CJC is not compliant with the staffing terms articulated in the Agreement. Professional staffing is not clinically adequate to provide mental health treatment programs, nor is there sufficient correctional staff to support that mission. There continues to be no system of accountability for contracted hours of psychiatric time and evidence that contracted psychiatric hours are not actually provided. Serious concerns about clinical productivity and practice persist (e.g., failure to conduct timely assessments, failure to monitor inmates for response to prescribed medication and side effects, failure to examine inmates at appropriate intervals or increase treatment interventions during mental health crises, etc.)

Segregation – includes procedures for rounds as surveillance for inmates experiencing difficulty, prohibition against placing mentally ill into segregation, mental health input to disciplinary process, and use of force incidents, minimize segregation time, adequate out of cell time	
Settlement Agreement Sections: IVH1f; V2t, V2u, V2v, V2w	Not compliant

There is no update to the information contained in the baseline report. I have simply repeated it here for reference.

> "No policies or procedures regarding segregation were provided. There was no evidence that actual practice prohibits housing inmates with serious mental illness (SMI) in isolation or any evidence of review to minimize time in segregation or provide adequate out-of-

cell time as required by the Agreement. There was no documentation in the mental health files that any sort of mental health review or consultation is provided at any time in the disciplinary process as required in the Agreement. This provision is important because inmate behaviors may be a manifestation of psychiatric illness; it can be identified and treated rapidly if inmates receiving disciplinary reports are referred to mental health staff. If not referred, and given a lockdown sanction, access to care is impeded, mental conditions worsen and treatment is delayed.

Additionally, some inmates are locked down on regular housing units, including the mental health treatment housing unit, cluster 1. Although not technically "segregation", the conditions experienced by the locked down inmates are similar to those of segregation in terms of out-of-cell time, access to care, property restriction, etc., and should be considered when the policy and procedures are developed for this area of the Agreement."

Appendix A case 5 illustrates the use of lockdown status on the mental health unit of an inmate with serious mental illness who has been confined to his cell for months. His condition continues to deteriorate and he is refusing treatment. Symptoms of persons with serious mental illness get worse with segregation and such appears to be the case with this man. He is at increased risk of suicide and is potentially at risk of harm from other inmates and officers who are ill prepared to manage him except through the application of physical force and restraint (as in case 4). The inmate's condition is not going to improve without treatment. He has had no psychotropic medication since November 2014, and even if it were re-started today, it would likely take months to evidence some improvement. He requires transfer to a treatment facility; keeping him confined in his cell/segregation is not an appropriate placement and is making him worse. Further, he has no legal charges against him at this time and shouldn't even be in jail, much less maintained in a segregation status.

Mental health care – includes timely access acute and chronic care, access to inpatient or intermediate care if clinically appropriate, psychotropic medications, staff training, special procedures (seclusion and restraint), appropriate housing, adequate treatment space	
Settlement Agreement Sections: IVB1d; IVIe; IVF7;V2e; V2w; V2x (sections i-xii)	Not compliant

As previously reported, the institution provided information that mental health care services include individual assessments, psychosocial assessments, individual and group therapy, referral and education services; discharge planning and linkage to community services. With the exception of co-facilitated group weekly group treatment, these services are provided almost exclusively by Ms. Warren as her time permits. Mental health staffing is insufficient to actually do a course of individual therapy for a specific problem or issue but Ms. Warren can and does provide supportive counseling sessions primarily on an as-needed or requested basis. She has also begun to better document her clinical encounters with inmates on the mental health caseload. She interacts with them individually at intervals of one or two weeks and some of the mental health caseload inmates have also participated in a number of group sessions offered as well. There has been no increase in the number of group sessions offered since the last site visit.

There is no policy addressing levels of mental health care or written protocols to describe the frequency or types of contacts to be provided for chronic or acute conditions. Although Ms. Warren is works full time and tries to do as much as possible inmates on the mental health caseload, the fact is that CJC mental health staffing levels simply do not permit appropriate levels of mental health care; neither is the physical plant conducive to meeting the treatment needs of acutely or chronically mentally ill inmates.

I asked Ms. Warren to name the three inmates about whom she had the most concern with respect to managing in the jail. She immediately listed five inmates (cases 5, 3, 4, 8 and 7) and quickly added another three (cases 1, 2 and 6). All were inmates with serious and persistent mental illness who would be better managed in a treatment facility than the jail. One of the persons identified continues

to be the man who was found not guilty by reason of insanity who is still being held in the jail in spite of having no pending legal charges. He has refused treatment with medication and displays disturbed and aggressive behavior. He is being managed only by being locked down in his cell where he has remained for months. I interviewed all of the inmates identified by Ms. Warren as they are on the mental health caseload (except case 5 who refused) and agree that these men need more treatment than can be provided at the CJC – there is insufficient treatment space, no appropriate housing and insufficient staffing resources there to provide a higher level of mental health care. These are the very type of inmates that the Agreement requirement for "development and implementation of a memoranda of understanding to ensure timely transfers of seriously mentally ill prisoners in need of inpatient or intermediate care, or those in need of acute stabilization, to an appropriate hospital or mental health facility" was intended to address. Cases 1, 4, 5, 6, 9, 12 and 15 required inpatient care; cases 2, 3 and 11 require a higher level of mental health care than can be provided at the jail but could be managed in an intermediate care facility.

