United States Virgin Islands
GOLDEN GROVE ADULT CORRECTIONAL FACILITY
St. Croix, VI

FOURTH COMPLIANCE MONITORING REPORT

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

Kenneth A. Ray, M.Ed., Monitor
September 01, 2014

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PURPOSE

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

EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

The fourth onsite compliance monitoring assessment was conducted during two separate visits due to conflicts with monitoring team schedules. Dr. Shansky conducted his compliance assessment of medical provisions June 3-6, 2014; This Monitor and Dr. Stellman (mental health / suicide prevention provisions) were onsite June 17-20, 2014. Prior to this site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite assessment.

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

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

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

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

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

1. Policies, procedures, protocols, and/or plans required of a provision are properly approved;
2. the above documents are promulgated and staff are adequately trained on those documents and related performance expectations; and,
3. those documents are adequately and effectively implemented.

Provisions are eligible to advance from partial to substantial compliance when efficacious assessment and evaluation of implemented policies, procedures, protocols, plans, etc. quantitatively and/or qualitatively evidence 1) that implementation efforts are producing outcomes intended in the Agreement, and 2) implementation outcome performance is reliable (assessments and evaluations evidence consistency in producing outcomes intended in the Agreement). The entire Agreement is eligible for termination once all provisions have reached and maintained substantial compliance for a minimum of 12 consecutive months. Although this Monitor will not withhold substantial compliance rating where advancement is adequately evidenced, this Monitor will and has reversed a compliance rating when the evidence supports doing so.

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

GGACF FOURTH COMPLIANCE ASSESSMENT SCORE CARD				
Agreement Compliance Provision Topic Areas	Total Provisions	Non Compliance	Partial Compliance	Substantial Compliance
IV. Safety & Supervision	59	52	7	0
V. Medical & Mental Health Care	36	36	0	0
VI. Fire & Life Safety	10	10	0	0
VII. Environmental Health & Safety	11	5	6	0
VIII. Training	4	4	0	0
Total Substantive Provisions	120	107	13	0
	100%	89%	11%	0%
Primary Assessor:				
Kenneth A. Ray, Monitor:	IV. Safety & Supervision			59
	VI. Fire & Life Safety			10
	VII. Environmental Health & Safety			11
	VIII. Training			4
Dr. Ron Shansky / Dr. Roberta Stellman:	V. Medical & Mental Health Care			36
			Total:	120

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

FOURTH ASSESSMENT FINDINGS OVERVIEW:

This assessment found virtually no progress from any of the three previous reports. Notwithstanding the commendable efforts by the Territory to maintain the measure of improved housing unit sanitation and complete the required security staffing analysis, GGACF operations and conditions remain much the same as described in the Findings of Fact Report (filed on 02/08/13) and all monitoring reports. Simply stated, GGACF conditions continue to promote real and potential serious harm risks to the physical and psych-emotional safety and security of the community, staff, and inmates as stated in the previous report,

> *"...based on staff and inmate interviews; reviews of various official logs and records, and direct observations, GGACF remains a very dangerous, violent, unhealthy, under-supervised, under-maintained, and deleteriously understaffed correctional environment. Inmates and staff are unnecessarily exposed to real and potential psycho-social and physical violence, inmates cannot receive adequate levels of medical or mental health services and care, and the lack of an adequate fire suppression system places everyone working and incarcerated at GGACF at constant substantial risk. Substandard and inconsistent security practices i.e. consistently closing and locking security doors and gates are exacerbated by inoperable locking mechanisms. Housing units continue to flood during heavy rains and mold remains profuse throughout most inmate housing areas. The training program, based on documents provided, requires significant overhaul with focus on promulgation and evaluation of standardized curricula that emphasizes contemporary pre and in-service correctional subjects and practices as its priority. GGACF remains very penetrable for dangerous contraband (knives, shanks, cutting devices, impact tools, etc.) as well as cell phones and drugs, and a variety of the kinds of contraband according to evidence logs and incident reports. The inmate grievance process is not consistently managed nor adequately documented according to grievance records review, and the inmate disciplinary process appears to deliver inconsistent consequences and fails to consistently administer due process hearings due to staffing shortages. Inmates continue to be allowed to keep in their cells used prescription needles and unused syringes, which is an extremely hazardous practice, especially considering the regularity that housing units are left with no or inadequate staffing levels. Inmates with mental illness, some with serious mental illness, are housing in segregation or locked in their cells (segregated) for long periods of time and without ongoing assessment and monitoring by mental health professionals. Housing unit logs also report that inmates remain able to "pop" their cell door locks and gain unauthorized access to housing unit areas. Suicidal inmates continue to be placed on suicide watch by correctional officers without the knowledge or involvement by mental health staff, and housing unit logs report that officers either have difficulty summoning medical staff when needed for inmate medical issues or decide to respond to medical issues on their own without*

consulting medical staff. Events involving use of force against inmates is not reported consistently, and there have been delays in reporting to management potentially serious medical issues involving inmates assaulted by other inmates."

Overshadowing Fourth assessment findings are ongoing serious assaults of officers and inmates. Between the third and fourth on-site assessment tours, there were at least two serious prisoner-on-prisoner assaults, both requiring emergency medical treatment. There was also the May 11, 2014 escape of a dangerous inmate who reportedly sexually assaulted one of his previous victims while at large. There was also an attempted escape, where five inmates were apprehended by the Virgin Islands Police Department just prior to breaching the outside perimeter fence. During the fourth on-site assessment, there was an inmate-on-staff assault in one of the lock-down units. Following the fourth on-site assessment, there was another prisoner-on-prisoner assault, resulting in stab wounds; no incident reports or follow up information was provided for this event. These events further demonstrate the Territory's inability to timely and effectively protect staff, inmates, and the community from violence, a fundamental purpose of the Agreement (II.1, 2. Introduction):

1. ***The purpose of this Agreement*** is to remedy the ongoing constitutional violations identified subsequent to the July 28, 2011 filing of Defendants' Motion to Terminate pursuant to the Prison Litigation Reform Act, 18 U.S.C. § 3626(b) [Dkt. 565]. Through the provisions of this Agreement, the parties seek to ensure that the conditions at the Golden Grove Adult Correctional and Detention Facility ("Golden Grove") ***respect the rights of prisoners confined there. By ensuring that the conditions in Golden Grove are constitutional, Defendants also will provide for the safety of staff and promote public safety in the community.***

2. Defendants consent to the entry of findings that the conditions at Golden Grove necessitate the remedial measures contained in this Agreement. The parties recognize that the conditions at Golden Grove and the treatment of prisoners confined therein have an impact on ***whether prisoners will be successfully re-integrated on release, whether released prisoners will re-offend, and public confidence in the criminal justice system***.

GGACF continues to allow inmate-occupied housing units to operate without staff and/or inadequate staff. Shift supervision staffing levels are so low most of the time that line staff receive virtually no supervision or monitoring for entire shifts. In one reported instance, a supervisor concerned about shift staffing shortages telephoned an off-duty corrections administrator, only to be told "*you're on your own.*" The supervisor provided no assistance. This Monitor finds that administrator's lack of support, if true as reported, incredible and deliberately indifferent to the safety and security needs of staff, inmates, and the community.

Inmates are still able to defeat locking systems, get out of their cells and housing units, gain access to other inmates for social or dangerous motives, and even escape to commit violence against the community as reported in the May 11, 2014 escape investigation.

Officers continue to be violently attacked and inmates severely assaulted requiring emergency medical care. GGACF continues to lock-down inmates with mental illness without providing adequate rounds by medical and mental health staff or consistent, reliable access to psychiatric care. Housing unit temperatures are quite high – so high that they jeopardize the health of inmates

being prescribed certain psychotropic medications. Access to timely, consistent, and qualify health care remains seriously inadequate. There is a severe shortage of qualified nurses, and vacant positions have not been filled; medication administration is not consistent due to security staffing problems; the medical records system is devoid of adequate oversight and management; and the hiring of the new medical director is reportedly jeopardized by professional licensing prohibitions against supervising the GGACF medical program.

The facility remains penetrable to contraband. Evidence confiscation logs reveal that inmates continue to have access to weapons, drugs, and cell phones. Despite the Territory's intentional efforts to eliminate the presence of contraband (via the GIST program), the inmate population remains a constant violent threat due to having seemingly unstoppable access to weapons.

The inmate discipline program continues to yield inconsistent discipline or no discipline at all. This is because GGACF consistently fails to give inmates timely disciplinary hearings to contest the disciplinary charges filed against them. GGACF is unable to conduct timely hearings because there is not enough staff to assemble hearing panels on a regular and consistent basis. Subsequently, the GGACF disciplinary system cannot provide meaningful levels of consistent inmate discipline – a fundamental outcome of an effective program.

The two inmate-caused fires that reportedly occurred in a housing unit demonstrate ongoing real and potential life-safety risks to staff and inmates. The automatic fire alarm and suppression system remains inoperable. The fire detection and suppression system consists only of fire extinguishers located in the officer pods within housing units. Effective use of these extinguishers during a fire emergency requires adequate staffing of housing units. GGACF is commended for maintaining operable handheld fire extinguishers in housing units. Fire extinguishers are not, however, an adequate *detection* and response system, especially given the extreme staffing shortages at GGACF. Moreover, inmates continue to be allowed to use sprinkler heads in their cells to anchor clotheslines. As noted in each prior report, this practice must stop immediately, as it creates a safety and fire hazard for inmates.
GGACF also attempted to conduct two emergency evacuation exercises. One of these exercises was cancelled mid-way through, however, because a fight broke out. This means that, to the best of the Monitor's knowledge, GGACF has only conducted one full emergency evacuation exercise of one housing unit in the last year.

The Territory is commended for maintaining improved sanitation, as found during the third assessment. Housing units and inmate cells did seemed cleaner than they were prior to the previous visit. However, some cells were still filthy, and inmates continue to block cell door windows with various items, preventing good security visibility for inmate counts and reliable welfare inspections. Although the Territory continues to report that they do not condone this practice, the Monitor has noticed such obstructions during each tour, without significant change.

Inmates still do not have consistent and reliable access to drinkable water. Several cell sinks are inoperable, requiring inmates to rely on water containers in the day rooms for hydration. However, inmates have virtually no access to water after lockdown, and no access to water when housing units are not staffed. High temperatures and humidity in the housing units and cells necessitate that inmate have unencumbered access to drinkable water 24/7. This problem has been mentioned in each of the previous reports, but the sinks remain broken, with no plan provided for when they will be fixed.

Notwithstanding the findings in this assessment, the Territory continues to voice commitment to complying with the Agreement. However, it is this Monitor's opinion that the Territory has not provided GGACF nearly adequate resources to comply with this Agreement, and various compliance efforts have resulted in delays and missteps. It is clear that, as currently funded and staffed, GGACF does not have the leadership and resources necessary to come into substantial compliance with this Agreement. GGACF will remain a dangerous and unhealthy correctional institution until such time as resources are allocated and leadership are committed to actually creating lasting changes.

IV. SAFETY AND SUPERVISION

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

A. Supervision

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No measurable changes were apparent regarding stratification of inmate housing for institutional classification, housing, policy or procedure since previous onsite assessments. Recommendations provided in the previous reports remain appropriate.

On June 5, 2014, Territory representatives submitted to this Monitor and USDOJ documents intended to satisfy this Provision. The documents included 1) definition for general population inmates and, 2) a custody level chart showing custody levels for most housing areas. However, these documents did not adequately and completely show stratification and housing assignment for all populations, as it did not include Detention populations. No policies or procedures were submitted for population stratification and/or housing.

A review of the Incident Report and Contraband Logs, incident reports, and classification documents evidence that appropriate stratification for classification housing is inadequate and inconsistent. As detailed in other sections of this report, the lack of appropriate screening instruments, housing stratification schemes, and policies and procedures regarding classification continues to place inmates at risk of harm.

RECOMMENDATIONS:

4th Assessment:

1. Stratify population showing Prison and Detention classifications.
2. Include all housing buildings and units in the plan. Specifically, breakdown the data showing locations of all locations, total capacity of each, numbers of cells and beds, classification for each building and unit..

3. Show all bed-capacities for each custody level per housing building and unit.
4. Define custody levels more clearly and completely for all inmate classifications in each custody level.
5. Include intake unit - inmates are held and housed in that location.
6. Specific female unit uses – convicted (where), detention (where).

Previous Recommendations Remain Appropriate:

1. Revise/develop housing classification policies based on a current validated intake and review classification instrument. Submit document drafts as indicated in the Agreement before implementation.
2. Timely complete and submit a policy development plan that includes, at a minimum, the following elements:
   A. Policy title with related procedure titles
   B. Primary policy references
   C. Person(s) responsible for document development
   D. Expected dates to be forwarded to the Monitor and USDOJ for review and approval, date(s) of staff training, implementation date
3. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
4. Refer to IV.F. regarding specific classification and housing policy recommendations.

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

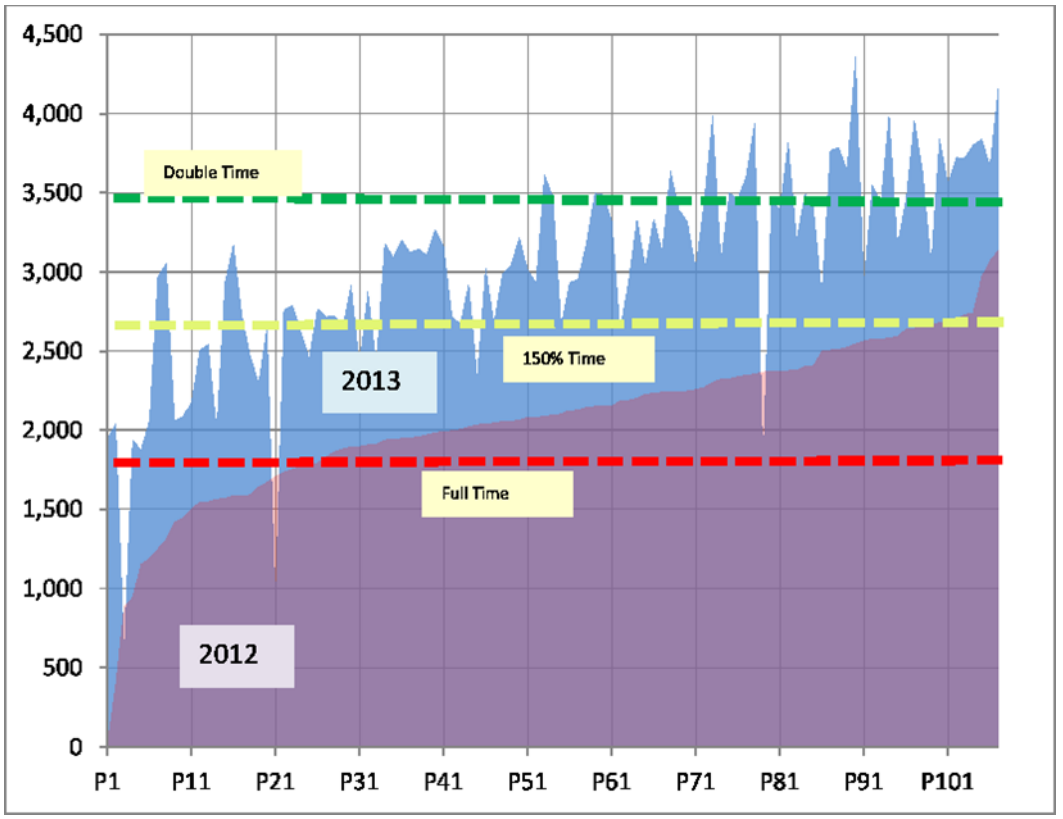
ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: GGACF staff are dangerously overworked. Inmate-occupied housing units continue to go unstaffed and/or understaffed for extended time periods. In some instances, entire buildings are not assigned officers for entire shifts. Housing-unit officers continue to leave the facility without authorization. Recent staff and inmate assaults, and the May 11, 2014 escape of a dangerous inmate, who reportedly committed a sexual assault of his previous victim following this escape, demonstrate ongoing real and present dangers resulting from noncompliance with this Provision.

The required Staffing Analysis was recently completed by the National Institute of Corrections (NIC) and submitted to the Territory, who shared it with this Monitor and USDOJ. The findings illustrate this Monitor's concerns regarding inadequate staffing levels. The analysis proposes necessary increases in staffing as well as strategies for improved deployment of existing staff. The assessment also found that correctional officers are working dangerously high amounts of overtime and those amounts increased two-fold since 2012.

According to payroll records examined by the NIC consultant, almost 50% of GGACF correctional officers worked an average of 60 hours per week or more in 2012. This number increased to nearly 80% in 2013, with 25 employees averaging more than 80 hours (double time) per week in 2013. A graph illustrating this serious problem was pulled from the NIC Staffing Analysis and is shown below. The Purple (or non-jagged) area represents 2012 hrs.

The blue jagged area represents 2013 employee annual average work hours. Dotted horizontal lines represent full-time hours (red/lower), time and one-half hours (yellow/middle), and double time hours (green/upper).



Additionally, payroll documents provided to this Monitor following the May 11, 2014 escape revealed that some officers had worked upwards of 24 consecutive hours the week of the escape, with other officers working in excess of 16 consecutive hours. Such high amounts of overtime create serious staff and inmate safety and security risks in the form of staff chronic fatigue; inattention to the presence of security risks; incomplete inmate and unit searches; and overall burnout/inattention to one's post. Inadequate staffing levels combined with overworked staff is likely a major contributor to the ongoing personal harm occurring at GGACF, and must be corrected without delay.

Supervisor logs examined by this Monitor during previous monitoring visits, and in the completion of the staffing analysis by the NIC Consultant, continue to evidence seemingly perpetual noncompliance with this provision. It is important, however, to first describe inconsistencies found in the supervisor's log, and to urge caution in generalizing conclusions with the data abstracted from these logs due to evident inconsistencies.

The supervisor's log is used to document staffing levels and various activities by shift supervisors for each of the three shifts (shifts A, B, C) on a daily basis. This log should be relied upon by GGACF supervisors and management for effective and reliable management of the facility. Therefore, information and data in the log should be consistent, legible, and complete. This is not the case. The Supervisor log is unreliable for making valid and reliable management decisions, because the log is replete with incomplete information and inconsistency. The level

of detail and information contained in the log seems to vary depending on which supervisor was on duty that day. An examination of the supervisor's log from May 20 thru June 5, 2014 (17 days) vividly demonstrates this problem. The supervisor log for the 17-day period were examined by the NIC consultant in an effort to clarify staffing levels as part of the staffing analysis.

For example, GGACF operates three work shifts each day; these three shifts make up a 24-hour coverage schedule. There are, therefore, 51 work shifts during a 17-day work period (3 shifts x 17 days = 51). If there was a policy in place governing the use of the Supervisor's Log, it should say that each shift supervisor should record staffing levels for all post assignments during their shift each day. There is not currently a policy stating this, however, so this practice is not followed consistently. There were only four days during this 17-day period with complete staff assignment data for all three shifts recorded in the Log Book. On all other days, some shifts were recorded, while others were not:

Supervisor Log Dates	Shifts Per Day	Shift A Staffing Logged	Shift B Staffing Logged	Shift C Staffing Logged	Total Logged Per Day	Percent Logged
5/20/2013	3	0	0	1	1	33%
5/21/2013	3	1	0	1	2	67%
5/22/2013	3	1	0	1	2	67%
5/23/2013	3	0	0	1	1	33%
5/24/2013	3	0	0	0	0	0%
5/25/2013	3	0	0	1	1	33%
5/26/2013	3	1	1	1	3	100%
5/27/2013	3	1	1	1	3	100%
5/28/2013	3	1	1	0	2	67%
5/29/2013	3	1	0	0	1	33%
5/30/2013	3	0	1	1	2	67%
5/31/2013	3	1	1	0	2	67%
6/1/2013	3	0	1	1	2	67%
6/2/2013	3	1	1	1	3	100%
6/3/2013	3	1	1	1	3	100%
6/4/2013	3	1	0	1	2	67%
6/5/2013	3	1	0	1	2	67%
Days / Validate	17	17	17	17	17	17
Total Shifts / Logged	51	11	8	13	32	AVG
Percent Shifts Logged		65%	47%	76%	63%	63%
Percent Days Logged						24%

Notwithstanding these inconsistencies, this Monitor made best-efforts to analyze data that were logged by supervisors to gain a reasonable measure of clarity for assessing compliance.

Approximately 30 of 51 shifts for this 17-day period reported what appeared to be complete staffing assignment/level information, including the presence of shift supervisors. Shift supervisors include (1) T/C (Tour Commander) and (3) Asst. T/Cs. According to the log entries, there was a T/C on duty 28 of the approximate 30 shifts examined; 11 shifts where only one Asst. T/C was on duty; 5 shifts where two Asst. T/Cs were on duty; and only 4 shifts where all three Asst. T/Cs were on duty. Log entries showed no supervisors (no T/C or Asst. T/Cs) on

duty May 20 or 22 (12a-8a), and only one (1) supervisor on duty May 26 (12a-8a); May 27 (12a-8a & 8a-4p); May 28 (4p-12a); May 30 (8a-4p); May 31 (12a-8a & 8a-4p); June 1 (8a-4p &4p-12a); June 2 (all three shifts); June 3 (8am-4p & 4p-12a); June 4 (12a-8a & 4p-12a); and, June 5 (12a-8a). The chart below illustrates these findings:

Date	5/20	5/21	5/21	5/22	5/22	5/23	5/25	5/26	5/26	5/27	5/27	5/27	5/28	5/28	5/29	5/30	5/30	5/31	5/31	6/1	6/1	6/2	6/2	6/2	6/3	6/3	6/3	6/4	6/4	6/5
Shift (Reg / OT Staffing Logged) (Shifts: A=12a-8a / B=8a-4p / C=4p-12a	C	A	C	A	C	C	C	A	C	A	B	C	B	C	A	B	C	A	B	B	C	A	B	C	A	B	C	A	C	A
T/C (Tour Command)	1	0	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Asst. T/C	1	0	1	1	1	0	1	0	1	0	0	1	1	0	1	1	0	0	0	0	0	0	0	0	1	0	0	0	0	0
Asst. T/C	1	0	1	0	2	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Asst. T/C	1	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Reported on Shift	4	0	4	2	6	0	2	1	2	1	1	3	2	1	2	2	1	1	1	1	1	1	1	1	2	1	1	1	1	1
Total 24/7 Shift Supervisor Posts	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Percent on Shift	100%	0%	100%	50%	150%	0%	50%	25%	50%	25%	25%	75%	50%	25%	50%	50%	25%	25%	25%	25%	25%	25%	25%	25%	50%	25%	25%	25%	25%	25%

The Supervisor's Log (to the extent logged information is reliable) clearly evidences GGACF's inability to provide adequate, reliable, and consistent shift supervision. It is this Monitor's professional opinion (based on 34 years of experience in this industry) that GGACF requires a minimum of four (4) shift supervisors on duty during the hours of 8a to 9p (lockdown) and not less than three (3) supervisors on duty from 9pm – 8am.