Cluster 1, the "mental health unit", is not therapeutic and continues to be frankly unsafe. The population housed there contains vulnerable inmates with serious mental illness and predatory inmates. (See case 3 and 13 in the Appendix for examples.) More recent incident reports and logs continue to document inmate-on-inmate physical fights, assaults and attacks requiring emergency transport to the outside hospital for physical care. There are also incident reports of officers using force to manage inmates in Cluster 1 resulting in inmate injury and emergency transport to the outside hospital. (Case 4) Some of these uses of physical force incidents appear to be excessive and in response to behaviors resulting from mental illness. Although Ms. Warren has provided some training to some officers since the last site visit, the need for additional instruction in how to deal with or manage inmates with serious mental illness is obvious. As previously stated, such training would assist officers in better communicating with special needs inmates, help de-escalate crises to reduce the need for using force,

lockdown and physical restraint. There is no mental health group treatment or programming offered to the men housed on this unit which would be useful in helping inmates manage/deal with psychiatric symptoms, improve socialization skills and engage them in activities to reduce boredom and unproductive idle time.

The Agreement requires implementation of special policies on the use of seclusion and restraint consistent with professional guidelines that include face-to-face assessments by a psychiatrist and monitoring by nursing and limited duration. None of these special policies have been produced. It appears that correctional staff continue to make unilateral decisions regarding placement of inmates in lockdown status or restraint. Case 5 had been locked down in his cell for nearly a year at the time of the site visit and cases 4 and 10 were restrained by correctional staff without involvement or notice to mental health.

Conclusions:

My conclusions following the second site visit are unchanged: "Mental health care at CJC remains deficient in virtually every aspect: inadequate treatment space; inappropriate housing including deficient "safety cells" for suicidal inmates or those experiencing crises; insufficient mental health staffing levels; minimal treatment other than psychotropic medication; inadequate security staffing; no capacity to increase or respond to need for higher level of care; and no policies or procedures including those for high risk occurrences (suicide watch, restraint, therapeutic seclusion). Ms. Warren is a hard working, organized and dedicated mental health professional but one person simply cannot do everything. Additional treatment providers are necessary and the psychiatrist must be held accountable for his time and productivity in terms of patient care. Inmates with serious mental illnesses are not seen timely by psychiatry nor are they seen at regular intervals. Additionally, some interactions are not conducted in private or confidential settings… The Agreement requires adequate mental health programs for all inmates with serious mental illness and includes psychosocial

rehabilitation services. These types interventions serve as an adjunct to treatment with medication, help inmates manage their illnesses/deal with symptoms, increase pro-social skills, prepare for release and ultimately, reduce criminal recidivism. Additionally, engaging inmates in structured activities is also extremely helpful in terms of jail population management – inmates have less idle, unproductive time and fewer incidents result. Also, as stated a number of times, correctional officers must be present in sufficient numbers and receive appropriate training to manage inmates with serious mental illness.

There are no contracts or memoranda of understanding regarding the transfer and provision of mental health care to prisoners in outside treatment facilities such as inpatient hospitalization or intermediate care. The Agreement requires timely transfer to a higher level of care when clinically necessary." This does not happen. Even Ms. Warren identified at least eight inmates that needed a higher level of mental health care than could be provided at the jail. "…Clinical studies demonstrate that timely access to care is vital to ensure a positive outcome/treatment response. If care is delayed, the response to treatment is less complete/robust and takes longer to achieve than when care is provided timely – and people continue to suffer."

Mental health care is not compliant with the specific terms of the Agreement or the over-arching requirement for "timely medical and mental health care consistent with community standards and constitutional requirements including screening, assessment, treatment and monitoring of prisoners' medical and mental health needs." (Section V.1.)

In the first report, I made a number of recommendations regarding the development of a plan to prioritize and address the Agreement mental health requirements in a staged or phased manner. The Territory has not adopted this recommendation for mental health care specifically. Rather, all provisions of the Agreement were given a priority level rating of A, B or C. Priority level A are those items deemed "most critical to safety, security and health care"; Priority B items are "very important to safety, security and health

care." All of mental health was assigned priority level A but at the time of the site visit, even the most basic of the required policies had not been completed. I found no areas of compliance or even partial compliance with any of the mental health terms of the Agreement. In light of this lack of progress, I continue to recommend the BOC focus on addressing high-risk practices and situations as the first priority: revision of the intake screening process to ensure that emergency needs are identified, continuity of care is preserved and mental health referrals and referral responses are timely. Suicide prevention policy and procedure must be revised to include the creation of safety cells; improvement in monitoring, documentation and communication among staff; standardized risk assessment and procedures that call for increased frequency and intensity of mental health treatment efforts during periods of increased suicide risk. This includes the option to hospitalize inmates requiring a higher level of care rather than maintaining them in the jail with limited treatment resources. As the December suicide illustrated, correctional staff need instruction and training in how to handle a suicide in progress or when a suicide is discovered. Policies and procedures for the use of seclusion and restraint must also be updated to reflect contemporary treatment standards which include authorization by psychiatry, monitoring by correctional and health care staff and use as a last resort when other methods to manage the inmate have been tried and failed or are impractical given the degree of danger posed by the inmate's behavior (such as intervening when an inmate is in the act of attempting suicide.) The policies, procedures and practices for screening and evaluation, suicide prevention and seclusion and restraint are absolutely critical to inmate health and safety as well as the safety of staff and must be addressed immediately.

Respectfully submitted,

/s/
Kathryn A. Burns, MD, MPH
July 25, 2015

APPENDIX A: INMATE SUMMARIES

Case 1

Arrested 1/18/15; referred to mental health 1/21/15. Initial MH assessment conducted 1/23/15 that concluded "no mental health treatment needed" but he was referred to Dr. Lu for assessment. Sgt. Gumbs referred him to mental health 1/20/15.

Seen by Ms. Warren during cluster visits 1/23/15; 1/28/15. Next documentation is 3/9/15 when he was seen following a referral by Assistant Warden Williams. Inmate was talking to himself and withdrawn. Ms. Warren saw inmate again 3/11/15 after he had a physical altercation with another inmate. He said he feared the other inmate and so attacked him first.

Dr. Lu examined 3/13/15: "Schizophreniform disorder; Schizoid?; Paranoid?" Ordered medication (Fluphenazine 2.5 mg and Sertraline 25 mg daily) which inmate refused.

Seen during cluster visits by Ms. Warren 3/16/15, 3/23/14 (with Dr. Lu); 4/10/15 (with Dr. Lu.) Ms. Warren also attempted to see him 4/8/15, but he refused. She also spoke with his mother 4/9/15 and learned that his brother was mentally ill and prescribed medication.

At visit 4/10/15 with Dr. Lu and Ms. Warren, both noted bizarre behavior, disorganization and confusion. Dr. Lu changed diagnosis to Schizophrenia and noted inmate to be "disorganized, irrational, reacting to internal stimuli." Dr. Lu ordered different medications: Haldol 5 mg and Cogentin twice daily, Sertraline 25 mg twice daily. (Previous orders for Fluphenazine and Sertraline were not discontinued.)

Inmate is refusing to take oral medications. He remains psychotic. He was moved out of the mental health cluster following the altercation with another inmate in Cluster 1 for his own protection against retaliation. He was housed in cluster 3 at the time of the site visit.

Interview: Not sure of his charges, how long he's been in the jail or how long he has to stay in jail. He denies any symptoms but is guarded in his responses, appears preoccupied (as if hallucinating); mumbles indistinct responses to questions; flat affect & poverty of speech. Refuses medication because he "ain't crazy."

Comment: Delayed screening; psychiatric assessment delayed nearly 2 months leading to worsening of condition. Psychotic thought processes influencing behavior – struck another inmate out of misperceived self-defense. He is an imminent and serious danger to self and others as a result of his untreated mental illness. Remains acutely psychotic, refusing psychotropic medication. Not housed in MH cluster. This man needs psychiatric hospitalization for his protection and the safety of others and to initiate involuntary treatment proceedings.

Case 2

Received into jail 1/27/15 on charge of simple assault (domestic violence). Intake screening by CO Vanterpool identified "mood swings and depression – needs to be evaluated by mental health staff." Seen for initial assessment by Ms. Warren same date. She noted apparent cognitive deficits, odd behaviors and strange speech and referred him to Dr. Lu for evaluation.

There is a doctor's order for "psychology testing for IQ" dated 2/4/15 and the WAIS-IV intelligence test was administered 2/11/15. Dr. Lu's only note indicating that he actually saw the inmate is dated 3/8/15 and concludes "Schizophrenia and Substance Abuse Disorder (THC); IQ 61-63." His plan was to "request additional test and consider medication." Dr. Lu had not seen the inmate again at the time of the site visit (a month later) and no medications were prescribed. The "Woodcock Johnson Test of Achievement" was administered 3/11/15 by the psychologist.

Ms. Warren has documented contacts with the inmate 3/2/15, 3/9/15, 3/16/15, 3/23/15 and 4/10/15. She has also spoken with his mother to gather additional information.

Interview: Inappropriate smiling during interview, preoccupied; repeats questions posed or last few words of questions (echolalia); nods "yes" when asked if he sees or hears things but cannot provide detail on these experiences. Unaware of charges, his length of stay in jail. Intellectual ability estimated below average. Not on medications.

Comment: Screening and referral appropriate and timely. Psychiatric evaluation delayed by more than a month. Inmate diagnosis and treatment of psychotic symptoms delayed. He is prescribed no medication and was not housed in the mental health cluster until sometime after 3/26/15. (He was in the mental health cluster at the time of the site visit.) Interview presentation consistent with psychotic thought disorder and intellectual disability disorder. He requires a higher level of mental health care.

Case 3

Inmate has been in BOC custody since 11/18/10. He has a diagnosis of Chronic Schizophrenia, is prescribed psychotropic medication and housed in the mental health cluster. For the past year, psychotropic medication orders are written at approximately one-month intervals (3/20/14, 4/30/14, 6/4/14, 6/12/14, 7/8/14, 9/2/14, 10/1/14, 10/31/14, 12/1/14, 1/1/15, 1/23/15, 2/1/15, 3/1/15, 4/7/15). Current medication is Zyprexa 5 mg daily. Medications were adjusted over the course of the past year: inmate was on Prolixin and Cogentin earlier and this was changed to the current Zyprexa medication through a cross tapering process. During this process, Dr. Lu saw the inmate only twice: 6/5/14 (note in mental health file) and 2/24/15 (seen at medication room).

For calendar year 2015, Ms. Warren has seen inmate during cluster visits 1/23/15, 1/28/15, 3/2/15, 3/9/15, 3/16/15, 3/23/15 and 4/10/15.