The Supervisor Log also revealed that in the same 17-day period (May 20 – June 5) there were severe staffing shortages for housing units. There are 14 occupied housing units holding convicted and pretrial inmates, including units holding high risk and mentally ill prisoners. An examination of the 51 shifts during this date range found that only three of the 14 housing units (G,, I, 9C) were staffed 24/7 during this date range.. On May 31, there were five (5) housing units that went unstaffed during the entire 12a-8a shift (Intake, J, K, L, and 9A). RSAT and Intake units reportedly operated without staff for multiple shifts during several consecutive days. It is estimated that 55 shifts for the 14 housing units operated without staff, from May 20 to June 6. The chart below presents these estimates per housing unit:

Occupied Housing Units	Days /Shifts Post Not Staffed	% Shifts Not Staffed
A Dorm/RSAT	7	23%
RSAT	15	50%
Intake	18	60%
X or X-Ray	1	3%
G	0	0%
H	1	3%
I	0	0%
J	1	3%
K	2	7%
L	3	10%
9A	3	10%
9B	3	10%
9C	0	0%
9D	1	3%
TOTAL	55	

The chart below shows shift staffing estimates (staffed= 1/green, not staffed=0/red).

Date	5/20	5/21	5/21	5/22	5/22	5/23	5/25	5/26	5/26	5/27	5/27	5/27	5/28	5/28	5/29	5/30	5/30	5/31	5/31	6/1	6/1	6/2	6/2	6/2	6/3	6/3	6/3	6/4	6/4	6/5
Shift (Reg / OT Staffing Logged) (Shifts: A=12a-8a / B=8a-4p / C=4p-12a	C	A	C	A	C	C	C	A	C	A	B	C	B	C	A	B	C	A	B	B	C	A	B	C	A	B	C	A	C	A
A Dorm/RSAT	1	0	1	0	1	1	1	1	1	1	0	1	1	0	1	1	1	1	0	1	1	1	1	0	1	1	0	1	1	1
RSAT	1	0	1	1	1	1	1	1	1	1	0	1	1	0	0	0	0	1	1	0	0	0	0	1	0	0	0	0	1	0
Intake	1	0	2	0	1	0	1	1	1	0	1	1	0	0	1	0	0	0	0	0	0	0	0	1	1	0	0	0	0	1
X or X-Ray	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
G	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
H	1	1	1	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1
I	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
J	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1
K	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1
L	1	0	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	2	0	1	1	1	1	1	1	2	1
9A	2	1	2	1	3	1	2	1	2	1	1	2	2	2	1	1	0	0	1	1	0	1	2	2	2	2	1	1	1	1
9B	1	1	1	1	2	1	1	1	1	0	0	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1
9C	1	1	1	1	2	1	1	1	1	1	1	2	1	1	1	1	1	2	1	1	1	1	1	1	1	1	1	1	1	1
9D	1	1	1	1	2	2	1	1	2	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1
TOTAL	15	10	16	11	20	14	15	14	18	12	11	16	14	12	13	12	11	10	10	12	12	11	13	14	12	13	11	12	14	13
Total 24/7 Security Posts:	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14	14
Post Staffed Per Day:	14	10	14	11	14	13	14	14	14	12	11	14	13	11	13	12	11	9	10	12	11	11	12	13	11	12	11	12	11	11
Percent Post Staffed / Shift	100%	71%	100%	79%	100%	93%	100%	100%	100%	86%	79%	100%	93%	79%	93%	86%	79%	64%	71%	86%	79%	79%	86%	93%	79%	86%	79%	86%	79%	79%

The lack of inmate supervision by correctional officers and staff supervision from T/Cs clearly demonstrates that the Territory will not be able to comply with this or other related provisions until both correctional officer and supervisor staffing levels are adequately increased and supervisors are consistently supervising all shifts daily.

It is important to note, however, that the new Warden has implemented a shift roster system, primarily to control overtime costs that seems to provide some measure of attention to ensuring housing units are properly staffed. However, based on this Monitor's discussions with the Warden about this document consideration revision is required to ensure the document is completed, accurate, and understandable for evidencing compliance with staffing level requirements. Nonetheless, the Warden is commended to taking action to improve these conditions.

RECOMMENDATIONS:

1. Rapidly implement the NIC Staffing Analysis recommendations.
2. Create a staffing plan, as required under the Agreement, that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff
3. Take immediate steps to either reduce the inmate population commensurate with existing staffing levels or increase staffing levels commensurate with current inmate population volume. Using the staffing analysis, determine net additional staffing levels needed once inmate population is reduced.
4. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff who work overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.
5. Improve consistency, accuracy, and reliability of supervisor logs entries.
6. Contact the VI Guard to provide temporary internal and perimeter security presence until staffing levels are adequate.
7. Use off-duty VIPD officers to cover unstaffed housing units.
8. Hire PRN nurses with trauma care experience until approved FTEs are onsite.
9. Reassign correctional leadership/supervisory/specialty staff across all shifts to ensure post coverage and consistent inmate monitoring and supervision.
10. Use enabling statues that allow for immediate procurement of security hardware and systems services.
11. Fast-track movement of prisoners off-island.
12. Request emergency funding from the Governor and/or legislator for rapid hiring of additional officers pursuant to the Staffing Study; remove ALL administrative and bureaucratic barriers that have and can impair rapid hiring of qualified candidates.
13. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.
14. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.

Previous Recommendations Remain Appropriate:

1. Subsequent to policy and procedure development and revisions, conduct a complete review of existing Specific and General Post Orders to ensure they are:
   A. post specific;
   B. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   C. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   D. maintained at each post, kept current, and easily accessible;

E. regularly reviewed, revised, updated;
F. consistently enforced;
G. known to staff through pre-service, in-service, and ongoing training.

2. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues to be known and resolved in a timely manner.
3. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: All but one housing-unit officer possessed a radio during this assessment; the RSAT officer had no radio or telephone. Additionally, the telephone system remains virtually inoperable throughout the facility. Territory officials report that the new fiber optic system should be functional by the end of September and allow for phone-system operability.

The Territory submitted to this Monitor and USDOJ on June 1st a draft Radio Communications policies and procedures. The policy was generally complete but required several revisions. This Monitor and USDOJ provided the Territory with written comments and recommendations within the 45-day requirement. It is the Territory's intention to finalize this policy during the September TA visit by this Monitor.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. Revise and/or develop, implement, and evaluate policies and procedures governing radio communication equipment, usage, repair and maintenance.
2. Ensure that all posts are equipped with functionally reliable communications equipment; it is recommended that reliable radios are issued to ALL officers and staff working with and/or around inmates.
3. Repair, replace nonfunctioning radio and telephone communications equipment throughout the facility, and add additional communications equipment where indicated.
4. The Monitor will review radio equipment inventories and functionality during the next onsite assessment.
5. Provide portable radio communications policies and procedures.
6. Provide portable radio communication training curriculum.

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

(i) conducting of adequate rounds by corrections officers and security supervisors in all cellblocks; and

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As previously described, housing units and entire buildings continue to go under-staffed or not staffed for extended time periods. Certain housing units and buildings are continually staffed by only one officer. This lack of adequate staff directly contributed to the May 11, 2014 escape.

The A (mental health) and RSAT buildings are routinely staffed by only one officer who must leave one building to supervise inmates in the other. This leaves both inmate populations not supervised for extended time periods. During this visit, however, there was an officer assigned to each building, but the A building officer stated she had no suicide cut-down tool and the RSAT officer had no radio and only a personal cell phone for communications.

Shifts continue to operate without a supervisor onsite and/or the assistance of off-site supervision. An extreme example of this problem is evidenced on May 11, 2014, the day before the escape. Investigation and incident reports for this escape document that the on-duty supervisor called the Assistant Warden for assistance due to that shift having a severe staffing shortage. Reports indicated that the Assistant Warden not only refused to provide this supervisor with any assistance to mitigate the staffing shortage, but reportedly told the requesting supervisor, "… *you are on your own…"* This supervisor, having worked in excess of 20 consecutive hours, ultimately abandoned his or her post, reporting fatigue and concerns about an existing chronic disease being exacerbated by situational stress and no meal breaks during the shift. Incident reports also revealed that no other supervisors or leadership staff were available for assistance. This means that there were no officers or supervisors conducting adequate rounds in housing units during that shift, as required by this provision. The Territory's failure to meet this requirement resulted in a serious security breach, and the alleged re-victimization of a community member.

This event also evidences inadequate and/or non-existent perimeter security rounds because the inmate was able to easily penetrate the perimeter fence through previously damaged and/or non-maintained gate structures, and the fencing was found to have been cut prior to the escape. Regular and routine inspection and consistent repair of perimeter fencing could have thwarted this escape and prevented the reported assault on a community member.

The Territory's failure to comply with this provision was also apparent during an incident that occurred two weeks later. On June 7, 2014 as many as five inmates exited building 9 and gained access to the rear perimeter fencing. Fortunately, a VIPD patrol unit was near this location, and upon observing the VIPD patrol, the inmates ran back into the building. Although VIPD was conducting a patrol, GGACF staff were not, as required by this provision. This case likely demonstrates inadequate housing unit and officer monitoring by supervisors, as it is suspected that the on-duty housing unit officer, either by act or omission, allowed these inmates the ability to exit the building.

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

identified in earlier reports and remain uncorrected: 1) the continued presence of dangerous contraband, 2) the continued covering of cell-door windows with various items, 3) the drying of clothing on lines tied to sprinkler heads and other anchors in their cells, 4) fires being started in inmates' cells, 5) inmates' continued failure to wear official ID cards, or covering the ID cards with clothing, 6) inmates wearing non-issued inmate apparel, 7) supervisors not adequately inspecting housing unit logs and taking steps to remedy problems identified therein.

To summarize, supervision of inmates and staff is inconsistent and inadequate, while \security inspections of housing units and the campus by both correctional officers and supervisory staff seem non-existent or very negligent at best.

It is, however, notable that the new Warden took the initiative to arrange for additional VIPD perimeter patrols, which contributed to thwarting an otherwise potentially successful escape attempt.

Recommendations provided in previous reports remain appropriate.

RECOMMENDATIONS:

1. Refer to recommendations regarding Post Orders.
2. Revise and/or develop policies and procedures to ensure consistent and reliable monitoring of housing units and cell blocks as stated above. For example, develop policies and procedures for inmate supervision that require regular but randomized checks of all cells in each housing unit, and regular rounds of all other areas of the facility, including the perimeter fences.
3. Ensure housing units and cell blocks are consistently staffed at levels required to ensure staff and inmate safety and security, and according to inmate risks and needs.
4. Create a schedule for regular rounds by medical and mental health care staff for each shift to ensure that special needs inmates (suicidal, mentally ill, medical infirm, vulnerable, etc.) are monitored more frequently and by qualified health care staff.
5. Create a schedule for supervisory rounds, by shift, to ensure that supervisors routinely inspect general and special housing units to ensure compliance staffing requirements, policy and procedures, and to interview inmates presenting problem conditions. Supervisors should also ensure that all safety and security equipment is present and functional during these inspections and immediately replace any nonfunctional equipment.
6. Repair all broken lights in housing units and cells, issue flashlights to staff for cell inspections, keep all housing unit doors locked, repair broken control panels to improve unit security.

B. Contraband

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

a. Clear definitions of what items constitute contraband;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The Territory submitted to the Monitor and USDOJ draft contraband policies and procedures on May 27 and June 10, 2014. These draft policies include definitions of what constitutes contraband at GGACF and a process for collecting and disposing of confiscated contraband. This document was thoroughly reviewed by the Monitor and USDOJ; neither reviewer approved the document and both provided detailed comments and recommendations for revising the policy. This Monitor, subsequent to a review of this policy document and a cursory review of several other non-related policy documents provided by the Territory, rejected all submitted policies wholesale. The policy documents submitted by the Territory contained numerous writing errors, inconsistent formatting, omitted important content, and various other basic policy and procedure document elements. This Monitor believes that draft documents should only be submitted for review that contain all basic elements and are well written. Otherwise, the Monitor cannot efficiently manage the approved monitoring budget efficiently if time is spent correcting basic document deficiencies. This Monitor provided the Territory written and verbal recommendations to the Territory regarding this issue.

Notwithstanding technical problems with policy and procedure drafts, observations during this assessment evidence that staff remain unclear about the definition of contraband. As previously stated, for example, inmates continue to block cell door windows with various objects that remain in the inmates' possession, which illustrates the importance for definition clarity with regard to consistent security management. Although this Monitor did find a significant decrease in blocked cell door windows, the Territory must take steps to completely eliminate any tolerance of this inmate behavior and ensure that all cell door windows remain unobstructed at all times. This provision is at partial compliance because of the draft document; to move to full compliance, the Territory will need to finalize the policies regarding contraband, get Monitor and USDOJ approval, and fully implement the policies. The effect of those policies will then be evaluated while on-site to assure that the policy has remedied the problems described above.

RECOMMENDATIONS:

1. Issue a post order or memo that clearly defines what constitutes contraband and require supervisors to daily ensure compliance by staff.
2. Prepare for the September onsite TA with the Monitor, during which time the contraband policies will be revised.

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

ASSESSMENT: NONCOMPLIANCE No substantive improvement from previous assessment.

FINDINGS: Notwithstanding the draft contraband policies referred to above, a revised, comprehensive contraband policy draft has not yet been submitted to this Monitor or the USDOJ for review and comment and the facility remains porous to contraband to include very dangerous items.

However, the monitoring team and their belongings were searched each day of this assessment upon entry into the facility, but not when we departed. This Monitor also witnessed on several occasions other staff and civilians being searched before entering the administration area. There was some inconsistency on the procedures used to search visitors entering the facility. For example, certain correctional officers assigned to the entrance post required visitors to lift up their pant legs and show their ankles. Other officers did not follow this practice. The thoroughness of the bag searches was also inconsistent amongst officers. This suggests that there is no policy or directive governing how inspections/searches of visitors should be conducted. No vehicle inspections were observed.

This Monitor did not assess other contraband control practices involving mail or package inspections during this assessment and will address this Provision during the 5th onsite assessment.

Although GGACF records indicate significant reduction in the presence of dangerous contraband within the facility since the previous two assessments, it is unknown whether this decrease results from fewer searches, or less contraband, or extra effort by the Territory to control contraband. Increases in items confiscate does suggest better attention to this problem by the Territory. This Monitor was provided documents from the Territory demonstrating additional efforts to control contraband via large-scare shakedowns. The Evidence Collection Log (since the 3rd assessment) also records continued noncompliance with this Provision and ongoing real and present safety and security dangers to which staff and inmates are exposed daily. An examination of this record shows 56 entries involving collection of the following dangerous items:

- 15 Weapons (knives, shanks, razors, blunt objects)
- 12 Cell phones
- 16 Drugs (marijuana)
- Other tools

GGACF Dangerous Contraband Collection			
Contraband	**Nov 2012 - June 2013**	**July 2013 - Feb 2014**	**March - May 2014**
Cell Phones	74	52	12
Weapons	42	130	15
Intoxicants/ Drugs	58	27	16
Total	174	209	43

RECOMMENDATIONS:

1. Continue positive efforts in searching people before entering the facility.
2. Develop a policy and procedure and/or directive governing how these searches should be conducted (see below).
3. A "stop and check" protocol for inspecting staff packages after initial entry into the facility must be developed and implemented.
4. Provide handheld metal detectors for contraband inspections at facility entry points and as needed for on-campus inspection.
5. Be prepared to thoroughly discuss current vehicle, mail, and package inspection methods and process during the 5th assessment.

Previous Recommendations Remain Appropriate:

1. Review, revise, develop, train, implement, evaluate contraband control policies that contain, at a minimum, the following elements:
   A. The purposes for contraband control;
   B. Safe methods and tactics for identification, seizure, recovery, and disposition;
   C. All locations where contraband can be hidden and disguised;
   D. Methods and points of delivery and access;
   E. Unannounced and irregularly time searches of cells, inmates, and inmate program; recreation and work areas;
   F. Keeping all cabinets and doors locked at all times to prevent access to contraband;
   G. Use of metal detection equipment;
   H. Use of other mechanical devices for detection and recovery;
   I. Respect of inmates' rights to authorized personal property;
   J. Clearly articulated differences in inmate property allowed according to gender, religion, health conditions, conviction status, etc.

2. Review, revise, develop, implement, train, and evaluate training policies, procedures, methods, and demonstration of staff proficiency in the prevention, detection, recognition, recovery, and disposition of contraband.

3. Ensure that all posts and high-risk contraband access points are properly secured at all times, adequately staffed, equipped with reliable video surveillance devices, and consistently enforce contraband rules and laws involving inmate, staff, contractors, volunteers, the public, etc.

4. Develop a uniformed incident tracking/reporting system using standardized contraband titles and locations; implement a continuous quality improvement program to ensure the accuracy and completeness of incident reports.

5. The Monitor renews the previous request for electronic submission of evidence logs each month for review and analysis purposes, and to provide technical assistance as indicated.

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

(i) supervision of prisoners in common areas, the kitchen, shops, laundry, clinic, and other areas of Golden Grove to which prisoners may have access;

(ii) pat-down, metal detector, and other appropriate searches of prisoners coming from areas where they may have had access to contraband, such as at intake, returning from visitation or returning from the kitchen, shops, laundry, or clinic;

(iii) regular and random searches of physical areas in which contraband may be hidden or placed, such as cells and common areas where prisoners have access (e.g., clinic, kitchen, dayrooms, storage areas, showers);

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Refer to 1B above. Previous findings

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

RECOMMENDATIONS: Previous Recommendations Remain Appropriate:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Refer to above findings.

RECOMMENDATIONS:

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

Previous Recommendations Remain Appropriate:

1. Review, revise, develop, train, and implement, evaluate policies and procedures involving confiscation and preservation of contraband as evidence for administrative and legal enforcement purposes.

2. Ensure staff access to appropriate equipment and supplies needed to safely collect and preserve contraband while maintaining evidentiary integrity.
3. Ensure adequacy of chain-of-custody methods and procedures.
4. Review, revise, develop, implement, train, and evaluate training policies, procedures, methods, and demonstration of staff proficiency in the proper collection/confiscation and disposition of contraband.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Security staff posted at the main entrance conducted a reasonable, but inconsistent search of the Monitoring team and other visitors during this visit (see above, B.1.b) The Monitoring team was appropriately escorted throughout the campus, but did not witness escorts of visitors. However, USDOJ representatives reported moving about the campus unescorted. At one point, a USDOJ representative walked from the administrative building to the medical unit, through an open gate that should have remained locked. There were no supervisors or other staff patrolling the grounds at that time and no escort was made available upon request.

RECOMMENDATIONS:

1. Similar to above specific to admissions policies and procedures, internal and external escorts for facility visitors.
2. Ensure timely and consistent escorts for the monitoring team and USDOJ officials during all onsite visits.
3. Continue to maintain adequate supplies of visitor identification cards and ensure that all visitors conspicuously wear badges at all times while inside the security perimeter.

C. General Security

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As reported in all previous reports, inmates continue to wear and possess personal clothing items. This was observed on the yard and in the housing areas. There has been virtually no change. Additionally, during this visit the Monitor observed GGACF staff who were on-post, but not wearing the required GGACF uniforms. When one officer was asked why he was not wearing his uniform shirt, but instead was wearing a t-shirt, the officer replied that it was too hot on the unit to wear his GGACF-issued uniform.

Failure to comply with this Provision allowed the inmate who escaped on May 11, 2014 to go undetected in the community, until GGACF staff were notified of the escape. Because the

escapee wore personal clothing before and during the escape, he was able to blend in to the community for many hours prior to his apprehension.

RECOMMENDATIONS:

1. Require inmates to wear issued institutional clothing ONLY.
2. Take timely and appropriate corrective action with staff who fail to enforce inmate uniform policies and inmates who refuse to comply with those policies.
3. Ensure that all staff wear their required GGACF uniform at all times, and take timely and appropriate corrective action with staff who refuse to do so.

Previous Recommendations Remain Appropriate:

1. Review, revise, develop, implement, train, and evaluate policies and procedures requiring all inmates to wear standard-issue correctional uniforms.
2. Consider acquiring correctional apparel that provides obvious recognition of the inmates' classification/status.
3. Ensure there is a consistently sufficient supply of uniforms for regular laundry exchanges and changes in an inmate's classification and/or status.
4. Consider developing a correctional industry for making uniforms onsite.
5. Select/make uniforms specifically designed to reduce/eliminate places to hide contraband and weapons.
6. Mark all uniforms with highly visible letters/numbers.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As reported in the previous report, none of the inmates were observed to visibly wear correctional identification that was to be implemented. On March 21, 2014, the Warden issued a memorandum to staff providing written instructions regarding inmates wearing identification cards. However, staff did not enforce or otherwise follow the Warden's instructions. This lack of attention by staff to this requirement also reflects a lack of staff supervision and monitoring by supervisors. Importantly, a new inmate identification system is only effective if inmates are required to wear the identification badges and the system is properly enforced. Otherwise, any resources dedicated to developing and implementing this system are wasted.

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

RECOMMENDATIONS:

Recommendations from previous reports remain appropriate.

1. Ensure staff compliance with this provision.
2. Ensure appropriate policies and procedures are in place and made available to staff.