Inmate also has end stage glaucoma bilaterally and is vision-impaired. There are reports in the records indicating that he was sexually victimized by inmate 13 on more than one occasion while both were residents of the mental health cluster. (Subsequently, inmate 13 was moved out of Cluster 1 and into Cluster 2.) "Victim of sexual assault" was added to [redacted] mental health treatment plan problem list after the assaults by inmate 13.

Interview: Has been in jail almost 5 years; takes his medications and stays in his room. He meets with Ms. Warren and talks about stress and problems; participated in prior groups but not enrolled in current batch. Sees Dr. Lu when he goes to the med window. He was pleasant, cooperative; hygiene fair. Denied depression currently, no thoughts suicide. No hallucinations, not preoccupied, guarded or suspicious.

Comment: 5 years confinement pre-trial! Inmate is mentally ill and physically vulnerable in the jail; sexually assaulted. He is not receiving an appropriate level of mental health care nor being protected from predatory inmates in the jail. He should be released and placed into a residential treatment program in the community.

Case 4

Received 2/19/15 on charge of first degree assault. CO Robles completed the intake health services form on the same date. Inmate had multiple lacerations at time of admission that had been medically attended on the outside. He had stitches and staples which were removed by jail nursing staff 2/21/15. (Mental health file indicates he had been in a knife fight prior to arrest.) Medical physical exam 2/24/15.

Medication orders for Depakote and Lithium are dated 2/19/15 and were received over the phone. Medications renewed 3/1/15 and serum levels ordered. On 3/24/15, there is a telephone order for Geodon, Benadryl and Ativan to be given by injection "prn agitation q 8 hours". April 7, 2015: Depakote reordered (same dose), lithium increased and Ativan ordered as standing order oral medication. Order for injectable Geodon and Benadryl "prn q 8 hours" also present. 4/24/15 order changes Depakote pills to a liquid preparation (but also oral.) Dr. Lu's *only* note during this incarceration is dated 4/9/15 and indicates inmate has Bipolar Affective Disorder and is "psychotic, incompetent, delusional and irrational." Dr. Lu's note indicates medications are Depakote, lithium and Zyprexa – but there is no order for Zyprexa at all. Lab results indicate both Depakote and lithium levels are subtherapeutic; doses were not adjusted.

Medical file indicates [redacted] has sustained multiple injuries while at the jail:

3/24/15 – left ear "split" due to "trying to control" inmate; sent out to local emergency room and returned. (Logbook indicates this incident involved a spontaneous use of force with 7 officers and 3 sergeants. The inmate was originally in his cell on his bunk and failed to comply with a verbal order of one officer to get off his bunk. The original officer "made contact" with the inmate who resisted, leading to the use of force and inmate injury.)

3/26/15 – Laceration "inner" ear

3/28/15 – Nurse administered an injection of short-acting medication. A description of the emergency precipitating this involuntary medication was not provided. The logbook indicates that 6 officers restrained the inmate during this event. Neither the type or duration of restraint were recorded.

4/2/15 – Multiple healed lacerations/abrasions to "both ears, forehead and lower jaw" noted in medical progress note.

4/1/15 – Spitting. Hit head on metal bunk when being restrained by COs.

Interview: Sullen and guarded in interview; somewhat hostile and unwilling to answer questions. Says he is not mentally ill but forced to take medications and if he doesn't, guards beat him. Interview terminated early due to his level of hostility.

Comment: Inadequate psychiatric care; inappropriate use of physical force. Inmate clearly psychiatrically ill and decompensating since at least 3/23/15 according to documentation in the medical

and mental health file but not seen by Dr. Lu until 4/9/15 and not seen since to check on condition. Psychotic, manic and out-of-control; jail is not equipped to handle this degree of illness. COs are not trained to handle this type of behavior resulting in multiple injuries to inmate. Staffing levels are insufficient to deal with an inmate that is this ill. He needs to be in a psychiatric facility/acute care hospital.

Case 5

This man was sent to Sylmar Rehabilitation Center in California in 2009 after having been found Not Guilty by Reason of Insanity (NGRI). He was sent back to St. Thomas 1/25/13 and has been in the jail since that time. He was receiving long-acting injections of Haldol at the hospital, but medication was not ordered upon his return. There is an order for medication 11/21/14, almost two years after his return, but the inmate refused medication at that time and all medications were discontinued 12/1/14.

Dr. Lu saw [redacted] 3/14/13, nearly two months after his return, and diagnosed "Personality Disorder, defiant, immature and aggressive, antisocial. No real psychotic thought disorder but mood instability and personality disorder." (This is interesting because it was Dr. Lu's report in 1997 that indicated the inmate was severely mentally ill and that the criminal act was a result of his mental disorder and led to the NGRI finding.) He also noted that [redacted] refused medications. Dr. Napier saw [redacted] during cluster visits 2/10/14, 5/21/14 and 7/3/14. [redacted] was not seen by psychiatry again until 11/21/14, and he had not been seen since at the time of the site visit. (Dr. Lu did order meds 11/21/14 as noted above, but discontinued them a week later.)

Ms. Warren checks on [redacted] regularly during cluster visits and has documented concerns about the inappropriateness of jail as a placement for him. She has also expressed these views regularly to the Warden and assistant attorneys general.

Comment: Held in jail in spite of a finding NGRI. Level of care he needs exceeds that which can be provided in the jail. He has basically been locked down in his cell without treatment since May 2014. He has refused medications but no motion seeking involuntary medication has been filed. He has been seen by psychiatry only five times in the 2+ years since his return from a hospital level of care. He refused to come out of his cell to speak with me. This seriously mentally ill man needs a hospital level of care. Continued confinement in jail, without treatment is inhumane.

Case 6

Intake health services form completed 3/20/15. Initial mental health assessment by Ms. Warren attempted 3/23/15 but much of it could not be completed due to the delusional, confused and disorganized state of the inmate's thinking at the time. Dr. Lu saw the inmate 3/24/15 and diagnosed Schizoaffective Disorder, paranoid. A mood stabilizing medication (Depakote) and antipsychotic (Zyprexa) were ordered. Dr. Lu had not seen the inmate again at the time of the site visit. Ms. Warren had additional contacts 3/27/15 and 4/10/15.

The inmate appeared to be taking the prescribed medication after they were ordered in March and continued in April. No serum levels of medication had been ordered. The inmate was moved into the mental health cluster 3/26/15 at the request of Ms. Warren and he was housed there at the time of the site visit.

Interview: Grandiose and poorly organized thought processes; thoughts and sentences are disconnected and illogical. Reported that he created the world, invented reggae music in the 1960's and became very rich; has been shot in the top of the head with the bullet traveling through his neck, down his torso and out his groin and that he has also been a math and English teacher. Psychotic (grandiose & disorganized).

Comment: This man should have been diverted to a hospital level of care at the time of intake. At the time of the site visit, a month after his arrest, he remained quite ill with grandiose delusional and disorganized thought processes. He requires more assertive mental health treatment – a higher level of care – than can be provided in the jail.

Case 7

Received into the jail 4/14/15 and referred to mental health by CO Nibbs for bizarre behavior and statements, talking to himself. Seen by Ms. Warren for an initial mental health assessment 4/16/15 and she referred him to Dr. Lu for medication assessment. He was seen by Dr. Lu 4/17/15 who diagnosed Paranoid Schizophrenia; observations included that the inmate was "flighty" and said he had special powers. He also "adamantly refused" medications but Zyprexa (antipsychotic) and Lorazepam (benzodiazepine) were ordered. MAR indicates inmate is actually taking them. He was housed in cluster 4 at the time of the site visit though Ms. Warren indicated that he would be moving to the mental health cluster.

Interview: Pleasant and spontaneous but illogical and disjointed thinking. Reports Dr. Lu recommended medication but he declined it. However, they do call him over everyday for a "little pill to relax" his body and he takes it. Was fired from dishwasher job but says that's what he'd like to go back to doing when released. Says he was arrested for disturbing peace, DV with his father which is why he is in jail. His plan upon release is to go stay with his parents.

Comment: Inmate is seriously mentally ill. He should have been diverted to a higher level of care at the time of intake or at least referred for an immediate psychiatric evaluation. He clearly cannot give informed consent for the prescribed medications. His treatment needs exceed that which can be provided in a jail. He is vulnerable to abuse/attach by other inmates.

Case 8

Received into the jail on 4/15/15 with charges of disturbance of the peace. His initial screening was done on 4/15/15. Initial mental health assessment by Ms. Warren was completed 4/20/15. She documented that he "appears somewhat bizarre in thought" and referred him to the psychiatrist. Dr. Lu saw the inmate on 4/21/15 who diagnosed Anxiety and Panic Disorder. The medication clonazepam (an anti-anxiety, benzodiazepine) was ordered twice daily.

Interview: During the interview with me, the inmate was pleasant and cooperative. He said he arrived in St. Thomas five days prior to his arrest. He had been "camping." He is not employed or in college. He left his parents' home in Texas and lived in New York City for a while before deciding to come to St. Thomas. He planned to go to Colorado sometime later in the summer or fall, but could not explain how he was going to finance his travels. He reported being on the city bus just prior to his arrest and said he was concerned about the way an adult woman was interacting with some minor children who clearly were not related to her. He said that he asked the children if they wanted him to walk home from their bus stop with them because of this adult woman and they said yes. Other bus riders told him to get off the bus and called the police about him. He was arrested. While he appeared calm and rational with organized thought processes initially, he began to talk about there being "gangsters" on the bus who were talking about the children and preoccupied with children's safety (the ones on the bus and all other children), "black culture" and the interactions between "black culture" and white people on the island. He seemed to interpret fairly innocuous events/actions in a paranoid way. He said he had a court date on May 7 and was not particularly concerned about whether he would be released or had spend additional time in jail.

Comment: Apparent misperceptions of some events and reinterpretation in a rather paranoid fashion; atypical/homeless/wandering lifestyle. Possible first break In a psychotic disorder of some type. Additional collateral information needed from family and comprehensive psychiatric assessment necessary. This degree of attention/diagnostic clarification is not possible in the jail.

Case 9 (released)

Inmate has been in the jail on several occasions. He was not in the jail at the time of the site visit. He was in jail 12/7/13 to 5/6/14 and returned 8/13/14 and stayed until 3/4/15. The inmate's initial mental health assessment was completed 1/10/14 (a month after his arrest) and it was not repeated following his second arrest in August, although he was seen by Ms. Warren on that date. Ms. Warren saw the inmate at intervals of 1-2 weeks during his second jail say. Dr. Lu saw the inmate only one time during his second incarceration and that was on 12/29/14 – four and a half months after his arrival. This is in spite of mental health progress notes from Ms. Warren detailing the inmate's mania, agitation and thought disorganization. Although Dr. Lu did not document seeing the patient, he did make multiple medication changes and adjustments; and he also ordered medication be administered intramuscularly if oral medications were refused. There is no documentation indicating that forcing medications was legally authorized. Although the inmate remained "very manic" in early January as documented by Ms. Warren, he was not examined again by Dr. Lu. He was released from the jail on Depakote (a mood stabilizer), olanzapine (an oral antipsychotic) and Prolixin decanoate (a long-acting injectable antipsychotic medication.)