3. Ensure adequate supplies for making identification cards.
4. Regularly audit identification card inventory and maintain proper controls to prevent inappropriate acquisition of cards. Conduct regular "identification card counts" using methods similar to key control inventories.
5. Consistently enforce identification card policies and procedures.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The Territory submitted a draft document ("Supervision of Inmates and Detainees" Policy) intended to satisfy this provision on June 6, 2014. However, the document submitted was not fully responsive to this provision and was rejected for failing to include basic elements and formatting. On July 21, 2014, the Territory submitted lesson plan documents pertaining to locking and unlocking doors and gates. This Monitor provided the Territory written recommendations and feedback regarding this lesson plan. On August 22, 2014, the Territory submitted to this Monitor and USDOJ documents demonstrating that this training was conducted July 21 thru August 1, 2014. These documents included:

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

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

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

During this assessment, this monitor found all internal housing unit gates and officer stations to be locked upon entry. However, none of the exterior security slider-doors were locked. These doors – often referred to as the "sally port" doors – were left standing open or unlocked upon entry into the units; we were once again advised that the electronic locking mechanisms are inoperable. Although the various security gates throughout the facility were locked when the Monitoring team first approached, the gates were not locked behind the team when the

monitoring team toured the housing units. Moreover, on several occasions during the onsite inspection, the monitoring team/USDOJ representatives were able to simply open the outer perimeter gate upon arrival at GGACF, revealing that the gate did not always lock. These observations clearly support a security culture that lacks enforcement and consistency; it also demonstrates the need for additional training, monitoring, and supervision by GGACF leadership. GGACF staff must consistently practice good security habits by keeping security doors and gates closed and locked. Officers still report that inadequate staffing levels require them to not lock security gates upon entry into the housing units for safety reasons. Housing unit logs report that fire escape doors and locks are inoperable. There was improvement found in yard-gate security, but some of the locking mechanisms remain inoperable and prevent the gates from being locked. Most notably, the last gate from the yard to the administrative building (which provides access to the outside of the facility) was broken. The supervisor bubble that looks out at this gate is frequently unstaffed, meaning that inmates can enter or exit the administrative building area as they please.

Despite some progress to fixing locks, there are still delays and many non-functioning locks. Logbook entries continue to report key door/lock issues not being timely addressed. For example, the Detention R&D entrance door was observed by this Monitor nonfunctional requiring use of a metal pipe to secure it closed. The door must be operated manually, keys don't work, a metal pipe must be placed behind the outer sally port door to provide security to the area, etc. It appears that the lock work report does not mention this door.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Review, revise, develop, train, implement, evaluation policies and procedures related to facility security pertaining to locking and unlocking access points, units and cell doors, and other locations requiring consistent access controls.
2. Repair/replace all broken locks and keys.
3. Develop, revise, implement, audit lock/key inventory.
4. Regularly inspect keys, locks, and electronic locking systems to ensure reliable functionality, detection of tampering, and timely repair/replacement.
5. Ensure staff are adequately trained in the proper use of mechanical and/or electronic locking systems according to their post assignments.
6. Consistently sanction inmates for attempting to manipulate or manipulating any security locking system or device.
7. Secure access to keys and electronic locking control panels.
8. Keep security doors locked!
9. Replace or upgrading existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.

10. Improve video surveillance of internal by placing cameras in all housing units and inmate locations, and add additional cameras to monitor external access points to ensure rapid detection of attempts to disable or damage locking devices/systems.
11. Increase perimeter and internal lighting to improve detection of sabotage to locking devices and mechanisms.
12. Supervisor should inspect all locking systems during each shift and report for investigation and/or repair any signs of lock disrepair, malfunctioning, or manipulations.
13. Consistently enforce security locking policies and procedures with staff and inmates.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As stated in the 3rd Report, *"[This] Monitor met with the facility maintenance director and examined existing and revised locking mechanism repair logs. This interview and document examination revealed positive effort for ongoing lock repair and maintenance. Several housing cell locks have been repaired or replaced; it appears that cell pad locks have been replaced with standard security locks, and efforts are being made to repair or replace inoperable electronic locks located at housing unit entrances and yard gates. However, an "all-locks" maintenance plan has not been provided as previously requested.* ***Additionally, it is the Monitor's opinion, based on interviews with the maintenance director and facility conditions, that the maintenance program is inadequately staffed to provide the level of attention to facility upkeep needed to comply with this Agreement."***

During the 4th assessment, this monitor reviewed the Maintenance Log to find that the inspection program remains inadequately staffed to comply with this Provision. There are simply too many locking mechanisms for current maintenance staffing levels to timely inspect and maintain. Electronic entrance doors of many housing units and R&D remain inoperable and open. The lack of routine inspection of cell door locks by unit officers allows inmates to jam locks with contraband, rendering those locks subject to tampering; inmates reportedly can open their cell doors whether or not housing units are staffed by officers. Inmates can and have escaped and gained access and assaulted other inmates under these conditions.

Notable, this Monitor has requested an "all-locks" plan in each of the previous three reports, yet the Territory has not developed this plan. Without this plan, it is impossible for GGACF maintenance staff to know which locks need repair, when those repairs are scheduled to occur, and whether repairs were successful.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate:

1. Employ and maintain adequate maintenance staffing levels.
2. As requested in the previous two reports, develop an "all-locks" maintenance plan for review with the Monitor. The plan should include a complete inventory of all locks, locking mechanisms, date lock found non-functional, date repair/replacement was completed, and a list of all locks and locking systems taken offline. The plan should include, at a minimum, the following elements and should use an Excel spreadsheet: Where the lock is specifically

located – (Perimeter gate, housing unit 9A, cell #, emergency door, etc.), and lock number, lock type, condition, etc.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The HR/Training director did not participate in this assessment. The HR/Training director was available and present for only one previous on-site assessment, despite knowing the dates for these week-long visits at least two months in advance. This lack of participating in monitoring visits frustrates visit completeness. No additional documentation, including policy and procedure drafts, was provided to move this Provision to Partial Compliance. Third Assessment Findings are as follows:

"Documents provided to the Monitor and discussions with the HR/Training director during this assessment confirm that pre-employment background checks are conducted for all GGACF applications. A review of documents shows a requirement to self-report histories of arrests and convictions. However, personnel records for all GGACF staff were not provided for inspection and verification. Additionally, there remains no centralized tracking and periodic supervisory review process for early staff intervention purpose. These records are reportedly maintained off-campus and available for review by supervisors."

RECOMMENDATIONS:

1. This Monitor requests inspection personnel records including employment applications; criminal history checks, and background investigations for all housing unit staff working Units 9A/B during the reported escape attempt occurring June 7, 2014.

Previous Recommendations Remain Appropriate:

1. Review, revise, develop, train, implement, evaluate policies and procedures for the applicant and staff records process as indicated by the training assistant.
2. Ensure access to applicant and staff records is adequately controlled and protected, and that access to these records is based on a legitimate, work related "need to know" basis.
3. Ensure there is an adequate centralized information tracking system in place to support periodic supervisory review of staff records for professional development, counseling, and corrective action decision-making.
4. Make records available to the Monitor for inspection and verification of compliance.

D. Security Staffing

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The National Institute of Corrections completed and submitted the requested staffing analysis on July 21, 2014, following this site assessment. A cursory review of this report indicates that shift factors for all levels of security were determined based on industry standard methodologies.

This Monitor accepted and approved the study and believes that it provides clear and accurate guidance to Territory officials for developing and implementing required policies and procedures.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate:

1. Appropriate funding to hire sufficient numbers of staff to establish and maintain adequate levels of facility safety and security in accordance with staffing analysis results.
2. Shorten the time required to hire staff to no more than 90 days, not including basic correctional officer training.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since the previous report. Now that the Territory has a full staffing analysis, it must develop a security staffing plan to implement the recommendations in that analysis.

The Territory continues to struggle to hire additional correctional staff. As reported in the previous report, *"… [t]he Monitor met with the HR/Director and BOC Director regarding the Territory's hiring process. It was learned that it typically takes one year before a correctional officer applicant is hired and working in the facility. Six-months of this time is spent in the VI Police Academy mostly learning subjects not related to correctional practices or operations. Requiring correctional recruits to attend a full police academy is an unusual practice in the Monitor's experience as a law enforcement and corrections academy director, and significantly contributes to the current staffing problems. This time period can and should be significantly shortened due to facility safety and security needs combined with ongoing staff attrition."*

As of the time of this assessment, the Territory continues to require correctional cadets to complete the full police academy before working at GGACF. As discussed in the third assessment, this Monitor believes this practice unnecessarily prevents the Territory from meeting urgent GGACF staffing needs. This practice should stop immediately.

Additionally, as discussed at the April 28, 2014 status conference, 14 new correctional cadets began this academy in January of 2014. Only eight remained in the academy as of the June assessment; and only six reportedly remain in training as of the submission of this report. This means that during the six month academy, GGACF went from 14 potential new correctional officers down to 4 – an attrition rate of over 71%.

As noted throughout this report, examination of certain unit logs, incident reports, and the NIC staffing analysis continue to demonstrate the following:

- Inmate housing units are either not staffed or operate with only one staff for extended periods of time.
- There are periods of time where there are no supervisors on duty and/or available to provide supervision for staff.
- Staff are working excessive overtime hours as previously discussed.

In general, there appears to be no substantive improvement in staffing levels since previous assessments, and no significant effort to increase staffing levels quickly. GGACF continues to remain a dangerous environment for inmates, the staff, and community. The May 11, 2014 escape, the June 7, 2014 attempted escape, and the four serious assaults occurring over the last few months demonstrate the real and present dangers associated with housing units not being adequately staffed and monitored.

RECOMMENDATIONS: Previously provided recommendations remain appropriate

1. Update existing security staffing plans for review with the Monitor during the December site visit.
2. Identify current and anticipated security staffing deficiencies.
3. Complete the required staffing analysis and base this plan on that analysis.
4. Contact the VI Guard to provide temporary internal and perimeter security presence until staffing levels are adequate.
5. Use off-duty VIPD officers to cover unstaffed housing units.
6. Hire PRN nurses with trauma care experience until approved FTEs are onsite.
7. Reassign correctional leadership/supervisory/specialty staff across all shifts to ensure post coverage and consistent inmate monitoring and supervision.
8. Use enabling statues that allow for immediate procurement of security hardware and systems services.
9. Fast-track movement of prisoners off-island.
10. Request emergency funding from the Governor and/or legislator for rapid hiring of additional officers pursuant to the Staffing Study; remove ALL administrative and bureaucratic barriers that have and can impair rapid hiring of qualified candidates.
11. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS: Previous Recommendations Remain Appropriate:

Review, revise, develop, train, implement, evaluate policies and procedures related to facility staffing with particular focus on staffing levels, deployment, recruitment, selection, training, promotion, development, attrition, maintenance of staffing levels, etc.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS: Refer to previous recommendations.

E. Sexual Abuse of Prisoners.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: According to the Territory's May 16, 2014 Status Update Report to the court, "*The Bureau has begun educating staff and inmates on the policy with training materials from NIC [The National Institute of Corrections]. The PREA policy has been drafted and will be submitted to all parties"*. The Territory submitted a draft PREA policy to this Monitor and USDOJ on June 11, 2014. This policy generally meets PREA requirements but requires additional review and revision before it can be approved and fully implemented. Also, staff and inmate training plans or documents verifying completion of training have not been submitted to this Monitor or USDOJ as of yet. Presumably, since training documents must be tied to GGACF policy, these documents will be submitted once the PREA policy is approved.

The Territory has not reported completion of the pre-audit required by PREA but national inspections have begun. It is vital that BOC take steps to complete the required pre-audit as

soon as possible. PREA policy and procedure content compliance requirements are listed below:

Standards
§ 115.5 General definitions
§ 115.6 Definitions related to sexual abuse
Prevention Planning
§ 115.11 Zero tolerance of sexual abuse and sexual harassment; PREA coordinator
§ 115.12 Contracting with other entities for the confinement of inmates
§ 115.13 Supervision and monitoring
§ 115.14 Youthful inmates
§ 115.15 Limits to cross-gender viewing and searches
§ 115.16 Inmates with disabilities and inmates who are limited English proficient
§ 115.17 Hiring and promotion decisions
§ 115.18 Upgrades to facilities and technologies
Responsive Planning
§ 115.21 Evidence protocol and forensic medical examinations
§ 115.22 Policies to ensure referrals of allegations for investigations
Training and Education
§ 115.31 Employee training
§ 115.32 Volunteer and contractor training
§ 115.33 Inmate education
§ 115.34 Specialized training: Investigations
§ 115.35 Specialized training: Medical and mental health care
Screening for Risk of Sexual Victimization and Abusiveness
§ 115.41 Screening for risk of victimization and abusiveness
§ 115.42 Use of screening information
§ 115.43 Protective custody
Reporting
§ 115.51 Inmate reporting
§ 115.52 Exhaustion of administrative remedies
§ 115.53 Inmate access to outside confidential support services
§ 115.54 Third-party reporting
Official Response Following an Inmate Report
§ 115.61 Staff and agency reporting duties
§ 115.62 Agency protection duties
§ 115.63 Reporting to other confinement facilities
§ 115.64 Staff first responder duties
§ 115.65 Coordinated response
§ 115.66 Preservation of ability to protect inmates from contact with abusers
§ 115.67 Agency protection against retaliation
§ 115.68 Post-allegation protective custody
Investigations
§ 115.71 Criminal and administrative agency investigations
§ 115.72 Evidentiary standard for administrative investigations
§ 115.73 Reporting to inmates
Discipline
§ 115.76 Disciplinary sanctions for staff
§ 115.77 Corrective action for contractors and volunteers

§ 115.78 Disciplinary sanctions for inmates

Medical and Mental Care

§ 115.81 Medical and mental health screenings; history of sexual abuse
§ 115.82 Access to emergency medical and mental health services
§ 115.83 Ongoing medical and mental health care for sexual abuse victims and abusers

Data Collection and Review

§ 115.86 Sexual abuse incident reviews
§ 115.87 Data collection
§ 115.88 Data review for corrective action
§ 115.89 Data storage, publication, and destruction

Audits

§ 115.93 Audits of standards

Auditing and Corrective Action

§ 115.401 Frequency and scope of audits
§ 115.402 Auditor qualifications
§ 115.403 Audit contents and findings
§ 115.404 Audit corrective action plan
§ 115.405 Audit appeals

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

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

RECOMMENDATIONS: Previously provided recommendations remain appropriate.

1. GGACF should take advantage of the National PREA Resource Center at http://www.prearesourcecenter.org/, and the National Institute of Corrections at http://nicic.gov/ for qualified information about PREA compliance, training, and other related resources.
2. Review PREA and develop an action plan for the implementation of PREA requirements.
3. Appoint a PREA Compliance Coordinator as soon as possible.

4. BOC officials are encouraged to send at least one qualified staff person to USDOJ's PREA auditor certification training. All costs are covered by USDOJ.
5. Complete the PREA Self-Audit.
6. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:

Policy Organization Definitions Inmate Reporting Staff and Agency Reporting Protection from Retaliation Hiring and Staffing Viewing and Searches	Staff, Volunteer, and Contractor Training Inmate Education Inmate Intake and Classification Agency and Staff Response to Inmate Reports Investigations Staff and Inmate Discipline Medical and Mental Health Care Monitoring

F. Classification and Housing of Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: There has been no change since the previous reports. Policies and procedures need to be revised according to the outcomes of a classification instrument validation study that should be performed very soon. Although the current classification system does include many of the decision components required in this Provision, classification staff interviewed were generally confused about how to accurately use the classification tools and procedures. Moreover, much of the current classification system seems to be based on the inmate's offense of conviction or charged offense, and does not account for other risk factors in accordance with best practices. Compliance with this Provision requires a high level of technical expertise and qualification; it is likely that GGACF officials will require outside technical assistance to comply with this Provision and are encouraged to contact the USDOJ / NIC for this assistance.

Notwithstanding the above assessment and findings, Territory officials submitted to this Monitor and USDOJ on June 6, 2014, a draft classification policy. This document contains many of the necessary policy elements but is not based on an updated and valid classification instrument and related classification process. The policy was therefore rejected. The Territory is commended for its efforts in developing this draft policy, but it must seriously engage in a

process designed to develop and implement a validated classification system. The policy needs to be revised according to the classification study, once it has been completed.

RECOMMENDATIONS: Recommendations previously provided remain appropriate.

1. Complete an empirical validation of the current classification instrument(s).
2. Review, revise, develop, train, implement, and evaluate policies and procedures that provide more accurate and complete guidance for a valid and reliable classification system for non-convicted and convicted inmate populations.
3. Consider requesting assistance from the National Institute of Corrections for assistance in this process and the development of an objective classification system.
4. Contact USDOJ / NIC for Objective Classification Technical Assistance.
5. Ensure classification staff are well-trained in classification protocols and routinely monitor classification documents for accuracy.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As found in the previous reports, detainees and convicted offenders are generally held in separate buildings, except for sentenced and un-sentenced female inmates who are in separate wings of the same building. Inmates are generally housed according to their security level based on their offense of conviction or their charged offense and whether their background includes violent criminal acts. Inmates are also housed according to administrative, disciplinary, special needs, and/or work assignments. This is a very basic but dangerously unreliable practice for managing inmates and is not based on a reliable classification system. Such a practice is known to facilitate violence against inmates and staff, the introduction of contraband, and can create substantial barriers to inmate health and wellbeing. For example, some inmates with serious mental illness (SMI) are being housed in segregation/lockdown unit for unknown reasons and without justification. Many of these inmates are placed on lockdown units because of their mental health problems; GGACF's lack of an effective and valid classification system prevents GGACF staff from identifying other more appropriate and less punitive housing placements. Indiscriminately housing prisoners on 23 hour-a-day lock down units can exacerbate inmate behavior management problems, their mental illness, and is specifically prohibited by the Order per Provision V.1.p:

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

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

RECOMMENDATIONS: Previous recommendations remain appropriate:

1. Inmates should be housed and separated according to reliable classification process as previously discussed.
2. Pending completion of a reliable classification process, GGACF officials should use the Incident Log Report and other reliable information sources to target population cohorts for housing and separation that is more consistent with behavioral risks and needs.
3. Comply with the Order's prohibition against housing seriously mentally ill inmates in an isolation cell or housing unit. Direct mental health staff to conduct a serious, comprehensive assessment of all prisoners on both the detention and sentenced-side lock down units to determine mental health needs and if a different, less punitive housing placement is available.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

Additionally, a lack of housing unit security cameras and monitoring capabilities provides no ability to monitor inmates effectively to detect and potentially prevent them from obtaining unauthorized access to each other. Furthermore, until all locking systems are repaired and maintained consistently, as described above, inmates will be able to disable cell locks and access each other with both social and dangerous intentions.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: This provision reverts to noncompliance due to there being no action taken to improve grievance and incident report tracking, as described in the previous report. Additionally, a review of classification records and interviews with classification staff clearly

demonstrate serious flaws in the re-classification process. For example, a review of one initial and re-classification record showed that the inmate was correctly classified as maximum security upon initial entry into the facility. Later, the inmate was re-classified as minimum risk, but placed in a medium security housing unit. The inmate then escaped from that housing unit.

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

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

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

Additionally, an examination of Grievance and Discipline Logs continues to show they are incomplete and inconsistent. The Grievance Log is missing several important entries indicating that some important grievances go unanswered. The Discipline Log and disciplinary documents provided evidence that many disciplinary cases are dismissed because timely due process was not provided to the inmate. The table below reflects inmate disciplinary cases dismissed during the months of March, April, and May 2014:

March: 6
April: 7
May: 25

Hearing and Disciplinary Committee Monthly Report(s) for April and May both state, "*The numbers of Due Process Violation submittals have decreased tremendously*", but reported due process violations increased in April and May.

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

RECOMMENDATIONS:

1. Refer to previous classification findings and recommendations.
2. Refer to recommendations related to grievance and disciplinary policies and procedures.
3. Ensure accuracy of monthly disciplinary committee reports.
4. The Territory must correct problems reported in the monthly disciplinary.
5. Train classification staff to accurately and consistently complete initial and re-classifications accordingly.

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

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

FINDINGS: As stated in the 3rd report:

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

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

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

RECOMMENDATIONS: Previous recommendations remain appropriate:

1. Develop policies and procedures for the accurate and complete use of the Incident Tracking System.
2. Develop and implement a continuous quality assurance policy and program to ensure that incident reports and logs are consistently accurate and complete.
3. Revise incident report forms to include all essential elements to track incident data in a systematic and unified manner.
4. Establish an incident tracking database to produce and regularly review valid and reliable incident information and data.
5. Revise use of the incident reporting system as discussed above
6. Assign additional staff to GIST as described above.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As reported previously, there remains no formal mechanism or process for regularly reviewing status and conditions of inmates housed in segregation. Additionally, the Monitor was provided no evidence that GGACF tracks and monitors inmate lengths of stay in

segregation or why inmates are segregated. When viewed in combination with the flawed disciplinary process, outdated classification system, and the incomplete grievance tracking process, it is clear that segregated inmates are not provided adequate levels of due process, monitoring, and review. This practice is very serious and remains in direct violation of the Agreement. It is also clear that mental health staff are not involved in the decision to place a prisoner in a segregation unit, nor do they conduct evaluations or otherwise monitor the mental health of prisoners on these units. This is discussed further below.

Additionally, the frequent practice of "modified" or "full" lockdown due to staffing shortages remains very troubling. This practice, though apparently necessary for security purposes, effectively creates facility-wide segregation/lockdown conditions for days at a time. This must be corrected.

RECOMMENDATIONS:

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

G. Incidents and Referrals

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: These policies have not been submitted as required.

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

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

RECOMMENDATIONS:

1. Complete and submit policies as indicated.
2. Integrate the Incident Tracking system into this policy.
3. Develop protocols for current tracking system to improve data validity and reliability; this document is replete with duplication and misleading entries.
4. Develop a unified incident coding system for valid and reliable information and data collection, reporting, and analysis.
5. Establish regular monthly quality assurance meeting process involving all major department team leaders to review serious incident reports and recommend evidence-based remedial measures for eliminating/mitigating incident frequency and severity.
6. Train staff in applying adopted policies and use of forms, implement a continuous quality assurance protocol.
7. Require supervisors to carefully review all incident reports for completeness, accuracy, and consistency.

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

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

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

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

RECOMMENDATIONS:

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

1. Refer to previous recommendations regarding incident reporting and tracking.
2. Consider implementation of an electronic jail management system for centralization of incident reporting and data analysis.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Such a policy has not been provided.