Comment: Psychiatrist failed to follow a seriously mentally ill and unstable inmate at appropriate intervals in order to assertively treat manic condition. Dr. Lu failed to see the inmate timely upon his return to jail. Involuntary/forced medication orders without legal authorization. Inmate clearly exceeded jail capacity to manage his serious mental illness. He should have been transferred to a facility with the capacity to provide a higher level of mental health care.

Case 10 (released)

Inmate arrested 10/22/14 and underwent intake screening. He was referred to mental health as a result of the screening and Ms. Warren conducted her initial assessment 10/22/14. The inmate was referred to Dr. Lu for an assessment and was to be "monitored for suicidal ideation." Dr. Lu did not see the inmate until 10/28/14, about a week after his arrival. Dr. Lu diagnosed "anxiety, stress disorder and depression" and ordered an antidepressant and antianxiety medication. Dr. Lu did not see the inmate again for the duration of his jail stay which was about 6 ½ months. (Neither the medical nor mental health file are clear on when the inmate was released from the jail but his classification file indicates his case was closed 4/8/15.) However, multiple medication changes were made including discontinuation of the antianxiety medication; reducing the dosage of the antidepressant medication and orders for adding a second antidepressant about a week before the inmate's jail release. Therefore, the effect(s) of these medication changes/adjustments/additions were not assessed.

Ms. Warren saw the inmate at intervals of 1-2 weeks throughout his jail stay. He was placed on a suicide watch in late October as there are documents indicating watch placement 10/27/14, 10/28/14 and 10/29/14 but there is no documentation about when, why or if the watch was discontinued. (The document entitled "Bureau of Corrections Suicidal Attempts/Ideations" indicates the inmate was placed on watch 10/27/14 and released from watch 11/7/14 but there are no officer observation sheets for the last week of the supposed "watch.") Watch sheets that were produced demonstrate that officer monitoring was not consistent with the instruction that checks be made at irregular intervals not to exceed 20 minutes. Observation logs record documentation at intervals that range from 20 minutes to more than an hour.

The inmate attended one group during his jail stay. There is an incident report in the classification file that the inmate was placed in restraints and secured to a bench on 10/22/14. There is no documentation authorizing this as any sort of medical or mental health intervention.

Comment: Untimely psychiatric assessment after admission to jail; inappropriate follow-up intervals and failure to assess the effect(s) of psychotropic medications. No documentation of suicide watch for days. Inconsistent monitoring while on suicide watch. Use of some form of restraint without notice or involvement of medical or mental health staff.

Case 11 (released)

This inmate was returned to jail 1/1/15 and remained there until his release 4/8/15. Prior to his return to the jail on an assault and battery charge, the inmate had been released from the jail to the community in October 2014. At that time, Dr. Lu had recommended placement at The Village in St. Croix due to the nature and severity of the inmate's mental illness. However, the inmate was credited with time served and simply released to the community with the judge's instruction to continue his medication. When the inmate was re-arrested 1/1/15, his previous jail medication orders were re-instituted with a phone call to Dr. Lu. Dr. Lu didn't see the inmate until 3/9/15 – two months after his return to jail. The diagnoses are "schizoaffective, schizophrenia and sociopathic." Dr. Lu prescribed two mood stabilizers and a long-acting injectable Haldol without examining the patient.

Comment: In spite of Dr. Lu's recommendation regarding the need for long-term care; he did not examine the inmate for two months after his return to jail. This is inconsistent with Dr. Lu's own assessment of the level of care required for this inmate. This case illustrates problems with intake/assessment, psychotropic medication use and lack of access to a higher level of mental health care.

Case 12

This female inmate was in jail 5/24/14 and released after several months to the community on house arrest. However, she apparently violated the terms of house arrest and was returned to jail 1/20/15 in contempt of court. She was still in the jail at the time of the site visit. During her initial jail stay, Dr. Lu saw her 5/30/14, 6/3/14 and 6/20/14 and diagnosed her as having paranoid schizophrenia and paranoid personality. Dr. Lu prepared a forensic report dated 6/11/14 concluding that while she was actively psychotic, she was competent and the offense was a consequence of her delusional mental disorder. Dr. Lu ordered medications 6/4/14 (olanzapine); 6/11/14 (haloperidol); 7/17/14 (olanzapine and Depakote.) Since none of his orders indicated duration and none cancelled prior orders, his intent with respect to the medications (which ones, doses and for how long) cannot be ascertained.

The inmate returned in January 2015 but there was no documentation that she has been seen by Dr. Lu during this second jail stay. Nevertheless, there are medication orders dated 2/4/15, 2/9/15, 3/3/15, 3/27/15 and 4/7/15. Initially, haloperidol was ordered but is was discontinued in March and olanzapine was ordered in its stead. The inmate has consistently refused medication. The inmate's classification file also contained a second forensic report prepared by Dr. Lu dated 3/27/15. It contained the same conclusion.

Interview: Refusing medications. Sees Ms. Warren weekly or every 2 weeks; have to make an appointment to see Dr. Lu. Expresses some paranoia/victim of conspiracy delusional beliefs; local police are being vindictive towards her by arresting her because she stands up for injustice and the rights of others. She is polite, pleasant and spontaneous with me. Intelligent and articulate with normal mood and affect. Speech is coherent with regular rate and tone. Not preoccupied; denies hallucinations.