RECOMMENDATIONS:

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

H. Use of Force by Staff on Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The Territory provided to this Monitor and USDOJ a use of force policy draft for review and comment on June 6, 2014. Although these documents reflect good effort by the Territory to comply with this provision, these documents require considerable revision before being implemented. USDOJ provided detailed comments on how to revise this policy to ensure it meets the requirements of the Agreement. The Monitor will work with the Territory to revise this policy during the September technical assistance visit.

RECOMMENDATIONS:

1. Review, revise, develop, train, evaluate use of force policies as indicated and include, at a minimum, the following policy elements:
   A. Mission and purpose statement;
   B. Legal authority for use of force;
   C. Definitions: use of force, conditions, applications, non-physical and physical force; authorized weapons, deadly force, necessary and unnecessary force, etc.;
   D. Pre-service staff proficiency training, qualifications, certification, and regular in-service training;
   E. Use of deadly force;
   F. Use of any weapon authorized for use;
   G. Reporting requirements;
   H. Force event quality control and assurance program and methods;
   I. Self-defense;
   J. Impermissible force;
   K. Staff noncompliance corrective measures;
   L. Medical/mental health involvement in use of force events;
   M. Force against special populations, e.g., mentally ill, frail, medically ill, aged;
   N. Planned and unplanned force;
   O. Special force operations and equipment;
   P. Officer safety and protection;
   Q. Emergency first aid;
   R. Administrative reviews;
   S. Use of restraints;
   T. Centralized incident, training, and qualification record keeping;
   U. Armory operations and instructor training and certification;

V. Photographing, videotaping, recording of planned force events;
W. Other.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since previous reports. See above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: See above findings.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since previous reports. Per the 3rd report, "Documents were provided that show the names of several officers who participated in weapons qualifications. However, these documents do not clarify whether all officers currently authorized to carry weapons are trained in accordance with the Agreement. The term "weapon" should include any device issued to staff in the use of force against an inmate. This includes, but is not limited to: firearms, batons, impact weapons, chemical weapons, etc."

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. Refer to Training Provision recommendations and apply to this requirement.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since previous reports.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. Develop a use of force tracking log that includes elements to verify that reports are submitted complete and timely.

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft use of force policy included a provision that requires videotaping by the shift supervisor of all "planned" use of force events. However, the draft should define the term "planned event". Additionally, the policy should specify who is responsible for video equipment upkeep and reliability, and how videotapes are handled and managed for incident review and investigative purposes.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft use of force policy contained specific (but not comprehensive) provisions for medical evaluation and treatment of inmates following a use of force event, but does not include a requirement for photographic documentation of injuries.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. Revise the draft use of force policy to include all content requirements in this provision.

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

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

FINDINGS: A review of incident reports demonstrates several examples of noncompliance with this provision to include the following:

On March 11, 2014, an incident occurred involving confiscation of a cell phone during a random cell search. This confiscation included use of force (GGACF-03-0397-14-IR / GGACF-03-0394-14-IR). However, officer reports conflicted regarding when force was used. One report states that force was used immediately upon entering the cell to confiscate the contraband; another report stated that force was used after the inmate failed to follow verbal orders from an officer. The incident review does not resolve these conflicting reports to determine whether force was appropriately used.

On April 11, 2014, an incident occurred involving an altercation among several inmates (GGACF-04-0082-14-IR). The incident report indicated that correctional officers used force to

quell the altercation. This use of force was reported in the incident report, but no use of force report was completed nor was there documentation indicating whether this use of force was reviewed and/or investigated.

Although several other reports reveal problems with reporting accuracies, these events demonstrate the need for consistent utilization of a use of force tracking log and supervisory monitoring of incident reports to ensure compliance with use of force reporting requirements.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. Ensure that supervisor/administrative reviews of incidents involving use of force resolve problems related to reporting accuracy, completeness, and consistency.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft use of force policy provided to this Monitor and USDOJ for review and comment includes some, but not all, of the elements required in this provision. The policy should 1) specify circumstances and guidelines for referring use of force events for criminal investigation, 2) include language for resolving report inconsistencies, and 3) describe how prison complaints are resolved. This Monitor will work with the Territory to add these elements to the policy during the September technical assistance meeting.

RECOMMENDATIONS:

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

l. Administrative investigation of uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Territory has produced no documents or other information demonstrating compliance with this provision. This Monitor review a draft use of force policy for technical assistance purposes while conducting the SEA assessment. This draft policy was basically well written by lacked specific and complete provisions for administrative investigations of use of force events. This Monitor will be onsite September 8-12 to assist Territory officials to complete this policy.

The Territory provide this Monitor and USDOJ supervisor review documentation for a small number force events. The review document entitled, "Incident Commander's Review/Critique [of] Use of Force Incidents", is intended to provide supervisory staff a structured review process "…as

a means to ensure that the Use of Force Policy and its related procedures/training were adhered to," according to the printed form.

The form directs supervisors completing it to include explanations for any areas "checked no" unless otherwise specified.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft use of force policy does not include language requiring a central tracking system, as required by this provision. This system must be developed and implemented. Deficiencies previously reported in the inmate complaint/ grievance and disciplinary system must be corrected prior to implementing this system, so that the system is comprehensive and accurate.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. Correct deficiencies in the inmate complaint/grievance and disciplinary system

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft use of force policy includes a provision for supervisor review of use of force incidents to determine whether and what corrective action is required. This section of the draft policy should be revised to include:

1. Review the reports/investigation for sufficiency and completeness of the documentation surrounding the event;
2. Training needs as related not only to decision making by staff involved in the incident, but also training needs related to compliance with policy and skill applied when using force.

Moreover, supervisors should be reviewing incident reports to determine whether a corresponding use of force report was required, and if required, adequately completed. There are too many incident reports which describe uses of force, but no use of force report is ever provided for review. These two systems must work in tandem with one another to ensure supervisors are reviewing the actions of officers and taking appropriate steps to correct inappropriate behavior.

RECOMMENDATIONS:

1. Include this requirement in policy, procedures, and training as discussed in recommendations H.a. (1A-W) above.
2. Revise the draft policy to specifically state the review elements listed in this provision.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Training records were again not provided to the Monitor for review during this visit, and the training director was not available during this assessment to discuss this topic. The draft use of force policy should specify conditions in which staff re-training and sanctions for policy violations will occur.

RECOMMENDATIONS:

1. Revise draft use of force policy to include retraining and staff sanctioning content described above.
2. Produce staff training records for review by this Monitor during the next onsite visit.

I. Use of Physical Restraints on Prisoners

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

a. Permissible and unauthorized types of use of restraints;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Draft policies and procedures on the use of physical restraints were submitted to this Monitor and USDOJ by the Territory on June 6, 2014. USDOJ provided detailed comments on this policy. The draft policy was unclear with regard to permissible and unauthorized types of use of restraints. The draft should be revised to clearly state and described permissible and unauthorized types of use of restraints. Additionally, it is acceptable and beneficial for training purposes to include use of restraints policies and procedures within a comprehensive use of force policy document.

RECOMMENDATIONS:

1. Revise the draft policy to clearly state and describe permissible and unauthorized types of use of restraints.
2. Consider including use of restraints policies and procedures in a comprehensive use of force policy.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As stated above, the draft policy does not clearly articulate circumstances under which the various types of restraints can be used. For example, the draft policy prohibits staff from using physical restraints until verbal orders have repeatedly failed. There are, however, exigent circumstances when restraint is required immediately to protect staff and/or inmates from imminent risk of serious physical harm. Such circumstances should be clearly stated and staff properly trained in the use of restraints under those circumstances.

The draft policy also fails to clearly articulate circumstances where certain types of restraints might be inappropriate, such the use of chemical restraints on inmates with known medical conditions. The lack of a clear policy in this regard has led to the inappropriate use of force and harm to prisoners. For example, on March 13, 2014, an officer used chemical restraint on an inmate known to have a seizure disorder (GGACF-03-0401-14-IR). In this incident, the inmate apparently became upset with officers for using force against another inmate and this inmate became verbally resistant toward officers. This inmate reportedly "lunged" at an officer and the officer deployed pepper spray at this inmate; the inmate immediately had a seizure. Additionally, other inmates and officers were affected by the pepper spray and had to be decontaminated.

Use of restraint policies and related training should clearly specify circumstances and conditions under which such force can and cannot be safely deployed.

RECOMMENDATIONS:

1. Revise draft policies and procedures to clearly articulate all circumstances under which various types of restraints are authorized for use.
2. Staff must be trained in the use of restraint options with regard to inmate medical conditions, environmental conditions, and controlled use of restraint deployment.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Duration of the use of permitted forms of restraints is included in the draft policy discussed above, but revision is required to ensure clarity. The policy draft should also clearly describe the basis for the length of time different restraints are used. For example, one part of the policy states that restraints should not exceed four (4) hours without a face-to-face evaluation by a physician. The policy should specify that the 4-hour limit pertains to "mechanical" restraints. Another part of the policy authorizes continued restraint use not to exceed 30 consecutive days unless approved by the Director. This section of the policy must specifically state what type of restraints can be used for 30 days and for what purposes, especially given the other limitation just described. Although it may be reasonable to require

additional security restraints during the movement of an inmate for security purposes, keeping an inmate physically restrained for 30 days is never acceptable and places the inmate at severe risk of medical and psych-emotional harm.

Overall, the policy must be revised to reflect that total duration of mechanical restraint should not exceed 12 hours without clear justification, approval by the Director, and only after all least restrictive alternatives are considered and verified as ineffective by a multi-disciplinary team consisting of appropriate corrections and health services personnel. Additionally, the 30-day duration period should specifically articulate conditions under which this duration period is used, intended purpose(s), and types of restraints authorized.

The policy should also include clear guidance for limiting the frequency and duration in the use of chemical restrains (e.g., pepper spray).

RECOMMENDATIONS:

1. Revise policy draft as discussed above.
2. Ensure all staff authorized to use restraints are properly trained, supervised, and monitored in the use of such force.

d. Required observation of prisoners placed in restraints;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft policy previously discussed includes required observation of prisoners placed in restraints. However, the policy requires significant revision before it will be approved.

For example, one part of the policy requires that prisoners placed in mechanical restraints are monitored every 15 minutes by health and security staff while restrained. However, another section seems to contradict this requirement, stating that prisoners are monitored by health care staff every 30 minutes for signs of health problems and injury. This assessment must be documented by medical staff during their 15-minute monitoring. Inconsistencies such as this must be corrected in the draft document before it will be approved.

RECOMMENDATIONS:

1. Revise policy draft as discussed above.
2. Ensure appropriate and consistent documentation and supervisor oversight of observation requirements.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft policy discussed does not include any provisions for using restraints on mentally ill prisoners or inmates suspected of suffering from mental illness. This must be addressed when the policy is revised during the technical assistance visit in September.

RECOMMENDATIONS:

1. Revise the draft policy to specifically address restraint use on mentally ill prisoners and prisoners suspected of mental illness.
2. The policy should include collaborative decision making requirements in the use of restraints involving security, medical, and mental health supervisory staff.
3. Require periodic, routine, structured and documented mental health status assessments by qualified medical / mental health staff for the duration the inmate is under restraint.
4. Include immediate and safe restraint alternatives when a qualified medical / mental health staff person determines such alternatives are required to prevent psycho-emotional harm of the prisoner.

f. Required termination of the use of restraints.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The draft policy previously discussed above includes a general requirement for terminating the use of restraints when the restrained inmate becomes cooperative/compliant. The policy should be revised to include requirements for terminating restraint use when not doing so subjects the inmate to serious physical and/or psycho-emotional injury and/or harm. Additional, the policy must contain elements mandating involvement of medical and mental health staff with regard to restraint termination decision-making.

RECOMMENDATIONS:

1. Revise policy draft to include requirements to terminate use of restraints when it is determined that not doing so will subjects the inmate to serious physical and/or psycho-emotional injury and/or harm.
2. Involve the collaborative decision making process previously discussed in making this determination and to determine less potentially harmful/injurious restraint alternatives.

J. Prisoner Complaints

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The Territory submitted to this Monitor and USDOJ a draft complaint and appeal process policy on June 9, 2014. The draft requires considerable revision to comply with this provision. This Monitor will provide the Territory specific recommendations once the draft policy is re-submitted to include all basic policy elements. In addition to (or perhaps because of) the deficiencies in the draft policy, the existing inmate complaint/grievance remains woefully deficient.

An examination of inmate complaints/grievances found numerous very troubling deficiencies. There were approximately 122 complaints/grievances written by inmates that were recorded in the GGACF Grievance Log for January – June 16, 2014. The complaints received fall into the following categories:

INM GRIEVANCES	COUNT
MEDICAL	11
MENTAL HEALTH	1
MEDICATION	5
ATTY ACCESS	7
WRDN ACCESS	16
FOOD / DIET	15
GT / RELEASE	0
RELIGION	1
PRS PROPERTY	7
WORK PMT	2
STAFF CONDUCT	3
HOUSING	5
GENERAL PRIVILEGES	7
PERSONAL HYGIENE PROC	0
SANITATION	15
RACIAL	0
DENIED HEARING	4
CHARGES	2
DISPUTES	12
INM PROBS	9
DEST GOV PROPERTY	0
APPROX TTL:	122

The log fails to: consistently record complaint types and descriptions; include the date the complaint was received; assign a complaint identification number; note the housing location from which the complaint was submitted; and note the date the complaint was sent to the chief for response. Although most complaints include the date the complaint was submitted to the chief, very few included the date when the complaining inmate received a response or a description of the response. It is exceptionally troubling that only one of the inmate health care complaints for this time period was provided a response by responsible GGACF officials, based

on log entries. Some of the most serious inmate complaints logged in the Grievance Log included issues involving medical and/or mental health concerns:

GRV#	Date Received	COMPLAINT DESCRIBED ON GGACF LOG (as written on log)	Date Sent to Chief	Date of Response	Response (as written)	Date Returned to Inmate
101069	01/10/14	Inmate is ready to come out of lock down. Said he is mentally competant. Taking meds daily	01/10/14	Not Logged	Not Logged	Not Logged
281287	01/10/14	Inmate requesting adequate medical treatment for bladder condition, catterat on both eyes, swelling of feet, stress & constipation	01/10/14	Not Logged	Not Logged	Not Logged
271131	01/10/14	Need immediate medical attention. Need to see an expert doctor specializing in traumatic brian injuries on the outside.	02/28/14	Not Logged	Not Logged	Not Logged
271131	02/20/14	No Dentist in Medical to do extractions. Inmate request to be allowed to see outside doctor to have it done.	02/20/14	Not Logged	Not Logged	Not Logged
281181	04/11/14	Inmate request medical treatment for ear problem	04/11/14	Not Logged	Not Logged	Not Logged
262051	04/29/14	Inmate said he got hurt in the yard by metal sticking out of the ground. He and Inmate []is best of friends. No conflict betweeen them.	04/29/14	Not Logged	Response 5.15.14: Chief [] stated that investigation is on going about the situatuion that took place on 1.10.14. Inmate would have a chance to voice his concern in court.	Not Logged
212076	05/15/14	Inmate had back & leg pain. Request to be taken to the hospital .	05/15/14	Not Logged	Not Logged	Not Logged
271131	05/15/14	Inmate need tooth extraction. Request adequate dental care.	05/15/14	Not Logged	Not Logged	Not Logged
271131	06/06/14	No Medical Provider	06/06/14	Not Logged	Not Logged	Not Logged
942081	06/13/14	Inmate has pain in leg, not getting enough food, no access to phone to call his athorney and no commisory.	06/13/14	Not Logged	Not Logged	Not Logged
201184	06/13/14	Inmate ha seisure in his cell & hit his	06/13/14	Not Logged	Not Logged	Not Logged
271131	06/16/14	No progress on Medical Condition since last Grievance	06/16/14	Not Logged	Not Logged	Not Logged

The grievance system is especially important given that there is inadequate medical and mental health care staff to conduct regular rounds on each housing unit. The grievance system may be one of the only ways for prisoners to get access to such staff. However, when the grievance system is not functioning properly and grievances are not tracked, logged, and timely responded to, prisoners will not get the help they need. This is evidenced in the log entries listed above. The GGACF prisoner complaint / grievance system does not provide a reliable mechanism for inmates to obtain legitimate relief and/or resolution for serious and important issues and concerns. The complaint system's records management is very problematic because of log

omissions, noted inconsistencies, and its unresponsiveness to inmate complaints. Furthermore, if the grievance log is an accurate reflection of the system's management, it would be virtually useless for proving exhaustion of administrative remedies required under PLRA.

RECOMMENDATIONS:

1. Revise draft complaint / appeals policy to comply with this provision.
2. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and correction action.
3. Ensure tracking log is consistently completed and accurate.
4. Develop from a valid and reliable tracking a quality management statistical report for monitoring inmate and facility needs and problems.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Same as above.
2. Include policy and provisions for timely investigations of complaints, prioritization of complaints related to risks of harm and safety, and medical and/or medical care.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: See above description of current complaint system deficiencies.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Complete required policies and procedures.
2. Include specific policy and procedural provisions requiring corrective action for staff noncompliance, and that ensures timely, consistent, and appropriate disciplinary action against staff who violate the policy.
3. Also consider Inmate Grievance Log issues described above in developing these policies and procedures.
4. Develop quality assurance process to ensure the completeness and accuracy of the Grievance Log documents and processes.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Develop and implement a formal and reliable centralized tracking system of inmate complaints and grievances that includes necessary complaint information and facts and complaint disposition.
2. Monitor the current tracking system to ensure timely, consistent, and complete administration.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: See above description of current complaint system deficiencies. The grievance log problems reported above were also described in previous compliance reports; yet, GGACF has done nothing to review or improve the grievance process. This demonstrates the absence of an effective management review process.

Deficiencies in the Inmate Grievance Log continue to demonstrate the absence of a systematic and reliable process for reviewing prisoner complaints, trends, or individual and systemic issue.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. See previous recommendations related to reporting and tracking complaints.
2. Conduct monthly administrative reviews of inmate complaint/grievance tracking reports and data to identify patterns of individual staff, inmate, and/or systemic problems and issues.

K. Administrative Investigations

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No policy or procedure revisions have been submitted to the Monitor for review and there have been no substantive changes since the previous assessment. Additionally, the Chief Investigator position is vacant due to the appointment of the previous Chief Investigator to GGACF Warden.

RECOMMENDATIONS:

1. Submit administrative investigation policies and procedures per this provision as indicated.
2. Ensure the policies and procedures clearly describe investigative timelines, officials responsible who are authorized to conduct interviews, methods and locations of interviews, and other relevant topics that maintain the integrity and legality of the investigative review process and determinations.
3. Fill the vacant investigator position.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No policy or procedure revisions have been submitted to the Monitor for review. Notably, despite the numerous high-level security incidents that occurred at GGACF in the last few months, only one investigative report was submitted to this Monitor for review. This report concerned the May 11, 2014 escape.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No substantive change since previous visit.

Additionally, and as previously discussed, even if an investigation determines that an inmate deserves some form of punishment for a disciplinary infraction, that punishment is often not determined or enforced because due process proceedings often do not occur. A review of prisoner disciplinary files from the last three months shows that some prisoners had disciplinary action taken against them, but the disciplinary charges were dismissed because there were not enough staff to conduct the due process hearings. Recommendations provided in the previous report remain appropriate. There were no administrative investigations initiated to look into staff misconduct, to the best of this Monitor's knowledge. These investigations must also be conducted, reviewed, and tracked.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No substantive change since the previous assessment. The Monitor has not received any information outlining when and how investigators will be trained. It is also unclear how many investigators are on staff and assigned to conduct investigations at GGACF. The only investigative report received during the last few months was completed by the Warden, not an investigator.
RECOMMENDATIONS: Fill the currently vacant Chief Investigator position.
Previous recommendations also remain appropriate:

1. Create a formal pre- or in-service training program to train staff who are involved in initial and/or administrative investigation.
2. Provide adequate training of investigative staff on topics in areas of incident scene investigation and appropriate administrative investigation methods, processes, techniques, legal and ethical issues, etc.
3. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.
4. Develop and implement, as an adjunct to these policies and procedures, an "Investigators Manual" that provides guidance to staff responsible for oversight and investigative activities.
5. Provide the Monitor qualification documents for the newly appointed Chief Investigator for review upon his/her appointment**.**

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No substantive change since previous assessment with regard to policy and procedure submissions. Regarding staff discipline, however, GGACF officials reported (but did not provide any documentation of) several instances of disciplining staff where their involvement in misconduct was determined. This Monitor requests full review of these instances during the upcoming site visit.

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

As previously stated, the monthly disciplinary hearing reports continue to report a high number of inmate disciplinary cases being dismissed as a result of due process violations. The coordinator continues to write in the March, April, and May monthly reports the following problems with regard to ensuring a timely, consistent, and reliable inmate disciplinary process:

"I am still having difficulty in forming a solid [inmate disciplinary] panel to conduct hearings. My dilemma is that all the officers that I have suggested/recommended to assist me to conduct these hearings are assigned to provide shift coverage/special assignments/re-assignments. This has resulted in my utilizing staff on an overtime basis."

"HDC are still receiving incident reports that are being submitted with supervisors signing off without proof reading the incident reports. As per last discussion with then Warden [], a report writing class is very much needed to assist and improve noticeable deficiencies among officers and supervisors alike".

"Security staff are still not utilizing the newly implemented incident report forms (Disciplinary Report & Incident Reports). Staff needs clarification and proper orientation on what is warranted for each report document for smooth transition. Those who are using the correct form are not inputting the codes that are being violated in the provided section or even a description of the incident. Responding or assisting officers are not submitting supplemental reports. A few reports are being tagged with a report number from central control."

[Regarding due process violations] "…I am still getting unaccounted reports after the fact and are not being properly documented, which is resulting in inaccurate numbers for reports/compilation".

These problems demonstrate an ongoing serious lack of quality control and staff and supervisor accountability that should be corrected without delay. The inmate discipline system is not only ineffective due to lack of adequate staffing, but lacks sufficient oversight and organization to deliver meaningful and consistent outcomes.

The following examples are demonstrative of the problems with inmate discipline at GGACF:

- 4/11/14: three inmates (AW, RB, JI) were charged with fighting and given 90 days in lock down. However, on 4/6/14 another inmate (CB) was also charged with fighting, plus additional charges for multiple other violations. Unlike AW, RB, and JI, CB was given only 60 days in lockdown with a good time loss of 12 days. It appears that a lesser penalty was issued for multiple violations.

- 4/6/14, 3/26/14, and 3/26/14: inmates RM, MR, and AS were each charged with disorderly conduct. RM received 15 days lockdown, MR received 44 days lockdown, and AS was given a verbal reprimand. Again, these penalties seem inconsistent considering these inmates were charged with the same violation.

- 3/27/14 and 4/15/14: inmates JI and AS were both charged with possession of an unauthorized sharpened instrument; AS was also charged with possession of contraband. Inmate JI (only charged with one violation) was given 120 days lockdown while inmate AS (charged with two violations) was given 50 days with a six day loss of good time. Again, these penalties seem inconsistent, and also suggest that staff are not clear about how to charge inmates with violations. If possession of an unauthorized sharpened weapon can be charged as two violations (possession of unauthorized weapon and possession of contraband), staff should be instructed to always charge an inmate with both of the violations or only one of the violations. Inconsistent charging practices cannot yield consistent meaningful outcomes and comport with due process.

The monthly disciplinary committee report also demonstrates ongoing reliability problems with the incident reporting system. The Incident Report Log for 3/5/14 to 6/6/14 is inconsistent with the Monthly Disciplinary Reports for March – May, 2014. Here just a couple of examples:

- The March incident log shows only one offender-on-offender assault occurring on 3/20/14, involving inmate JD. The disciplinary report also shows only one such assault, but reports that it occurred 3/1/14 and involved inmates KM and CF. (Note: the April disciplinary report does not show the 3/20/14 assault so it was not carried over to April for disposition).

- The April incident log shows three offender-on-offender assaults, occurring on 4/15, 4/16, and 4/28. These assaults involved inmates JD, LD, and PD respectively. The disciplinary report for April shows five such assaults (4/3, 4/10, 4/11, 4/23, 4/28, 4/29) involving inmates CP&RM, ED&EV, AW&RB&JI, ER&PD, AJ&FH, and FS&MJ respectively. The incident log reports two such assaults that were not reported on the disciplinary report. The discipline report shows four such assaults not reported on the incident log.

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

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

2. Integrate the information in the above into the administrative policies and procedures previously discussed.
3. Record and maintain onsite records of staff misconduct investigative reports and determinations.
4. Protect the integrity and confidentiality of these staff records, control access to records, provide a process for authorizing legitimate access and review of these records for general reporting purposes, monitoring, and supervision of staff.
5. Provide training to supervision staff in the appropriate use of this information for staff supervision, counseling, discipline, promotion, etc. purposes.
6. As with all training, especially training required for and that supports the monitoring of the Agreement, ensure complete training records are maintained onsite.

V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

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

MEDICAL FINDINGS: First, we reviewed with the Health Care Administrator and the new Medical Director the policy regarding intake screening as well as health assessment and tuberculosis screening. Based upon prior discussions, we worked on finalizing the intake screen form to be utilized by nursing staff as well as the health assessment form to be used by PAs or physicians. The new policy is designed to insure that, based on the intake screen, patients with positive screens would be seen for their health assessment by an advanced level clinician within one to three days. The intake screen policy includes an acuity scale which would describe to the nurses, based on the positive findings, the urgency with which the health assessment must be completed. More urgent problems must be assessed the same day or within 24 hours. The least urgent must be assessed within three days of entry. The only patients who would have their assessment in a longer timeframe would be based on a decision reviewed by a clinician that the patient needed to be monitored daily and the data for one week must be reviewed in order to determine the nature of the problem. As an example, a patient who had a history of hypertension and a normal blood pressure on intake, but who had been off medications for a month, would have his blood pressure repeated daily and then be assessed by the physician on day 7 to determine whether or not the patient needed to be enrolled in the hypertension program. Such a process is being utilized in other facilities and forces the intake process to utilize clinical data in making determinations with regard to assessments and their urgency. In fact, after revising the forms somewhat, both the intake screen and the health assessment form, we had each of the two registered nurses perform an intake screening, one on Dr. Burton and the other on Dr. Shansky. We then jointly had a discussion about how to interpret positive answers to questions in relationship to the utilization of the acuity scale. This exercise should be performed by the former Medical Director, , with the nurses on at least a weekly basis while the forms are being implemented. This way, questions can be resolved and the performance by the nurses will achieve the threshold level sought by the Medical Director. ***It is important to note that none of the new forms have been submitted to the Monitor or USDOJ per the Agreement and must be approved before full implementation.***

We also reviewed several records of patients who had entered the facility over the last few months, focusing on the intake process. Not surprisingly, we found major deficiencies. This was due to

shortages of nurses as well as shortages of advanced level clinicians. The problems we found included the absence of officer health questions which should be used to deflect unstable patients to a hospital for clearance, the absence of a nurse screen, the absence of a health assessment and also the incorrect performance of the health screen and lack of data in the record of TB skin test results. Finally, we found instances where the health screen was performed three days after the patient had arrived at the facility. Some examples follow.

Patient #1
A male in his twenties arrived at the facility on 4/11/14. In his record there was lack of an officer questionnaire, there was lack of a nurse screen and there was no health assessment. There was only a note by the doctor, which did include a physical exam but was deficient in that there was absolutely no subjective or historical data obtained from the patient.

Patient #2
A young man arrived at the facility on 4/10/14. His intake screen, performed by a nurse, had multiple blank spaces suggesting that the questions had not been asked. There was a record of a TB skin test having been planted but not read. There were vital signs performed. The patient was given an acuity number 3, but no health assessment was ever performed.

Patient #3
A 34-year-old inmate arrived on 4/19/14. In this record, there was an officer form but it was incompletely filled out. There was a nurse screen; however, it was performed three days after the patient arrived. This patient had an elevated blood pressure of 144/98. Much of the nurse screen was left blank. The acuity scale assigned was number 1, which should have necessitated a health assessment done on the same day or within 24 hours, and yet there was no history and physical. There was a note indicating a follow-up visit for the patient who had received a gunshot wound to the right thigh prior to entering the jail; however, this gunshot wound was not mentioned on the nurse screen.

Patient #4
A 43-year-old entered the facility in April 2014. There was a nurse screen done; however, there were many blank fields and no vitals were performed.

It is clear that the program needs to finalize its forms and the policy, and provide training to the nursing staff. However, that staff needs to be bolstered. There are at least two more vacant registered nurse positions and those need to be filled as soon as possible.

RECOMMENDATIONS:

1. Hire the additional two registered nurses.
2. Finalize with the Medical Director the intake policy and the forms, and once feedback is received from the monitor, begin training and implementation of the policy and the forms.
3. The Head Nurse should continue to review and provide feedback to the nurses with the assistance of the Medical Director, who should also review the timeliness and quality of the performance of the PA and physicians.
4. With regard to the after-hours ability to remove officers from any involvement in the medical screening process as opposed to the pre-book questions, develop a list of questions by the Medical Director geared to determine whether the patient can wait up to eight hours

in order to be screened. If those questions suggest instability, the nurse performing those screening questions over the telephone must contact the physician. If the questions reveal no instability, the patient can wait until screening can be performed in the morning at 8:00 a.m.

5. Hire the additional nursing staff so that both the intake screens and the nonemergency health care request policies can be consistently implemented without any disruptions due to vacations.
6. Complete the policies that address both scheduled and unscheduled offsite services so that follow up after the service has been provided is improved.
7. Make the changes on the chronic disease service policy in order for implementation to begin. It is especially important for the clinicians to utilize both the initial chronic care visit form and subsequently the follow-up chronic care form.
8. The following policies can begin to be drafted or modified:

    a. Hospital and specialty care
    b. Urgent/emergent services
    c. Access to care
    d. Responsible health authority
    e. Medical autonomy
    f. Segregated inmates
    g. Patient safety
    h. Infection control
    i. Right to refuse
    j. Grievance mechanisms
    k. Clinical performance enhancement reviews
    l. Health training for correctional officers
    m. Medication administration training

MENTAL HEALTH FINDINGS: - No substantive improvement from previous assessment.

During this fourth site visit all provisions of the settlement agreement were reviewed with the on-site health management team which included:

1. Vernita Charles, Health Services Administrator
2. Dr. Sang, psychiatrist
3. David Nowak, head nurse
4. Theresa Drigo, case management planner
5. Kendrick Robertson, Assistant Attorney General for the USVI

Mental health policies have never been sent through the required process under the Settlement Agreement. The Health Services Administrator will initiate that process and policies will be reviewed prior to or during the next site visit in September 2014. The staff are aware that Dr. Shansky and I are both willing to assist in any policy development under the technical assistance provision of the settlement agreement prior to their being advanced under the formal process in the agreement. Additions to the intake form were made at the time of the site visit and given to Ms. Charles.

RECOMMENDATIONS:

4th Assessment:

Continue to develop mental health policies to be vetted through the process defined in the settlement agreement

Previous Recommendations Remain Appropriate:

1. A more effective intake process should be developed so that medical staff has access to new detainees and prisoners within 24 hours. The initial security screening tool is not robust enough to provide good identification of medically and psychiatrically ill people. Security staff conducting these interviews will require additional training by health services (medical and mental health) and a quality assurance tool should be developed to monitor the completeness of their documentation and the accuracy of their triage to medical and mental health staff.
2. Medication bridging is problematic with evidence of medications being prescribed and administered but not ordered by a clinician. A review method needs to be developed to oversee the reliability of this process.
3. All of the medical policies need to be reviewed and modified as applicable to this facility.
4. The facility needs to purchase sufficient stethoscopes and sphygmomanometers to ensure availability of more than one of the latter on site. There should be sufficient instrumentation, at a minimum, for the treatment building, reception/suicide watch area, and the emergency response bag.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: See medical findings under (a). The deficiencies listed under (a) reflect both inadequate staffing as well as insufficient training of the health care staff as well as insufficient review and feedback to them. With the addition of the Medical Director and one registered nurse, the program is closer to but not yet in a place where staffing is considered adequate. The leadership team, while it strives to obtain additional resources, must work with the staff so that to the maximum extent possible, the performance of the existing staff meets the standards sought by the leadership team. We talked with the Medical Director about his role and especially his presence and involvement onsite. It is absolutely critical that both the health care staff as well as the custody staff view him as the practitioner who manages the patients at the correctional facility. Unfortunately, however, Dr. Burton's contract was terminated following this onsite assessment due to miss-steps by Territory officials with regard the selection process.

RECOMMENDATIONS:

1. See the recommendations under letter (a).
2. Provide training for the nurses using the intake screening form so that all fields are filled out, even when the response describes a negative answer.

3. Insure that the health screen includes vital signs.
4. The Medical Director should provide guidance to the nurses with regard to the level of abnormality that requires an immediate physician contact.
5. Insure that TB skin test results are documented in the record in the appropriate space and not only in a logbook.
6. Both the head nurse and the Medical Director should, on an ongoing basis, provide a review of the quality of the intake process as well as the completeness, with feedback to the nurses as well as the physician assistant.

MENTAL HEALTH FINDINGS: No substantive improvement from previous assessment. Currently the health service does not keep an intake log, sick call log, behavioral checklist referral log, or a chronic care log. Health service does have an emergency room log that tracks follow-up of the patient by a nurse or doctor within 24 hours.

RECOMMENDATIONS:

4th Assessment:

Appropriate logs need to be developed to track critical processes to ensure inmates have adequate access and follow-up for medical and mental health services.

Previous Recommendation(s) Remain Appropriate:

1. Despite significant improvements in the intake assessment form, there remain significant deficiencies in the nursing staff's capacity to identify inmates for referral to mental health services and the timeliness in delivering those referrals. Medical administration and the nursing director need to address these deficiencies and develop monitoring tools for quality improvement purposes to ensure that this process has been corrected.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: Given the shortage of nursing staff as well as the absence of a Medical Director, there were periods of time when the only RN available was required to perform other activities and was not able to perform sick call. In addition, there was no predictable onsite physician presence. Therefore, this area remains in noncompliance. The problem of access remains a critical one in that there frequently are insufficient officers to provide escort to patients. In addition, rooms in the housing units that could be and should be utilized for sick call assessments have neither been cleaned nor supplied with appropriate equipment and supplies. Therefore, all sick call has to be performed in the clinic area, requiring officer escorts. The sick call program cannot be effectively implemented until there are both adequate nursing and physician staff, adequate escort security staff to bring patients to and from appointments (where necessary), and the ability to perform the process in the housing units when appropriate. We identified records where patients had submitted requests and were either not seen by a nurse at all or were seen several days after the

sick call request was received. There is a sick call log in place and this is a step forward. However, in order for the program to achieve partial compliance, both the medical staff and custody staff support must be adequate and all related policies must be completed and approved. This requirement has proven thus far impossible to achieve.

RECOMMENDATIONS:

1. Obtain a schedule from the Medical Director such that he provides sufficient time onsite to acquit his responsibilities so that nurses can schedule both follow ups from sick call, chronic disease visits, and follow ups from scheduled and unscheduled offsite services as required.
2. Fix up the examination rooms in the housing units, providing the necessary equipment, including exam table, desk and chairs, along with the necessary medical equipment and supplies to insure appropriate sanitation.
3. Hire the remaining nursing staff so that the nurse staffing is four full-time RNs and at least three full-time LPNs.
4. Insure that your log tracks the sick call process from request placed in the box by the patient to collection by health care staff and receipt, which is time-stamped by the registered nurse and then triaged by the registered nurse. Symptom-describing requests should be assessed by a registered nurse within one day.
5. Have the head nurse utilize the sick call log to insure the timeliness and clinical appropriateness of the nursing assessments.

MENTAL HEALTH FINDINGS: The Psychiatry Service is maintaining a clinical log which still lacks the requirements necessary to determine timeliness of follow-up services. However, the psychiatrist has drafted a new spreadsheet that will address the monitoring aspects of this provision.

Access to permanently assigned escort officer(s) remains a major impediment in the operation of an efficient and timely clinic process for medical, dental, and mental health. The clinic officer is still leaving his post frequently to carry out other functions and repeatedly has difficulty obtaining escort officer assistance.

RECOMMENDATIONS:

4th Assessment:

1. Recommend creating two permanent security posts for the medical clinic, a clinic officer and an escort officer, to ensure that access to medical services is not impeded and safety of staff and inmates is preserved.
2. Mental health staff with the support of the Health Services Division, the Warden and the Bureau should design an adequate mental health delivery system for the facility and develop plans to staff and implement the required services.
3. The Monitor's team should be utilized for consultation and/or technical assistance.
4. The facility needs to define by policy the qualifications required for each clinical process as well as time frames to complete these processes and provide the clinically necessary follow-up.
5. Once an approved programming plan is established, an additional internal staffing analysis needs to be completed to determine the required minimum number of psychiatric hours and counseling hours needed to implement the plan.

6. Mental health staff should perform, at a minimum, weekly segregation rounds and monthly well-being checks on all sentenced inmates on the mental health caseload.

Previous Recommendations Remain Appropriate:

1. The elements in the above findings should be used to promulgate a policy and procedure related to access to care and sick call. A system for a confidential retrieval of sick call request by medical staff should be implemented and codified in policy.
2. Mental health staff, with the support of the Health Services Division, the warden and the Bureau should design an adequate mental health delivery system for the facility and develop plans to staff and implement the required services.
3. The Monitor's team should be utilized for consultation and/or technical assistance.
4. The facility needs to define by policy the qualifications required for each clinical process as well as time frames to complete these processes and provide the clinically necessary follow-up.
5. Again, a staffing analysis needs to be completed to determine the required minimum number of psychiatric hours and counseling hours needed.
6. Mental health staff should perform, at a minimum, weekly segregation rounds and monthly well-being checks on all sentenced inmates on the mental health caseload.
7. Nursing transcription omissions should be addressed through education, supervision, and monitored by a Quality Assurance process.
8. GGACF needs to closely monitor shift changes and assignments of officers to ensure that access to medical services is not impeded.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We did not have the opportunity to review the most recent version of the medication policy. We have seen a report prepared by the contract pharmacist which raises some serious questions. She performed a record review in which she found inconsistencies between orders that were present in the medical record or should have been present versus orders on the medical administration records (MARs). There were instances where there was a MAR but no order in the chart, there was an order in the chart that was inconsistent with what was on the MAR, and there were orders in the chart for which there was no MAR. She recommended a review of all records be accomplished and the inconsistencies be resolved and eliminated. This is necessary in order to protect the patients as well as the nurses and the community. We did find out that on at least one occasion, there were no nurses onsite and the medication pass was skipped. There have also been instances where there has been no officer to escort the nurse to do medication pass, thus completely compromising the ability of the nurse to perform this task. Finally, on some days, especially on weekends, we are aware that the nurse completed the evening pass by 4:30 in the afternoon, much too early and clinically inconsistent with what was required. We did not have an opportunity to

review the medication pass itself on this visit; however, it is important that the head nurse review with each nurse the appropriate requirements for a professionally correct medication administration.

RECOMMENDATIONS:

1. Fill the nursing positions.
2. Ensure adequate custody staffing to maintain consistent access to inmates for medication administration, whether cell-side or at the medical building.
3. Draft the medication management policy for review by the medical expert at the time of the next visit.
4. The lead nurse should work with the Medical Director in order to develop a procedure that allows the nurses to carry the medications with them to the cell houses and also to bring the medication administration records so that, at a minimum, they are recorded no later than when the nurses are ready to leave each housing unit.
5. The officers' post orders should require that they perform a mouth check after each administration.
6. Develop a procedure that enables timely provision of discharge medications to both sentenced and pretrial detainees at the time of release.
7. Perform a review of all of the records to look for inconsistencies between orders written on an order sheet and individual medication administration records. Any inconsistencies found must be corrected.

MENTAL HEALTH FINDINGS: Chart reviews demonstrated continued clinically significant problems in the timeliness and adequacy of psychiatric and medical follow-up as follows:

- A black male in his sixties presents with chronic schizophrenia. He has had active and persistent psychotic symptoms for the last several months. Yet despite the acuity of his symptomatology and repeated lockdowns because of it, he has been seen only on three occasions since January 2014 for mental health follow-up.
- A male in his thirties has been diagnosed with chronic paranoid schizophrenia. He has been incarcerated on several occasions with a recent readmission on March 25, 2014, at which time he was seen and immediately referred to the emergency room where Dr. Sang saw him. He eventually returned to GGACF but he has not been seen since that initial visit in March. His chart lacks an intake screening form and a 14-day history and physical as well.
- A male in his twenties has been incarcerated at least since March 2014. There is no intake screen or history and physical in his record. In fact, his medical record consists of three sheets of paper, one March 12, 2014, describing a lip injury for which he was sent to the emergency room; a follow-up for suture removal on March 20, 2014; and an evaluation by the psychiatrist June 6, 2014, where he was diagnosed with an adjustment disorder and placed on Haldol 2 mg and Ambien 10 mg at bedtime.
- A male inmate in his thirties (chart was reviewed upon referral from Ms. Myrthil) had an x-ray ordered in April 2014, following complaints of low back pain. The x-ray was never done; the referral was retained by the offsite scheduler and no appointment was scheduled because there was no medical director on staff to approve the request. The medical director began work two weeks prior to the June on-site assessment, but during that assessment it was discovered that the medical director never received the referral for review. The inmate was not been seen again after the referral was ordered in April.

- A male in his fifties has a diagnosis of cardiovascular disease (chart was reviewed upon referral from Ms. Myrthil). He has not had chronic care follow up for the 5 months between 10/1/13 and 3/12/14.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate:

1. Nursing staff should be instructed as to the proper procedure when administering medications to all inmates.
2. Supervisory observation of performance should be periodic and unannounced to ensure the effectiveness of in-service training on medication administration.
3. Quality measures should be implemented to monitor the timeliness and accuracy of order transcriptions.
4. Laboratory studies and requested medical records should always be reviewed and dated and initialed by the clinician prior to being filed in the medical record. This process ensures that critical information will not be missed by the treating clinician.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: The medical records we reviewed with the Medical Director were nothing short of appalling. There was no chronologic consistency, there was no filing within given sections consistently and it was extremely difficult, if not impossible, to track what was happening for each patient. There must be a medical records clerical position added to the staffing as soon as possible. Such a position does not have substantial budget implications. It is not clear why this has not been accomplished. It was extremely difficult to attempt to track the occurrence of encounters, lab reports and offsite services, given the state of the medical records.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. Hire a medical records technician as soon as possible, presumably before our next visit.
2. The medical records policy should include timeframes for filing of documents and for reviewing, initialing and dating by clinicians.
3. Continue to utilize the monitor's staff for input in modifying the medical record policy.

MENTAL HEALTH FINDINGS: Ms. Jennifer Charles, the mental health clinic coordinator, has not been at work since two weeks after our March visit. She has used up her sick leave and has not contacted the BOC with a formal notification of resignation. Staff report that she shredded all of the documents in her office the last day she was on site. It is unknown what materials were destroyed.

Since Ms. J. Charles was not in the habit of filing her clinical records in the medical chart, it is likely some of those encounters were among the papers shredded.

No medical records person has been hired and the clinic is still waiting for temporary help. The medical records remain disorganized. Cover sheets have been added to some charts to improve the format of the medical records.

The reviewer observed that the Medication Administration Records for the entire year 2014 were unfiled and reportedly stored in piles in the nursing station. This problem was discussed with the team and it is my understanding that during a lunch break that same day the administrator addressed this problem with the staff. She reports they all filed some forms during this break.

RECOMMENDATIONS: Unchanged from the prior reports. Failure to maintain comprehensive and accurate medical records is a major deficiency that hampers provision of adequate medical services and should be addressed with great priority.

4th Assessment:

1. It is essential that the clinic develop a culture of functioning as a whole and during periods when there is little inmate movement they all contribute to team building tasks.

Previous Recommendations Remain Appropriate:

1. There is a need to draft a more detailed medical record policy.
2. The Monitor's staff should be utilized as resources to facilitate development of the policy and procedure.
3. One chart per inmate, combining medical and mental health documentation for an integrated record.
4. It is recommended that the mental health professional immediately file her notes in the medical record so they are available for the psychiatrist to review.
5. A policy needs to be developed with documentation guidelines and instructions for organizing and maintaining the medical record.
6. Quality improvement effort should be undertaken to track compliance with policy once implemented.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: As stated above there is no mental health sick call log. Requests that come in are given to the psychiatrist by nursing staff but none are stamped with the time and date of receipt. Dr. Sang reported that if the inmate placed her name on the sick call request she will receive it quickly. The new medical case management planner also reported checking daily for sick call requests and referrals to mental health for which delays were noted in the Third Report and were a significant deficiency.