Comment: Remains psychotic with behavior the result of her psychotic thought processes. Refusing medications with no documentation of intent to pursue involuntary treatment or transfer to a higher level of mental health care. No intake assessment by psychiatrist; no regular monitoring of condition by psychiatrist; no follow-up regarding medication noncompliance; forensic evaluations rather than clinical care being provided.

Case 13

This inmate was released from the jail and out for only 16 days prior to being arrested on a simple assault charge. He was referred to mental health 3/19/15 and seen by Ms. Warren on the same day. The inmate is prescribed Depakote (a mood stabilizer) and Zoloft (an antidepressant.) There is also an order for lorazepam twice daily (an antianxiety medication) on 3/19/15, but with no duration identified. Subsequent orders are unclear with respect to whether or not it is to continue. Similarly, Depakote is not renewed in April when Zoloft is renewed and is also ambiguous with respect to Dr. Lu's intent regarding the medication.

Ms. Warren has seen the inmate at intervals of 2 weeks. Dr. Lu had not examined the inmate at the time of the site visit – a month after his arrest. This inmate was removed from Cluster 1 for predatory behavior toward a vulnerable inmate housed there.

Interview: Pleasant and polite; appearance and hygiene are good. Speech is more or less continuous and focused on a general theme of how he and others with mental illness and substance abuse issues need treatment, not jail. Some loosely organized discussion of constitutional rights; rambling at times. Speech was not pressured, just copious. He was able to be interrupted but returned to general advocacy themes. Believes his medications are Depakote, Zoloft and "something else." He takes them. Has participated in groups offered and sees Ms. Warren regularly.

Comment: Unacceptable delay in psychiatric assessment of inmate. Ambiguous medication orders. He is housed in Cluster 2 – not the mental health unit following accusations that he sexually abused a vulnerable older visually impaired inmate in Cluster 1. Inadequate physical plant and inadequate supervision in mental health Cluster.

Case 14

Inmate received and underwent receiving screening 3/8/14. He was initially followed by Dr. Napier (since resigned) and ordered Remeron (an antidepressant). Dr. Napier's last order for Remeron 60 mg (a high dose) is dated 4/12/14. There are no further medication orders until 8/22/14 and that order discontinues the Remeron. The inmate is referred to Dr. Lu 9/24/14 but not seen until 10/3/14. (This is the first and only note by Dr. Lu.) Dr. Lu re-started a lower dose of Remeron, started a second antidepressant (sertraline) and added clonazepam (an antianxiety medication.) Orders for Remeron and sertraline are re-written to renew them at approximately monthly intervals. The April order does not mention the clonazepam. It is ambiguous as to whether it is to continue or stop since none of the preceding orders identify duration (such as 60 days, 90 days, etc.)

The inmate has completed two different group group sessions. (Each session consists of multiple group meetings.) He is also attending the newly started conflict resolution group.

Interview: Reports he has less anxiety and depression currently than when he first arrived in jail. Takes antidepressant medication. Has completed 2 full sessions of groups and stated another one on the day of the visit on conflict resolution. He was organized, logical, cooperative. Not preoccupied, guarded or suspicious. Denies depression but anxious regarding upcoming trial scheduled to begin in June but this did not appear to be out of proportion to the seriousness of his charges (1st degree murder) and possible outcome. Acknowledges having thoughts of death, suicide from time to time but no plans and they do not occur as frequently as in the past.

Comment: Inadequate psychiatric follow-up and monitoring. Inmate is seen regularly by social worker in individual and group sessions. Dr. Lu has seen him only once; he is not regularly assessing for effects and side effects of medication. He does not appear to require a higher level of care at this time but does require more frequent psychiatric assessment and support. His trial on first degree murder charges is set to begin in June.

Case 15

Inmate completed suicide on December 21, 2014. She had been held in the jail since February 5, 2013 although she was also incarcerated there January 13, 2013 to January 26, 2013 on other charges. She had a known history of serious mental illness and Dr. Lu was aware of same as he did the competency reports. The jail problem list indicates a history of bipolar disorder and schizophrenia. Inmate consistently stated that she was born to be Jesus and that God spoke to her. Dr. Lu prescribed Zoloft (antidepressant) and Depakote (mood stabilizer) in mid-October 2013 which she refused to take. The medications were discontinued. No other psychotropic medication orders are documented. Some attempts were made to speak with her about medications but she consistently refused to consider medications. In the later months of her confinement, the inmate refused to speak with Dr. Lu or Ms. Warren altogether. She remained psychotic with alternating periods of depression and manic behaviors and without treatment throughout the course of her jail stay.

Inmate was sent out to Schneider Regional Medical Center 6/20/13 for medical assessment during a hunger strike. She engaged in another hunger strike in September 2013 as well.

The inmate was placed on suicide watches once or twice in 2013 (September and November – records are not clear as there are not orders to initiate and discontinue watches or corresponding observation logs) and in June 2014 when she was not eating or responding to people talking to her. (On this occasion, she was sent out to Schneider Regional Medical Center for a medical assessment and returned with a diagnosis of malingering.) She was placed on suicide watch again October 27, 2014 through November 7, 2014 based on doctor's orders. However, there is no indication of the watch in the Cluster logbook for that time span. Further, officer observations did not occur at 15-minute intervals, while on watch. Sometimes, officer observations occurred less often than once an hour. For many of the days on watch, there is no officer observation log sheet at all. Additionally, inmate was permitted to leave the housing unit while "on watch" with even less oversight or supervision. (It might be possible that the log sheets were completed and misplaced but that seems unlikely given that the bound Cluster log book which records unit activity, inmate movement, counts and shift changes also makes no mention that the inmate was on a special observation/watch status on any of those days.)