Women on X Dorm reported that the nurse stops by the outer lock gates to the unit and pass medication through the gate. If an inmate is unaware or unable to walk to the gate to be seen, no medical rounds are actually done in the unit.

RECOMMENDATIONS:

4th Assessment:

No change from the last report.

The Health Services Administrator stated that she would generate a mental health sick call log that will track:

1. the date the request is initiated
2. the date the request is received by medical
3. the date the request was triaged by a qualified health professional
4. the date the request is received by mental health
5. the date the request is resolved
6. Proper medical rounds should be completed in all housing units.

Previous Recommendations Remain Appropriate:

1. A confidential process needs to be established that enables:
   - monitoring of the timeliness of retrieval of sick call requests
   - appropriate triaging by a registered nurse or mental health professional (in the case of mental health requests)
   - timeliness of response by the appropriate qualified health professional
   - appropriateness and effectiveness of the treatment plan generated.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There has been some progress regarding the development of logs for intake processing, sick call, scheduled offsite services and unscheduled offsite services. Most of these logs have the recommended fields. However, what is lacking is the ability to insure that the data reflects the full complement of services scheduled and provided. We found unscheduled visit logs which had no dates for a week and a half. It strains our credulity to believe that there were no unscheduled send-outs during this time period. Similarly, the infrastructure has not been set up to insure that the

logbooks capture all of the relevant data. We would encourage the Health Care Administrator to sit down with the Head Nurse, the Medical Director and the offsite services coordinator and figure out how they can set up a procedure that insures that each of these individual logs contains the entire compliment of services provided.

RECOMMENDATIONS:

1. The Health Care Administrator, the Head Nurse, the Medical Director and the offsite services coordinator should meet and analyze what procedure should be put into place to insure that the intake processing log, the sick call log, the scheduled offsite services log and the unscheduled offsite services log all contain the full complement of required services provided. The same should be done for the chronic care log.
2. The monitor's staff are available as resources to assist in developing these procedures.

MENTAL HEALTH FINDINGS: There has been no change in the mental health caseload tracking form. Dr. Sang has developed a new spreadsheet that, when implemented, should address most all of the requirements of this provision.

RECOMMENDATIONS:

4th Assessment:

The new log should be maintained in a sortable format such as a Word table or Excel worksheet for ease of maintenance of an accurate record. Electronic logs can also be shared with the Health Services Administrator and Medical Director for quality management purposes.

Previous Recommendations Remain Appropriate:

1. The current log should be maintained in a sortable format such as a Word table or Excel worksheet for ease of maintenance of an accurate record.

2. Health services may consider developing an intake log that records the inmate's name, number, date a sick call request or behavioral referral is received, the date the request was triaged, the date it is received by the service responsible to respond (medical, dental, mental health), the date the issue has been resolved and the initials of the responding staff person. Such a log would assist in the quality assurance efforts when studying timeliness and access to care.

3. It is also recommended that the date of the last mental health and psychiatric visit as well as housing location, and the follow-up date be entered. This will enable quick assessment as to whether someone has accidentally fallen off the schedule and whether they are in a special housing unit.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This section addresses the medical chronic and acute care program. We reviewed records of patients with chronic illnesses and were frustrated by the difficulty in attempting to assess the care provided. The following are a few examples.

Patient #1
Male inmate in his thirties has a chart with a blank problem list but a history of diabetes type 2, including a toe amputation. There were no chronic care forms filled out in his chart except for an initial baseline visit that was used inappropriately as a follow-up visit. It was extremely difficult to track how his care had been given.

Patient #2
Inmate in his thirties arrived in 2013, and was assessed as having diabetes type 2 and bipolar disorder. There were no chronic care forms utilized and under assessment, rather than describing the degree of disease control, the assessment area literally said, "diabetes type 2 or diabetes stable." There was no hemoglobin A1c in the chart since October 2013. Given the absence of both physicians and nurses, it is not surprising that there would be these deficiencies. With the departure of the Medical Director, we are very concerned that the performance in this area will remain problematic, placing these inmates a serious health risk.

RECOMMENDATIONS:

1. The Head Nurse should work with the nursing staff, supervised by the Medical Director, to develop a list based on medications of patients being seen for each of the common chronic diseases. This list should then be turned over to another nurse who will be responsible for maintaining it, that is, adding new names of people who enter and eliminating the names of people who have been released. The patients should be seen based on disease control, with those in better control being scheduled for less frequent visits.
2. The Medical Director should contact the medical monitor to discuss the chronic care program.

MENTAL HEALTH FINDINGS: Currently, the mental health professional maintains the case list that identifies those inmates followed both on the detainee and the sentence side of the facility by the psychiatrist. The psychiatrist stated that inmates prescribed medications for a temporary problem will not be included in the caseload. The list contains the inmates name, diagnosis, medication regimen, BOC number, and date of birth. The list is lacking the date for the next psychiatric and counseling visit and should include the names of every inmate currently receiving any psychiatric medications and who is actively engaged in mental health treatment and follow up. In reviewing the medical records it is clear that people are not scheduled for follow-up as medically necessary or in a timely manner.

Patients are scheduled in the chronic care mental health clinic in unpredictable and inconsistent fashions. Frequently, people appear to be lost to follow-up despite a diagnosis of a serious mental illness.

There are no published mental health treatment guidelines provided to clinicians for appropriate and timely chronic and acute mental health patient follow-up.

RECOMMENDATIONS:

Develop and make available to clinical staff practice guidelines under this provision.

Previous Recommendations Remain Appropriate:

1. Contact the Monitor and his staff for consultation and/or technical assistance.
2. A minor modification to the current case list log as recommended above would improve the tracking capabilities of the facility.
3. The list should contain both the BOC number and the inmates' date of birth.
4. Any inmate followed by mental health should be captured on a log, perhaps one for psychiatry and one for counseling.
5. As mentioned previously, a policy that would dictate required time frames for follow-up of people in the chronic care mental health clinic may improve the timeliness of return visits and allow for tracking when looking for quality outcomes.
6. All prison inmates on a mental health caseload should have at a minimum a monthly well-being check by a mental health professional. Minimum frequency of psychiatric visits should be outlined by policy not to exceed every 90 days.
7. The mental health caseload should be modified to track the date of the follow-up visit for easy identification of overlooked appointments and housing unit to identify those in segregation or special housing.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: Given the shortage of staffing, there are lengthy periods of time when there are no medical staff onsite. This creates real gaps in understanding what happens to patients. We are told that when a patient presents with a serious condition, custody becomes aware and then sends the patient out. Once another Medical Director is appointed, there should be an arrangement with the Warden such that officers are trained that no patients will be sent out as medical emergencies unless the Medical Director has been contacted. We believe that from 8:00 a.m. to 8:00 p.m. Monday through Friday and possibly 8:00 a.m. to 6:00 p.m. on Saturday and Sunday, there are medical staff onsite. When they are onsite, they are contacted and they frequently make their own decision as to when to send the patient out. Even when medical staff are onsite, they should now be contacting the Medical Director and should arrange for the Medical Director to interview the patient by phone if he so indicates a need. We continue to find records in which patients were sent out emergently with no prior notes and patients were returned with no follow-up notes. All patients upon return who arrive when health care staff are there should be seen by a health staff member and then be scheduled for a follow up with a physician or a PA as soon as possible.

RECOMMENDATIONS:

1. Complete the urgent/emergent policy, insuring that the Medical Director is involved and there is timely follow up onsite.

2. The offsite service coordinator should be responsible for insuring the emergency room reports are available timely and that follow-up visits with the clinician are scheduled timely.
3. The emergency care policy should include requirements for training and certification in basic life support and first aid as well as the documentation of critiques of quarterly emergency drills.
4. Nurses should be trained that when patients return from unscheduled offsite services, they should document a note that describes the patient's condition along with a set of vital signs and insure that the appropriate paperwork is available.

MENTAL HEALTH FINDINGS: No change since previous report. The training on the management of mental health crises was to have been completed June 1, 2014, but had not been initiated at the time of the site visit. Importantly, the BOC made no attempt to involve any mental health staff in the development of this training. During the on site visit, we discussed the importance of involving Dr. Sang in the training curriculum development. This is discussed further below.

RECOMMENDATIONS:

4th Assessment:

Develop and submit required training curriculum to the Monitor for review and approval, commence training.

Previous Recommendation(s) Remain Appropriate:

1. Consider opportunities to improve coordination between GGACF staff and community case managers when dealing with these complex cases.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We discussed the role of the offsite service coordinator to both schedule offsite service visits as well as in obtaining the offsite service reports. The person assigned appears very conscientious and anxious to accomplish her responsibilities. Hopefully, when another Medical Director is appointed, the follow-up visits can be scheduled by the offsite service coordinator based on when the Medical Director is scheduled to be present. Our record review detailed an absence of offsite service reports as well as follow-up care.

Patient #1
A male in his late twenties arrived in 2010 with a seizure disorder. He was sent to the ER for a seizure on 2/15/14. The record was impossible to track chronologically. There was no note in the chart on 2/15/14 and no note on return, as well as no ER report and no CT scan report. This record was fairly typical.

RECOMMENDATIONS: The offsite service coordinator should track the date of the order, the date of the appointment, the date offsite service reports are received and the date of the follow-up visit with the Medical Director.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This has been discussed under number v.

RECOMMENDATIONS: See number v.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We discussed with the Medical Director the need to develop guidelines for the approach to intoxication and detoxification. He indicates he is prepared to do this. We offered to send him a model policy from which he can use to develop his own Golden Grove policy and guideline.

RECOMMENDATIONS:

1. The Medical Director should draft an intoxication and detoxification policy and clinical guideline.

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

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATION:

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

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

RECOMMENDATIONS: defer to Dr. Shansky's report

i. Adequate suicide prevention, including:

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS - On day one of the site visit the A-Unit security log from the last quarter was reviewed. What was noted were repeated and prolonged periods of cell restriction by the security officer of several seriously mentally ill inmates due to their behavioral dysfunctions. Evident from the review were three cases from A-Unit where medical and mental health staff were not notified of repeated lockdowns (cell restrictions). The psychiatrist has made rounds in the A dorm only twice since March 2014, despite reporting at the April status conference that such rounds would be conducted weekly. Inmates also reported that Ms. Drigo has been on the unit very briefly once or twice to begin case management services. Mental health rounds in the segregation units (both detention side and sentenced side) occurred only once since our site visit in March. Mental health staff identified the lack of an escort officer accompanying them to segregation as a deterrent to this generally accepted weekly standard.

Serious mental health crises inmates can be referred to the emergency room at the local hospital whenever the psychiatrist is not in the facility. Dr. Sang will see those inmates at the hospital whenever needed. However, St. Croix still lacks inpatient psychiatric beds and therefore inmates must be returned to the facility per emergency department guidelines.

Nursing staff does make rounds in the units and will refer inmates that concern them to Dr. Sang, who will see the inmate immediately onsite in the treatment building or in the hospital emergency department.

Inadequate recognition of mental health crises and appropriate referral to the medical/mental health service are partly due to the lack of promised training for security staff in the recognition, de-escalation and referral of the serious mentally ill inmate. Evidence of this is seen in the frequent use

of cell restriction by security for several acute mental health inmates for days and weeks on end without involvement by professional medical and mental health staff.

For example, a male inmate in his sixties has been diagnosed as having chronic schizophrenia and was observed directly by this auditor during the first and third site visits. The officer's log on March 29, 2014 noted that he was "still fasting". There is no acknowledgment of his fasting state in the medical record and no monitoring of his health status. The inmate was placed on cell restriction with limited access to fresh water (we have observed faucet water from three different faucets that does not appear potable, was discolored and had particulate matter in it). The officer's log has no comments of nursing making checks on this particular inmate. The log notes that he is on cell restriction, which may or may not have been continuous, until he was moved to the segregation unit on April 28, 2014. The officer's log is silent on whether he was ever removed from cell restriction during this period of time. Notations in the medical record for this inmate are inadequate as well. He was seen on January 27, 2014 by a psychiatrist, at which time he was actively delusional. Haldol was held and the plan was to observe him for decompensation. However, he was not seen again until March 28, 2014, an undue period of time considering medications were altered in January. The behavioral checklist was not initiated until March 30, 2014, which stated that he was in his room without clothing, asking the nurse for sex after chasing her down the hall and refusing to leave his cell in hiding. He was seen April 2, 2014, and his Haldol was restarted. When he was reviewed again on April 16, 2014, he was still sexually inappropriate around female officer, which he denied. His medications were continued and the plan was for him to return in one month. There are no follow-up psychiatric notes since April 16, 2014, although on April 21, 2014 the psychiatrist received a report that he was still sexually "expressive" and his Haldol was increased. On April 21, 2014, a behavioral checklist was sent stating he was refusing medications, argumentative, hiding, unable to sleep, depressed, and planning to inflict bodily harm. No other notes are in his file. During this site visit he allegedly struck a segregation officer on the back of her head when escorted outside his cell.

This problems at GGACF demonstrated by this case include:

- delayed psychiatric follow-up and management of an actively psychotic inmate;
- inadequate responsiveness to behavioral checklist issues, partly due to the lack of availability of mental health programming;
- serious lack of communication between medical and security when a mentally ill inmate has been secluded;
- use of isolation with no programming offered to redirect his behavior, and continued use of segregation rather than hospitalization;
- no report to medical that the inmate was fasting and therefore no medical monitoring of an inmate at increased risk of heat management issues secondary to his psychiatric medications and therefore at greater risk of serious to life threatening consequences of dehydration.

Significantly, during the discussions with the leadership staff it became evident that the Bureau of Corrections has not communicated with the on-site leadership regarding training of corrections staff on how to identify and respond to inmates with medical or mental health needs, as required by the Settlement Agreement and the Work Plan implementing it. Rather, the bureau scheduled a training coordinator from St. Thomas to arrive at Golden Grove the following day to do some level of suicide prevention training. However, the training promised was to also include crisis management instruction. Neither Dr. Sang nor the Health Services Administrator had been approached regarding developing the curriculum and implementing this training on site. Dr. Sang planned to do the training

once there were enough officers to provide relief and also has volunteered to develop pre-and post-tests.
GGACF does not have the structural or clinical capacity to monitor and treat acutely mentally ill persons.

RECOMMENDATIONS:

4th Assessment:

1. Substantial problems in the involvement of professional staff to specialty mental health housing in segregation units continues.
2. The facility needs to either develop internal capacity to manage acutely mentally ill cases or develop a reliable inpatient hospital referral source(s).
3. GGACF needs to develop a comprehensive vision of what an adequate mental health service should provide. Efforts should then be made to systematically develop the appropriate facilities, policies and procedures, programming curricula, professional staffing, and integration and support of security staff assigned to those areas.
4. The practice of cell restriction of inmates for behavioral health issues without notification of medical staff ASAP needs to terminate. Any inmate restricted to a single cell for the circumstances should be covered under a seclusion and restraint policy which clearly outlines time frames and who has the authority to issue and continue the states of confinement. In addition, any inmate in seclusion must be seen by professional qualified health providers, including the psychiatrist/QMHP on a daily basis accompanied by progress note documentation.

Previous Recommendations Remain Appropriate:

1. GGACF needs to develop a communication system that is timely and reliable for notification regarding inmates placed on suicide watch, behavioral referral requests, and intake referrals.
2. Medical Services needs to develop a reliable system to ensure that the mental health clinicians receive referrals in a timely manner.
3. Sufficient training needs to be provided to all staff when new policies are developed and implemented.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: A formal suicide prevention policy has not yet been vetted by the process outlined in the settlement agreement and approved by the Monitor.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. Quality assurance measures need to be implemented to ensure that all components of the new policy are effectively carried out.

2. Evidence of adequate training of staff should be provided to the monitoring team when new policies are implemented.

3. In the future, all policy drafts should be distributed electronically to the monitoring team and the parties for review prior to acceptance and implementation. The current suicide prevention policy includes provisions that are not possible given the current structural constraints of the facility and the lack of 24 hour daily staffing patterns for health services. Observation status requirements of correctional officers are too infrequent compared to the customary requirements, which impose 30-minute rounds as opposed to the "not less than every hour" requirement in this policy. The policy also requires that the mental health counselor will observe the offender every shift, which is not feasible given the staffing pattern of GGACF. The nature of this policy is such that the facility will perpetually be out of compliance with its own policy. This needs to be amended.

4. Please distribute any current mental health policies to the Monitor and USDOJ attorneys in an electronic format.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: There has been no instance reported of an inmate being placed on suicide watch during the last reporting period, so no assessment could be made to determine if there has been improvement since the last site visit. A standardized risk assessment form has not yet been developed by the mental health service

RECOMMENDATIONS:

Previous Recommendation(s) Remain Appropriate:

1. An after-hour protocol should be considered as well to allow for notification of mental health staff by the next morning. This is a requirement of the new policy in section H.1. But no 24-hour emergency mental health plan was presented to the monitors at the time of the March site visit.

2. It is suggested that the service develop a standardized suicide assessment progress note that would include a suicide risk assessment and a suicide watch treatment plan.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: There was no cut-down tool again found in the mental health housing unit nor RSAT, according to the Monitor who inspected these units. It seems obvious that recommendations pertaining to quality control that ensures the presence of cut-down tools as required is not being followed.

RECOMMENDATIONS:

Previous Recommendation(s) Remain Appropriate:

1. Cut down tools should be available in all housing areas, and areas where inmates could have an opportunity to harm themselves, i.e. kitchen, medical building, etc.
2. All staff required to use this tool should be well-trained and emergency drills demonstrating proficient use of the tool should be conducted on a regular basis.
3. Supervisors should regularly inventory and audit tool location and make immediate provisions to replace missing or non-functioning tools when found.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: As stated earlier, the required training was to have been completed June 1, 2014, but has not yet occurred and the curriculum has never been sent to the Monitor for review and approval.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. Develop and implement scenario-based suicide prevention, response, and recovery training program that requires application of policy and procedure, and that topic competence is proven by both written test and demonstration by staff.
2. Refer the completed materials to the Monitor for review and approval
3. Adequate initial and annual trainings should be documented and maintained.

Additionally, the Monitor's staff training discussion from the previous report should be used in developing policy and training materials.

Staff Training

The essential component to any suicide prevention program is properly trained staff, who form the backbone of any correctional facility. Very few suicides are actually prevented by mental health,

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

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

Identification/Referral/Evaluation

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

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

- Was the inmate a medical, mental health or suicide risk during any prior contact and/or confinement within this facility?
- Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency or facility, conversation with family member) that indicates inmate is a medical, mental health or suicide risk now?
- Have you ever attempted suicide?
- Have you ever considered suicide?
- Are you now or have you ever been treated for mental health or emotional problems?
- Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?
- Has a family member/close friend ever attempted or committed suicide?
- Do you feel there is nothing to look forward to in the immediate future (expressing helplessness and/or hopelessness)?
- Are you thinking of hurting and/or killing yourself?

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

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

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

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

Communication

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, can reduce the likelihood of suicide. In addition, most

suicides can be prevented by correctional staff who establish trust and rapport with inmates, gather pertinent information, and take action. There are essentially three levels of communication in preventing inmate suicides: between the arresting/transporting officer and correctional staff; between and among facility staff (including correctional, medical and mental health personnel); and between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. At Level 1, what an arrestee says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting officers should pay close attention to the arrestee during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the arrestee's well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

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

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

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

Housing

In determining the most appropriate housing location for a suicidal inmates, correctional facility officials (with concurrence from medical and/or mental health staff) often tend to physically isolate (or segregate) and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate since the use of isolation escalates the sense of

alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, mental health unit, or medical infirmary, located close to staff. Further, removal of an inmate's clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, handcuffs, and straitjackets) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.

All cells designated to house suicidal inmates should be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures, smoke detectors and ceiling/wall air vents that are protrusion-free. In addition, the cells should not contain any live electrical switches or outlets, bunks with open bottoms, any type of clothing hook, towel racks on desks and sinks, radiator vents, or any other object that provides an easy anchoring device for hanging. Each cell door should contain a heavy gauge Lexan (or equivalent grade) clear panel that is large enough to allow staff a full and unobstructed view of the cell interior. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

Levels of Observation/Management

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

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

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

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

In addition, mental health staff should assess and interact with (not just observe) the suicidal inmate on a daily basis. The daily assessment should focus on the current behavior, as well as changes in thoughts and behavior during the past 24 hours (e.g., "What are your current feelings and thoughts?"

"Have your feelings and thoughts changed over the past 24 hours?" "What are some of the things you have done or can do to change these thought and feelings?," etc.)

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

Finally, due to the strong correlation between suicide and prior suicidal behavior, in order to safeguard the continuity of care for suicidal inmates, all inmates discharged from suicide precautions should remain on mental health caseloads and receive regularly scheduled follow-up assessments by mental health personnel until their release from custody. Although there is not any nationally-acceptable schedule for follow-up, a suggested assessment schedule following discharge from suicide precautions might be: 24 hours, 72 hours, 1 week, and periodically until release from custody.

Intervention

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

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

Reporting

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

Follow-Up/Mortality-Morbidity Review

An inmate suicide is extremely stressful for both staff and other inmates. Staff may also feel ostracized by fellow personnel and administration officials. Following a suicide, misplaced guilt is sometimes displayed by a correctional officer who wonders: "What if I had made my cell check earlier?" Inmates are often traumatized by critical events occurring within a facility. Such trauma may lead to suicide contagion. When crises occur in which staff and inmates are affected by the traumatic event, they should be offered immediate assistance. One form of assistance is Critical Incident Stress Debriefing (CISD). A CISD team, comprised of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, and mental health personnel), provides affected staff and inmates an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

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

RECOMMENDATIONS:

1) Develop and implement scenario-based suicide prevention, response, and recovery training program that requires application of policy and procedure, and that topic competence is proven by both written test and demonstration by staff. Adequate initial and annual trainings should be documented and maintained.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: See f.iv.

RECOMMENDATIONS:

4th Assessment:

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

Previous Recommendations Remain Appropriate:

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

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: No change from previous reports. GGACF has no suicide-resistant cells.

RECOMMENDATIONS:

4th Assessment:

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

Previous Recommendations Remain Appropriate:

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

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

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

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

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

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

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

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

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

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

6. Beds should ideally be either heavy molded plastic or solid concrete slab with rounded edges, totally enclosed underneath. If metal bunks are utilized, they should be bolted flush to the wall with the frame constructed to prevent its use as an anchoring device. Bunk holes should be covered; ladders should be removed. (Traditional metal beds with holes in the bottom, not built flush to the wall and open underneath, have often been used to attach

suicide nooses. Lying flat on the floor, the inmate attaches the noose from above, runs it under his neck, turns over on his stomach and asphyxiates himself within minutes.);

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

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

9. CCTV monitoring does *not* prevent a suicide, it only identifies a suicide attempt in progress. If utilized, CCTV monitoring should *only* supplement the physical observation by staff. The camera should obviously be enclosed in a box that is tamper-proof and does not contain anchoring points. It should be placed in a high corner location of the cell and all edges around the housing should be caulked or grouted. Cells containing CCTV monitoring should be painted in pastel colors to allow for better visibility. To reduce camera glare and provide a contrast in monitoring, the headers above cell doors should be painted black or some other dark color. CCTV cameras should provide a clear and unobstructed view of the entire cell interior, including *all* four corners of the room. Camera lens should have the capacity for both night and low light level vision;

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

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

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

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

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

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

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

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

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

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

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No Change from prior reports. No suicide prevention policy has been formally submitted to the Bureau of Corrections and The Monitor per the Settlement Agreement. There does not appear to be a protocol in place for providing this supervision.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No change from previous reports.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: The Medical Director started the day we arrived as did one other registered nurse but the Medical Director was terminated shortly thereafter. That leaves no Medical Director to provide and supervise primary care, and at least two registered nurses and one LPN that still need to be hired. We understand the registered nurses have been budgeted but we are not aware that an additional LPN has been budgeted. Given the requirement to pass meds seven days a week, a task which the LPNs perform, it makes no sense to not build in relief so that when one of the LPNs cannot provide services there is a relief person. There was at least one medication pass when the entire pass was cancelled due to the absence of both medical staff and escort staff. At least two RNs and one LPN should be hired as soon as possible. In addition, a medical records technician should be hired also as soon as possible. The state of the medical records is unacceptable. This must be corrected immediately.

RECOMMENDATIONS:

1. Hire another qualified Medical Director without delay.
2. Hire two RNs and one LPN before our return.
3. Hire a medical records technician before our return.

MENTAL HEALTH FINDINGS: A bachelor-prepared Medical Case Management Planner has been hired by the Health Services Department. To date, the Qualified Mental Health Professional has not returned to duty and it is unclear whether she has any plans to return to work. The only Qualified Mental Health Professional remains the psychiatrist. Dr. Sang usually arrives on site at 11 a.m. because she has no access to inmates prior to that time due to the duty officer accompanying the nurse for medication passes. She is currently averaging about four hours per day on site but is available to see any inmate in the hospital emergency room seven days a week.

The required staffing analysis had not been completed at the time of this assessment.

RECOMMEDATIONS:

Previous Recommendations Remain Appropriate:

Refer to the Monitor's assessment, findings and recommendations pertaining to staffing analysis recommendations. Provide the staffing document to the Monitor along with the duties assigned to each staff member.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We have been constantly reminded that some of the services that do not occur are a result of lack of officer escort. In addition, if an officer is assigned to medication

administration, which occurs around 8:00 a.m. and again at 6:00 p.m., then during the day that officer could accompany a nurse or a doctor who would see patients in the hopefully soon-to-be refurbished exam rooms on each housing unit. This would be an efficient use of BOC resources, since it would mitigate the need in many instances to provide escorts to the clinic because patients would be seen in the housing areas.

RECOMMENDATIONS:

1. Provide a post assignment as a medical escort for both medication administration and sick call in the housing units to be available on two shifts, day shift and evening shift.
2. There should also be a current medical transfer post of at least one and possibly two officers.

MENTAL HEALTH FINDINGS: Based on observations and staff reporting there remains inadequate correctional officer staffing to ensure that all scheduled appointments occur and that there is the capacity for inmates with urgent issues to also be escorted to the clinic. In addition there can be no growth in the capacity to deliver clinical services until sufficient security staffing is available to support those measures. It was reported that medical personnel such as the consultant pharmacist has outstanding invoices pending payment with the BOC. The BOC must timely pay providers in order to retain their services.

RECOMMENDATIONS:

4th Assessment:

1. A review of accounts payable practices should be performed to ensure retention of critical medical personnel.
2. BOC, in conjunction with the health services staff, should develop a vision and mission for mental health services at GGACF. This should be reviewed by the monitoring team's expert and if deemed adequate, a plan should be developed to achieve established goals and implemented within acceptable time frames.

Previous Recommendations Remain Appropriate:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: This requirement is for the quality improvement program.Until a Medical Director is appointed and all staff positions are filed, creation of a meaningful and productive quality improvement policy and committee is impossible. Nonetheless, we discussed important elements of the quality improvement program which should be performed and reflected in the minutes of monthly meetings and reiterate that conversation with the medical program is fully staffed.

1. The quality improvement program should review the timeliness and appropriateness of both intake screening and health assessments as well as the completeness of the intake screening, including TB screening.
2. The quality improvement program should monitor emergency care, including the consistency of calls to the Medical Director as well as timeliness and appropriateness of follow up onsite.
3. The quality improvement program should monitor the non-emergent request program for both timeliness and appropriateness of response.
4. The quality improvement program should monitor the chronic disease program from initial entry and follow up with regard to appropriateness and consistency with chronic care guidelines.
5. The quality improvement program should monitor the timeliness and appropriateness and continuity of care of patients who received scheduled offsite services.
6. The quality improvement program should monitor the discharge planning process with respect to release medications for both detainees as well as sentenced prisoners.
7. The quality improvement program should monitor care for pregnant females for consistency with American College of OB/GYN guidelines.
8. The quality improvement program should monitor the medication program for (a) consistency between orders and medication administration records and (b) the timeliness of receipt of medications after initial order.
9. The quality improvement program should monitor the maintenance of medical records after a medical records technician has been hired and able to have had an impact on the quality of the records.

RECOMMENDATIONS:

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

MENTAL HEALTH FINDINGS: No change since previous visit.

RECOMMENDATIONS:

4th Assessment:

The Mental Health Department, under the supervision of the Medical Director needs to develop a schedule of quality improvement activities and systems to measure the clinical processes and their outcomes. Currently there is a monthly report, which was not provided for our review, to the Health Services Administrator.

Previous Recommendations Remain Appropriate:

1. Complete development, training, and implementation of required medical, mental health, and suicide prevention policies.
2. Include in each policy core measures, metrics, and methods for continuous quality improvement of these governing documents.
3. As the policies and procedures are finalized, staff are trained and the policies implemented, begin the monitoring of process performance with regard to intake, health assessments, TB screening, sick call, unscheduled onsite and offsite services, scheduled onsite and offsite services as well as chronic disease management and medication management.
4. Work with the monitor and his staff, who can provide technical assistance.

m. Adequate dental care;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We again had the opportunity to speak with the dentist and were told that his dental assistant/hygienist is sometimes not able to attend since she lives in St. Thomas. We also continue to hear that his biggest access obstacle is due to officer availability. This is an area that continues to need attention. Without the access problems, this area could achieve substantial compliance.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

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

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

RECOMMENDATIONS: defer to Dr. Shansky's report.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There have been no deaths or sentinel events since our last visit.

RECOMMENDATIONS:

Previous Recommendation Remains Appropriate:

1. Consider utilizing the services of an offsite clinician to perform a death review on all deaths of patients incarcerated in the Department of Corrections.

MENTAL HEALTH FINDINGS: No change since previous visit. No deaths or serious suicide attempts were reported during this assessment.

RECOMMENDATIONS: defer to Dr. Shansky's report

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We are still awaiting the drafting of the segregation round policy. It would make sense for both nursing and mental health to share this responsibility.

RECOMMENDATION:

Previous Recommendation Remains Appropriate:

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

MENTAL HEALTH FINDINGS: Despite reassurances at the March 28, 2014 federal court status conference that these rounds were occurring, while on site we learned that a mental health counselor has been to segregation to round only once, shortly after the third site visit. Segregation and isolation rounds are not occurring as required by the Agreement.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. A policy be developed that incorporates the requirements of national accrediting bodies such as the NCCHC or the ACA.
2. Medical and mental health segregation rounds be implemented following national guidelines.
3. Staff training regarding what are critical questions in areas to review during medical and mental health rounds on the segregation unit.
4. The facility will need to provide adequate security staffing and access in order for the medical staff to conduct the appropriate rounds and treatment services.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: GGACF continues to place inmates with serious mental illness in lock-down/isolated cell settings. There remains no regular review of inmates in segregation to 1) minimize time in segregation or 2) assess mental health status to ensure segregated inmates do not suffer adverse psychiatric conditions while segregated.

One inmate referenced earlier has been placed in segregation and, per the disciplinary hearing officer, no incident report or disciplinary report was filed associated with this placement. Not only is this a poor mental health practice because it does not meet any standard of care, it also violates, in this writer's opinion, his right to due process. It was also reported that persons isolated in administrative segregation on L-Unit go through no periodic review process, no matter how many years they may remain on that unit. Officers can place someone in their cell for 1-2 days but there is no policy allowing this practice.

As stated in the 3rd Report, *"Staff reported that inmates on the mental health caseload are not screened prior to placement in segregation. In addition, the mental health staff is not notified of this placement until they see the patient at the time of his\her next appointment. There is no enhanced mental health programming offered to mentally ill inmates housed in segregation units."*

As stated in the 3rd Report, the monitor once again observed mentally ill inmates locked in an isolated cell environment.

"The Monitor, an experienced licensed mental health clinician, observed inmates presenting symptoms of serious mental illness in segregation units having conditions that amount to an isolation environment. Many of these inmates were locked in their cells for most of the day. Many of the cells were very dark with virtually no social interaction other than inmates yelling.
These conditions, as reported by the Monitor, and this expert agrees, can seriously exacerbate mental health symptoms and adversely impair mental health recovery."

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. No inmate should be placed in segregation without a concomitant incident report or disciplinary report being generated, which would initiate a due process review.
2. This Provision mandates a strict prohibition on placing in isolation environment ANY inmate having or suspected of having a serious mental illness. Policies and procedures must articulate this mandate and be monitored by supervisors and mental health staff for compliance.
3. It is recommended that a detailed policy be developed to address this issue that incorporates the requirements of national accrediting bodies such as the NCCHC or the ACA.
4. The facility should develop an outline for therapeutic residential level of treatment on these units, identify the staffing needs and coordinate with security to effectively initiate enhanced treatment designed to stabilize and improve inmate function with the goal of possibly moving some of these men into general population and an outpatient level of care.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No change since previous visit. There is no process for review and consultation in place at this time. Mental health providers are not consulted prior to or following the imposition of disciplinary sanctions.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. A policy and procedure should be established to allow for an assessment by mental health staff of incidents potentially resulting in disciplinary sanctions in those inmates on the mental health caseload.
2. Input into the disciplinary process should be written and periodically monitored through a quality improvement process to determine if the disciplinary officer is collaborating with mental health staff in adjusting their sanctions when there are mitigating circumstances secondary to the person's illness.
3. Currently, there is no retrospective of use of force as part of the medical quality improvement process but such a process should be put in place.
4. Hire additional qualified mental health professional to ensure consistent and reliable involvement in this process.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: No change since previous visit; findings and recommendation remain the same.

The potential examination rooms in the housing units have still not been reestablished as appropriate examination rooms. This would require cleaning, the provision of both a table and chairs, as well as an exam table and appropriate medical equipment. Supplies to ensure sanitation should also be made available. Privacy screens may also be needed to ensure confidentiality during exams. We also looked at the space that is to be remodeled but no one has yet seen the official architectural plans, even though some construction is occurring.

RECOMMENDATIONS:

1. Reestablish clinically appropriate examination rooms in each of the housing units.
2. During our next visit, provide us with the architectural drawings for the new health care unit renovation.

MENTAL HEALTH FINDINGS: There is a private office within the medical treatment building for use by the psychiatrist. Currently the qualified mental health professional's position is unfilled, but it is anticipated that this staff person will have access to the smaller office next to the psychiatrist's office. An area in the treatment building, which is not sound private, has been created where small groups can be conducted. The lack of full privacy raises some concerns regarding confidentiality during group sessions.

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RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: The psychiatrist reported that she is only using the treatment plan form when asked for it by the courts because she does not have the time to complete this form for each inmate. She continues to do reports for the courts and was also acting as the interim medical director until Dr. Burton began on site two weeks before our June visit. In addition to her clinical assignments, she has been barraged by reviewing inmate materials from the Selma prison in California that houses the Virgin Islands inmates, as well as Department of Health competency reviews. The multiple demands on Dr. Sang's time prevent her from developing adequate treatment plans for all inmates as required by this Agreement.

RECOMMENDATIONS:

4th Assessment:

BOC should review all the tasks Dr. Sang is completing and give clear instruction to outside agencies regarding what should not be referred to the site psychiatrist but be handled through an outside agency.

Previous Recommendations Remain Appropriate:

1. Continue to monitor the plans to implement the new forms, modifications to the tracking case list including housing area, past visit and date of return to clinic.

2. Consider developing quality improvement process to monitor outcomes from data collected via the treatment forms.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: At the time of the second site visit a small housing area for the seriously mentally ill inmates was created (A-Unit). These inmates were interviewed in a group setting during the June visit. Several of the inmates were so psychologically impaired that, although they were physically present, they were unable to participate in the group process. Currently, there is extremely limited presence by a mental health professional on the unit. The new case management planner has visited only once or twice to begin working on case management issues. The officer's log indicates that Dr. Sang was on the unit only once, on May 30, 2014. There is absolutely no programming nor are there recreational activities on the unit. Supervision is by the correctional officer. Several inmates reported they spend most of their time sleeping. One positive change which has occurred since the time of our last visit, as reported to us by GGACF staff, is that this officer is now solely assigned to this unit.

Warden Redwood joined us for the meeting with the unit and expressed his interest in obtaining a television set for the unit and working with the mental health staff to improve conditions for these inmates. The only seating available in the dayroom area was two picnic tables with attached benches and one square spider table with four seats.

The inmates were enthusiastic about the possibility of therapeutic programming on the unit.
No mental health programming is currently available to the seriously mentally ill inmates, segregated mentally ill inmates, or the general population other than chronic care visits with the psychiatrist.

RECOMMENDATIONS:

4th Assessment

1. It is that the facility develop a description for A-Unit that would include admitting criteria and the components needed to create a therapeutic milieu. Since this is essentially a health services unit, control of movement in and out of this unit should be by authorization from the psychiatrist in cooperation with classification. This should be formalized into a policy and procedure that also outlines, at a minimum, the required number of activities per week driven by the inmates individualized treatment plans, frequency of psychiatry and mental health counseling individual visits, and the development of a multidisciplinary treatment team and time frames for review of treatment plans.
2. In order for mental health staff to conduct a variety of groups and activities throughout the facility, the facility should consider different types of correctional furniture that would lend themselves to the group setting. The psychiatrist on site can provide helpful input into the types of chairs and other equipment needed.

Previous Recommendations Remain Appropriate:

1. GGACF Mental Health Department should conduct a needs analysis and make recommendations to the Health Services Administrator, Medical Director, and Bureau of Corrections regarding required staff and other resources necessary to provide adequate services in both general population and segregated areas.

2. Comparable programming should be provided for female inmates and detainees as well.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: Dr. Sang has been reviewing patients on a regular basis and monitoring for the presence of side effects. A signed informed consent process is currently not in place. This is required under the Agreement but has not been submitted for approval. This Monitor is hopeful that the psychiatrist and I will have time to review medication practices in greater detail at the time of the next site visit.

A pharmacist consultant is onsite about one or two times a week for a few hours and is currently working on policies, licensure and formulary development. Reportedly, she will not be coming back until the new pharmacy construction is completed. It is unclear when this will be done.

However, no policies or procedures have been developed and approved for these practices, which causes this provision to remain in noncompliance.

RECOMMENDATIONS:

4th Assessment:

Ensure that duration of medication is included in all prescriptions and monitored appropriately.

Previous Recommendations Remain Appropriate:

1. A reasonable informed consent form should be developed and patient education documented.
2. A policy addressing the use of emergency and involuntary medication should be developed.
3. Improved methods of practice and a staffing and programs analysis needs to be completed.
4. GGACCF may wish to consider adding telepsychiatry to increase the availability of psychiatric resources by contracting with psychiatrists on the mainland who obtain licenses in the USVI. Of course, the latter would require capital investment in equipment and the development of a policy and procedures that would structure this type of service.
5. A reasonable informed consent form should be developed and patient education documented.
6. A policy addressing the use of emergency and involuntary medication should be developed.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: No change since previous visit. A training curriculum has not been submitted to and approved by the Monitor. Training has not been completed.

RECOMMENDATIONS:

4th Assessment:

1. A detailed curriculum should be submitted for review to the monitoring team and approval by the Monitor.
2. Once obtained, training should be implemented with pre-and post-testing or other performance measures that have been approved by the Monitor.

Previous Recommendations Remain Appropriate:

1. GGACF should ensure the training officer or her records are available at the time of the next site visit for review by the monitoring team.
2. Develop, implement, and evaluate comprehensive training curricula to comply with Provision.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: Inmates with serious and active mental illness continue to be placed in segregation, and in at least one case, without due process. On A-Unit (mental health housing), 9 inmates were interviewed and 5 reported being in lockdown on L-Unit at some point during their incarceration.

Also, the Monitor, a licensed and Board Certified mental health clinician, reported that he observed inmates presenting symptoms of mental health problems locked down in their cells. The Monitor reported several inmates presenting cognitive impairments manifesting in slowed speech, confusion, limited verbal responsiveness. The Monitor also reported some inmates presenting symptoms of a Major Depressive Disorder: flat affect, slowed speech and gate, anhedonia, poor hygiene, low energy, pessimism. It is obvious that these conditions of confinement and lack of adequate levels of qualified mental health staff create and exacerbate mental health problems for inmates.

RECOMMENDATIONS:

Previous Recommendations Remain Appropriate:

1. GGACF should develop a plan to introduce adequate programming for this population.

2. Increased out-of-cell time and life skills activities should be considered.
3. It is also recommended that all inmates with a serious mental illness should be seen in a confidential setting at a minimum of at least monthly by a psychiatrist and also monthly by a mental health counselor.
4. Weekly mental health rounds are also required for this population to identify mentally ill inmates housed in segregation who have not been referred for mental health services by sick call request or by officer referral.
5. GGACF is a facility that demonstrates fragmented communication and lack of inclusion at the table of critical professional staff when designing and attempting to implement new housing areas and programming. This seems to be a pervasive difficulty at all levels. Even when looking at the organizational chart for health services division, it is clear that the health services administrator does not have centralized authority for the management of the health services department. Rather, all functions and employees are placed beneath the medical director. This structure is problematic in several regards.

    a. Once again there is no Medical Director and the position must be filled without delay.
    b. Having the medical director be responsible for all personnel activities and administrative decisions for the service is a highly cost ineffective structure. The medical director should be responsible for the quality improvement program, policy and procedure development, and management and supervision of the clinical staff.
    c. The health services administrator should be responsible, at a minimum, for all personnel decisions not based on clinical performance and interface with the facility administration regularly. This would include the authority to dismiss personnel based on repetitive absenteeism, inability to follow facility policies, inappropriate behavior with inmates and staff, etc. In addition, they should oversee compliance with policy and procedure, supervise medical records, oversee pharmaceutical, equipment, and supplies availability and ordering. All directors (Medical, Nursing, Pharmacy, Dental, Mental Health) should administratively report to the HSA.
    6. These units need to be sanitized, wire grates should be replaced or removed since many are torn and have ragged metal edges. Sheets and other impediments to inmate observation should be removed.

VI. FIRE AND LIFE SAFETY

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS:. The Territory submitted on June 10, 2014 a draft policy intended to satisfy this provision, but this Monitor rejected it on June 13th due to inconsistencies, failure to include basic elements, and other problems, similar to the deficiencies with other draft policies noted throughout this report. No adequate fire and life safety policy currently governs GGACF. As a result, inmates and staff remain at risk of serious injury or death. Inmates continue to set fires inside their living units and the automatic fire suppression system remains inoperable.

Supervisor, housing unit, and incident logs, and monthly disciplinary reports indicate there were at least 17 fire and/or arson events inside housing units between January 1 and June 16, 2014. Although there appears to be some reporting inconsistencies between the documents examined, reconciliation of these records indicates the following:

Reported Fire Incidents	Incident Logs	Housing Unit Logs	Monthly Disciplinary Reports
Jan-14	0	10	
Feb-14	1	4	
Mar-14	2	0	2
Apr-14	0		0
May-14	0		0
Jun-14	1		
Totals:	4	14	2

On May 30, 2014, the Territory submitted to this Monitor documents demonstrating some efforts towards compliance with this provision. These included:

1. Fire drill calendar for October 2013 thru December 2014
2. Two fire drill exercise reports for March 13 and 28, 2014

The fire drill calendar shows fire and emergency drills occurring as follows:

1. **December 18, 2013 – Simulated Fire Drill, Unit Charlie 9 Delta**
2. **March 12, 2014 – Simulated Fire Drill, Unit Alpha 9 Bravo**
3. **March 28, 2014 – Evacuation Fire Drill, location illegible**
4. **May 5, 2014 – Evacuation Fire Drill, Units India / Juliette**
5. **May 29, 2014 – Evacuation Fire Drill, Units Gulf / Hotel**
6. **June 2, 2014 – Table Top Fire Drill Exercise for BOC Senior Staff**
7. June 23, 2014 – Full Scale Total Evacuation Fire Drill (scheduled)
8. July 11, 2014 – Simulated Fire Explosion, GGACF Kitchen (scheduled)
9. July 28, 2014 – Evacuation Fire Drill Kitchen and Laundry (scheduled)
10. September 24, 2014 – Evacuation Fire Drill at GGACF Housing Unit / Administration (scheduled)
11. October 8, 2014 – Chemical Fire Drill at GGACF w/ Haz-Mat Response (scheduled)
12. November 6, 2014 – Table Top Exercise w/ Medical Response (scheduled)
13. December 17, 2014 – Fire Drill Exercise at GGACF, Full Response (schedule)

However, the Monitor has not received any notification that the above drills were completed, with the exception of two reports – one for March 13, 2014 and one for March 28, 2014. The fire drill reports show some positive efforts. The reports included a description of the event scenario and specific notification protocols. The chronology of events provided shows a systematic approach was used to evaluate the exercise by qualified evaluators. Although some competencies were not tested (see section VI.1.c below), this is a positive first step. Unfortunately, however, the March 13 exercise ended prematurely due to fight between an officer and inmate. The March 28 exercise report indicates the fire drill was completed successfully.