On December 18, 2014, the inmate was visited by her father as he attempted to work with her attorney to secure her release from the jail. Apparently, the visit went poorly; the inmate became distraught and terminated the contact abruptly. Her father reported to Ms. Warren that the inmate had accused him of sexual abuse, which he denied. (He reported that the inmate herself had been accused of sexual abuse of a sibling.)

Ms. Warren attempted to speak with the inmate following the visit but she refused, as she had consistently done. No additional attempts were made to reach out to her following the interaction with her father. Subsequently, her risk of self-harm was not assessed. She was referred to Dr. Lu to be seen at his next scheduled jail day, 12/24 – six days after the upsetting visit with father. There is no

documentation that correctional staff were alerted to monitor her more closely given her failure to speak with mental health and the upsetting interaction with her father.

On 12/21/14, the inmate was discovered hanging by another inmate delivering her lunch tray. The inmate was in her cell and had used a plastic bang to fashion a noose that she tied to the upper bunk. Upon discovering that she was hanging, the inmate called for the officer who in turn, called for assistance. The responding officers attempted to untie the plastic noose. Eventually, one of them cut the plastic bag down from the upper bunk. There is no mention in incident reports or the master logbook that anyone retrieved the cut down tool. There is no mention in incident reports or any other reports that responding officers initiated any sort of first aid or CPR to the inmate. Outside EMS were summoned and the inmate was pronounced dead at the scene.

Ms. Warren was off the island at the time of the suicide but did make arrangements for psychology contractors to go to the jail and provide support/de-briefing to the remaining female inmates as well as staff requesting the opportunity to talk about what happened.

Neither the jail nor the BOC conducted any sort of critical incident or death review of this case. Videotapes of the jail demonstrate that officer welfare rounds on Cluster 7 did not occur at regular intervals as required by policy. This led to a delay in discovery of the inmate and first aid/CPR.

Comment: There are multiple problems with the management of this case. First, the inmate remained psychotic (delusional) with episodes of mania and depression – and without treatment for serious mental illness for nearly two years but was still in the jail. No petitions for involuntary treatment were filed; no attempts were made to get her into a psychiatric hospital. When she was placed on watch status, the watches were not conducted appropriately; she was in fact, not more closely monitored or observed nor did treatment efforts intensify. Even routine welfare rounds were not consistently conducted by correctional staff which presents a grave danger a inmate injury or death, as in this case. This inmate required a higher level of care and should not have remained in the jail.

With respect to the completed suicide, there were problems with communication (both information to heighten awareness of correctional staff regarding the upsetting incident with her father and notice to the jail warden of the critical incident); monitoring (welfare rounds not conducted for hours); lack of safe housing (which could have been used as a precautionary measure for an inmate with a history of depression, prior watches, psychotic thinking and an upsetting incident who refused to cooperate with an assessment); response (delay in discovering the suicide; no cut down tool to quickly remove the noose; delay in assessment and initiation of any sort of first aid/CPR – officers waited to for the arrival of outside EMS).

Appendix B: BOC POLICIES UNDER DEVELOPMENT

As of June 15, 2015, the Bureau of Corrections has begun developing the following medical and mental health policies, procedures, and forms:

1. P-A-01 Access to Care
2. P-A-06 Continuous Quality Improvement
3. P-A-09 Privacy of Care
4. P-A-10 Procedure in the event of inmate death
5. P-A-11 Grievance mechanism for health complaints
6. P-B-01 Infection Control Activities
7. P-B-02 Patient Safety
8. P-D-02 Medication Services
9. P-D-02B Psychotropic Medication
10. P-D-05 Hospital and Specialty Care
11. P-E-02 Intake Screening Form
12. P-E-02 Receiving Screen
13. P-E-02 Medical Placement Form
14. P-E-04 Health Policy (Individual Health Assessments, when clinically indicated)
15. P-E-06 Oral Care
16. P-E-07 Non-emergency health sick call
17. P-E-08 Emergency Services
18. P-E-09 Segregation Policy
19. P-E-10 Patient Escort
20. P-E-11 Nursing Assessment Protocols
21. P-E-12 Continuity of Care
22. P-E-13 Discharge planning
23. P-F-02 Medical diets
24. P-G-01 Chronic Disease Baseline Management and forms
25. P-G-04 Basic Mental Health Services
26. P-G-05 Suicide Prevention
27. P-G-06 &07- Alcohol and Drugs/Intoxication and Withdrawal, Detoxification-COWS form.
28. P-G-08 Contraception
29. P-G-09 Pregnant
30. P-G-10 Aids to Impairment
31. P-G-11 Terminally Ill
32. P-H-01 Medical Records Policy
33. P-H-02 Confidentiality
34. P-I-02 Restraints and Seclusion
35. P-I-02 Emergency Psychotropic Medication
36. P-I-04 Informed Consent and Refusal of Care
37. Glossary of Terms
38. Log of Seclusion and/or Restraint Rounds
39. Consent for Anti-psychotropic medication form
40. Consent for Psychotropic medication form