The outcome of the March 13 exercise is another example of how inadequate staffing levels can thwart GGACF's best efforts to comply with life and fire safety provision of the Agreement. Inmate disturbances during emergency exercises are not unusual and should be taken into account during exercise planning and execution. Emergency exercise scenarios for correctional facilities should incorporate responses to inmate disturbances, provide adequate staffing levels to respond, and complete the exercise as planned. The March 13 exercise provides clear evidence that GGACF, due to inadequate staffing levels, is unprepared to effectively protect staff and inmates from such emergencies. This condition must be corrected without delay.

Findings in the previous report remain appropriate:

Although the Fire Marshall is involved in fire safety program planning and inspections, the fire safety program lacks the following minimum elements:

- Policies and procedures
- An adequate fire suppression system for occupied buildings
- An adequate, policy-driven and competency-based training policies, procedures or curriculum
- Quarterly fire drills for all staff
- Multiple and easily accessible fire escape doors and pathways
- Fire response breathing apparatus for officers

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

1. Develop, train, implement, and evaluate a comprehensive life-fire safety program that includes all policy, procedure, resources, equipment, training, monitoring, and system/programming testing components.
2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.
3. Train all staff on this plan.
4. Install SCBAs or an appropriate alternatives at all locations where staff would need to search for or evacuate people.
5. Conduct and document quarterly fire drills for all shifts and document those activities.
6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.
7. Additional part-time fire safety officers should be selected from the officer corps, trained, and participate in the administration of a comprehensive fire safety program. It is unrealistic to expect one expert to develop and oversee such a complex program.
8. Supervisors should conduct routine, scheduled and unscheduled physical inspections of occupied structures, taking particular note of fire risks and hazards, document and report those findings to administration for timely and appropriate corrective action.
9. The fire inspection program must be clearly detailed in fire safety policies and procedures, and become a fundamental element of pre-and in-service training.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No changes. As stated in the previous report:

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

An adequate supply of handheld fire extinguishers were found in housing units, kitchen areas, the medical unit, and shops. All devices were tagged showing current inspections and all gauges showed positive pressures.

RECOMMENDATIONS:

1. Refer to recommendations above (a).
2. Consider purchasing fire safety program software from NFPA and/or the American Correctional Association to assist in program development and monitoring.
3. Continue to support fire safety officer.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: None of the fire drills reported incorporated competency in the use of fire and life safety equipment or use of emergency keys by touch as required by this provision. This should be corrected, and demonstration of such competency should be included for all future drills.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to previous recommendations for this provision.
2. Develop and implement a valid and reliable emergency key system as described above. Train and drill staff as discussed on system use.
3. Develop emergency key and locking mechanism inspection and reporting system as discussed above.
4. Implement competency-based staff training as discussed above.
5. Exercise fire safety program using onsite, scenario-based drills; include community responders in exercise planning and exercise events.
6. Send the training officer and part-time fire safety officers to the National Fire Institute, National Emergency Training Center, Emmetsburg, MD for additional training.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since previous reports. During this inspection, as previously described, some of the Housing Unit locks were found non-functional. However, the maintenance coordinator was not available during this assessment to discuss maintenance plans and progress. Additionally, the remote cell-lock technology remains inoperable and does not provide for remote locking and unlocking of the cells. This is partly why all cell locks must be reliably functional and maintained. Log books continued to note that certain emergency exit doors are inoperable.

RECOMMENDATIONS: Previous recommendations remain appropriate:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No substantive change since previous assessment.
No records were provided to verify that all staff have been trained and tested on safety procedures. The two fire drill exercise reports do not document what emergency procedures were exercised, and do not document that all staff were tested during these events or that their competency regarding GGACF policies was evaluated

RECOMMENDATIONS:

1. Develop / revise written emergency plans, policies, and procedures as required.
2. Test all staff on knowledge and application of emergency procedures.
3. Maintain records proving that staff have been trained and tested on emergency procedures. GGACF officials should create a statistical report showing percentages of staff who have and have not completed required testing.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The fire reporting and notification system remains operable. There is no audible fire alarm system at GGACF. Currently, the only means of adequately detecting and responding to fire emergencies is having an officer physically present at the scene of the emergency. Staff must then rely on operable portable radios, but there are still instances when a single housing unit officer does not have radio. Moreover, housing unit telephone systems remain unreliable.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. All officers must be provided operably reliable radios and communications equipment at all times while on duty.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: The March 2014 emergency exercise reports demonstrate positive efforts to comply with this provision. However, those are the only two reports submitted, and for one of the two exercises, the exercise was cancelled part way through. It is therefore inadequate to

rely on those two reports for evidence of compliance with this provision. It is important that all housing units, staff, and inmates participate in emergency evacuation exercises as required.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to previous recommendations for this provision.
2. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.

h. Fire suppression;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No change since previous visits. There remains no functional fire suppression system in the housing units other than fire extinguishers. This system must be made fully operational, regularly tested and maintained.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to previous recommendations for this provision.
2. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.
3. Ensure that the fire suppression system is fully operational, regularly tested, and maintained.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Neither of the March 2014 emergency exercises reported involvement by medical staff. Medical staff should be involved in future exercises so that they are aware of their obligations.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. The comprehensive fire safety program development must involve health care leadership to ensure that policies and procedures include adequate provisions for timely medical and mental health response to persons injured during a fire event.
3. Medical and mental health staff should be appropriately trained in relevant fire safety program components and drilled quarterly to ensure compliance with program response requirements.
4. Policy components involving medical and mental health staff should provide for their safety and security when involved in fire incident responses.
5. Qualified medical staff should participate in the development of fire program training topic that involves burns and smoke inhalation concerns. Qualified mental health staff

should participate in the development of training related to critical incident recovery and emotional injury and recovery.

j. Control of highly flammable materials.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: There were at least two inmate-caused housing unit fires reportedly occurring on March 24, 2014. In both of these events the inmates reportedly started fires outside of their cell doors. An inspection of these cell areas by this Monitor found large fire-scotched stains just outside these cells, indicating that these were very hot fires. Inmate used combustible items from their cells to ignite both fires. The risk of serious harm or death remains extremely high; the fact the inmates are left locked in their cells for long time periods with no officer in the housing unit further exacerbates this risk and begs for: expeditious increase in staffing levels; removal of combustible items from inmate cells; and repair of the automatic fire notification and suppression system.

As stated in the previous report:

Inmates continue to be allowed to possess quantities of combustible products in their cells. Although some of these items might be acceptable in a facility having adequate fire detection, response, and suppression systems and programming, GGACF conditions should not allow inmates to maintain large quantities of these items in their cells.

RECOMMENDATIONS:

1. Refer to previous recommendations for this provision.
2. Develop a formal writing "Combustion Control and Prevention Plan" component to the comprehensive fire safety program that includes regular and documented inspections and removal of combustible materials (solids, liquids, gases) from all areas and structures. Maintain a current inventory and tracking report of materials and locations, corrective actions and mitigation efforts.

VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

GENERAL COMMENT: No substantive improvement from previous assessment.

On May 30, 2014, the Territory submitted to this Monitor for review a Safety and Sanitation Assessment that was completed on May 25, 2014. This report states that this assessment was conducted of all housing units at GGACF but does not include units A, RSAT, and Intake. This assessment focused on mold infestation in the housing units but included other findings pertaining to structural integrity, cleanliness, and general repair. This assessment reported the following problems:

1. 9-Alpha — Multipurpose area showing severe signs of structural deterioration due to leaks in roof.
2. 9-Bravo — Unit showing signs of mold.
3. 9-Alpha/9Bravo — Showers need heavy cleaning.
4. 9-Charlie — Mold in sally port and shower doors are falling apart; need immediate repairs.
5. 9-Delta — Unit has signs of mold. Detainee in Cell#25 complained that his cell has mold; however, upon Inspection no mold was found.
6. Gulf/Hotel — Areas of roof with mold and also signs of algae where water was accumulating.
7. India/Juliette — No visual signs of mold were observed, however, showers need heavy cleaning.
8. Kilo/Lima — Heavy stain spots in ceilings of housing units that come from water leaking in roof.
9. In all showers in units that were not tiled there are heavy signs of mold as part of the remediation process. These showers should be tiled immediately.
10. GIST Office — Mold in ceiling tile at entrance to office.
11. Classification Unit — No visual signs of mold, however, mold spores might be present in the air and this situation can easily be remediated with an air purifier.

This assessment is consistent with observations of this Monitor during this onsite assessment. No remedial action plan was submitted to deal with these environmental issues.

Additionally, findings from the previous assessment indicate no significant change. As stated in the previous report:

Policies and procedures required under this Provision have not been provided to the Monitor or USDOJ for review and approval. However, it is important to note positive efforts continue to be made by the Territory to improve certain environmental conditions that were observed during this assessment.

In general, the housing units and most of the cells appeared cleaner; inmates and staff reported a "major effort" to steam clean housing areas. Notwithstanding other environmental improvement required in the kitchen area (broken tiles, deep cleaning of floors; equipment; vent hoods, etc.), the kitchen looked much cleaner and the tool/utensil cage was locked. Most of the housing units previously reported in need of repair were repaired, some with fresh paint. Efforts were made to provide hot water in the housing units but the water felt just above room temperature to the touch and may simply require thermostat changes. A review of the maintenance logs evidence timely inspection of generators, Grease-traps, and some lock repairs. These findings show positive effort to develop a strategic approach to improving environmental conditions and should be expanded to all facility areas and promulgated into well written policies and procedures.

1. *There is no hot water in the housing units, which creates serious health and sanitation risks for staff and inmates. Take necessary steps to ensure units are provided with sanitary hot water.*
2. *Many sinks in the cells were inoperable.*
3. *Some of the toilets did not flush properly.*
4. *Inmates are allowed to wash their clothes and linens in the toilets and/or sinks, then hang them to dry on clotheslines anchored to inoperable fire sprinklers in their cells.*
5. *Standing water was found in housing units and cells. Inmates and staff state that housing units will flood during heavy rains.*
6. *A few shower heads remain broken, some shower stalls remain covered with mold, as were ceilings and cell-block walls.*
7. *Mold remains on housing unit ceilings, maintenance closets, pipe chases, recreation areas, some areas in the kitchen.*
8. *Housing unit temperatures will rise in the hotter season which, combined with high humidity, can promote and spread infectious diseases, exacerbate certain chronic medical and mental illness, promote inmate frustration and violence, and dissuade correctional staff from leaving air-conditioned control rooms to conduct housing unit inspections, rounds, and security checks. High temperatures also pose very serious health risks to inmates on certain psychotropic medications current being administered to inmates.*
9. *Food trays being filled in the kitchen with food were still drying after being washed. Overall sanitation in the kitchen has improved some but remains in need of regular deep cleaning.*
10. *Housing unit water is essentially undrinkable and inmates are unable to access water when locked in their cells without the assistance of the housing unit officer. I was told by inmates that there are times when officers will not respond to requests for water or are away from control rooms for extended periods. This is evidenced by officer logs where officers have recorded leaving their units completely unattended to take breaks and/or where no relief officer was available. Unit logs also report a practice of "last call for water". This practice evidences that inmates do not have consistent access to potable drinking water.*
11. *Many of the inmate mattresses appeared old, tattered, and filthy but the Territory has purchased new mattress for distribution. Inmates and staff stated that mattresses are not routinely cleaned or disinfected during and between uses. Linens are allowed to be washed in toilets and hung to dry as previously described.*
12. *There is no written formal sanitation inspection and/or infection control program.*

13. *The facility appears inadequately staffed to provide adequate monitoring, oversight, and response to routine or emergency sanitation conditions or maintenance issues.*

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

ASSESSMENT: PARTIAL COMPLIANCE – No substantive change since previous assessment.

FINDINGS: The maintenance coordinator was not available during this assessment. Formal housekeeping and sanitation plans remain under development as stated in the previous assessment report. Formal plans should be completed and issued in the form of policies and post orders.

To its credit, however, the Territory appears to have maintained the measure of improved cleanliness as described in the previous report:

Most of the housing areas and cells were cleaner; fewer occupied cells were cluttered with empty food cartons, excessive personal items, and there was a noticeable decrease in the number of cell clotheslines as previously reported, but some inmates continue to use broken fire sprinklers to anchor the lines hanging across their cells. This effort should be consistently maintained and include other housing and cells areas found unacceptable.

The juvenile housing area still has vegetation growing through cell windows, and dirty sinks but rubbish on the floors was reduced greatly. The RSAT unit was in similar condition as the juvenile unit. Both units appeared to have mold growing on ceilings and shower areas. The A-unit was in a similar state of cleanliness with areas of mold and disrepair.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Replace, repair, and install reliable sinks in all cells and housing areas that provide safe drinking water for inmates.
2. Prohibit allowing inmates to use toilets, sinks, and described clotheslines for cleaning clothes and linens.
3. Laundry exchanges of clean, institution issued linens and clothing, should occur at least twice per week.
4. Replace, repair, and install working shower heads and plumbing to provide reliable personal hygiene, adhere slip-resistance materials at shower entrance points to reduce fall risks, repair water draining to eliminate standing water in unit and cell floors.
5. Develop a mold control/mitigation plan that includes routine inspection and cleaning activities. Control access to related cleaning chemicals and train staff and inmates in the proper use and storage of those chemicals.
6. Develop and implement a sanitation management plan that monitors and mitigates sanitation problems and hazards.
7. Improve practices involving mattress cleaning and ensure inmates and staff involved in this program are trained in proper cleaning methods and use of materials and chemicals. Ensure mattress storage areas are sanitary at all times.

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

b. Adequate ventilation throughout the facility;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

The lack of constant reliable access to drinkable water further prevents GGACF from ensuring that inmates live in a healthy environment. Many of the cell sinks were still inoperable and inmates rely on officers to provide water before and during lock down. Access to drinkable water is generally available during the "out of cell" periods but inmates must rely on the presence and actions by officers following lock down. Inmates have no access to drinkable water when there are no officers on the units to provide it and water from cell-sinks is considered not safe for drinking.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Timely complete an air quality assessment performed by a qualified provider.
2. Implement necessary improvements that reduce housing area and cell temperatures and increase air flow.
3. Ensure inmates have constant access to drinkable water.
4. Medical and mental health staff should monitor all inmates for heat and airflow-related health risks. All inmates in segregation or who are locked in their cells should be monitored by medical and mental health staff for signs of health conditions.
5. Train all staff in detecting and responding to health conditions related to heat and air circulation contributors.
6. Install environmental health condition monitoring devices, e.g., temperature, humidity, and air quality readers. Require regular monitoring and recording of readings and take timely action to mitigate environmental conditions that create health risks caused by those conditions.
7. Ensure that adequate amounts of drinkable water is always available to inmates.
8. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

c. Adequate lighting in all prisoner housing and work areas;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: The Monitor was pleased to see that all but one of the external perimeter security lights were functioning. However, many of the occupied cells remain very dark, as stated in the previous report. Dark cells create very dangerous conditions for staff and inmates because high

visibility into the inmate cells is fundamental for effective safety and security. Additionally, some inmates continue to block their cell door windows and hang blinds in their cells. These conditions must be permanently corrected without delay.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Develop a comprehensive campus/facility lighting plan that ensures constant illumination of all required internal and external perimeters, housing areas, support services structures and areas.
2. Maintain an ongoing lighting repair log that evidences repair activities.
3. Ensure rapid repair and replacement of inoperable lighting, add additional external and internal illumination where indicated by a comprehensive security lighting needs assessment.
4. Provide for adequate staffing levels to support lighting plan and maintenance.
5. Increase illumination in all occupied cells for improved security and inmate wellness.
6. Prohibit inmates from blocking cell door windows and from erecting anything in their cells that impedes good visibility from the cell door window.

d. Adequate pest control for housing units, medical units, and food storage areas;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: There has been no change since previous inspections and this provision remains in Partial Compliance has no decline in performance was found. Additionally, inmates housed in RSAT and Intake units again reported "constant" mosquito problems. An inspection of these cell areas again found broken and missing cell window screens that should be replaced.

RECOMMENDATIONS: Previous recommendations remain appropriate

1. Review, revise, develop, train, implement, evaluate environmental pest control policies and procedures that provide for both incidental and scheduled pest control inspections and mitigation.
2. Ensure that inmates involved in pest control activities are properly trained, equipped, and clothed for requirements of those activities.
3. Replace all missing and broken unit and cell window screens to prevent access by insects.

e. Prisoner and clinic staff access to hygiene and cleaning. supplies;

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

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

RECOMMENDATIONS: Continue to implement these recommendations:

1. Ensure that all inmates have access to hygiene products upon admission to the facility.

2. Continue to provide adequate supply of these personal care items in control pods or housing units to ensure timely exchange of use-for-new products.
3. Prohibit inmates from bartering these supplies and from hoarding empty containers in their cells and living areas.

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No substantive change from previous assessment. Related policies and procedures have not be submitted for review by this Monitor.

RECOMMENDATIONS:

1. Develop, as part of medical infection control policies and facility sanitation plans, a comprehensive bio-hazard control plan that includes:
   A. OSHA and CDC standards and protocols for biohazard safety and exposure control;
   B. Written and enforced procedures and protocols for biohazard handling; cleaning, disposal, storage, inspections, and clean-up;
   C. Staffing and inmate training on the plan and proper handling and disposal of biohazards;
   D. Consistently maintain adequate supplies of feminine hygiene products and disposal bags for all biowaste;
   E. Locate adequate supplies of bio-hazard disposal and clean-up supplies in or at all locations where biological waste and/or spills do and could occur;
   F. Provide appropriate clean-up apparel and training in the use of that apparel.
   G. Commence deep cleaning of all housing and cell area walls, floors, showers, and other living areas to remove all dried bio-products and waste. Do the same in the kitchen, medical areas, intake, and all washrooms throughout the facility.
   H. Develop a biohazardous control program that involves regular inspections of all potential contamination areas.
2. GGACF officials should consult an environmental specialist to assess these conditions and assist them in developing appropriate mitigation plans and policies.
3. This provision can advance to Substantial Compliance once related policies and procedures have been approved and implemented according to the Agreement.

g. Mattress care and replacement;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Several inmates were issued new mattresses but other inmates still use tattered and unsanitary mattresses. This provision can move into Partial Compliance once all inmates are issued new and/or intact and clean mattresses.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to previously discussed sanitation recommendations.
2. Consider replacing all mattresses with those that are more bacteria-resistant.
3. Complete a full inventory of non-usable mattresses and remove them from the supply.
4. Do not issue mattresses to inmates until after properly inspected for damage and contraband, cleaned and sanitized.
5. Maintain reliable records that verify mattress inventories, cleaning and maintenance requirements.

h. Control of chemicals in the facility, and supervision of prisoners who have access to these chemicals;

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No substantive change since previous assessment. Implementation of approved policies and procedures, and a quality assurance tracking system will aid in advancing this provision to Substantial Compliance.

RECOMMENDATIONS:

1. Develop comprehensive control plans for cleaning supplies and chemicals, chemical inspections, inventory control, and inmate training in use of supplies. Ensure adequate record keeping, monitoring, and property control logs.
2. Ensure the cleaning chemical control plan is coordinated with medical staff for harmful exposure mitigation, response, and recovery protocols.
3. This provision can advance to Substantial Compliance once related policies and procedures are approved and implemented according to the Agreement.

i. Laundry services and sanitation that provide adequate clean clothing, underclothing, and bedding at appropriate intervals;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Housing unit/cell inspection and inmate interviews found no substantive improvement. As stated in previous reports, inmates continue to routinely wash personal and issued clothing in cell sinks and toilets, and dry these items in their cells using clotheslines anchored to fire sprinkler heads, walls, window frames, bunks, etc. This Monitor also observed soiled bed linens, no linens, tattered and dirty mattress, and mattresses with no covers in several occupied cells.

RECOMMENDATIONS:

1. Cease the practice of allowing inmates to wash personal and issued clothing in toilets and sinks.
2. Cease the practice of allowing inmates to dry clothing on make-shift clotheslines in their cells.

3. Routine and consistent replacement of damaged mattresses, mattress cleaning, cleaning of bedding.
4. Review, revise, develop, train, implement, and evaluate a comprehensive laundry management plan that governs total laundry operations.
5. Develop specific policies and procedures for handling, containing, and washing contaminated clothing, linens, and mattresses.
6. Consider replacing all wood laundry carts made of non-absorbing materials that can be sanitized and completely cleaned. Discontinue the practice of moving laundry on carts that has not been cleaned and sanitized.
7. The initial issue of inmate supplies should include, at minimum: one (1) corrections issue shirt/pants, jumpsuit, undergarments, towel, bedding, mattress, sheet and blanket. Clothing should be exchanged with clean items twice per week at minimum, sheets and towels once per week at minimum. Blankets should be exchanged monthly at minimum. Any clothing, linens or bedding should be changed immediately if they appear damaged and/or unsanitary, or appear to present a risk to health.
8. Ensure that inmate handbooks provide clear rules and information about the laundry program, how to access clothing, linens, and bedding. Cease the practice of allowing inmates to wash clothing in housing unit or cell sinks and toilets.
9. Staff and inmates involved in the laundry work program should be properly trained and supervised.
10. Laundry equipment should reliable and properly maintained.

j. Safe and hygienic food services, including adequate meals maintained at safe temperatures along with cleaning and sanitation of utensils, food preparation and storage areas, and containers and vehicles used to transport food;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: An assessment of the kitchen was not performed during visit due to time constraints. The above compliance score is based on the aggregate of previous reports and the fact that no progress was reported in the Territory's May 15, 2014 Status Report.

RECOMMENDATIONS: Previous recommendations remain appropriate. This provision can advance to Partial Compliance when policies and procedures addressing recommendations are approved and implemented per this Agreement.

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

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

3. GGACF officials should review food service requirements promulgated by the National Correctional Association and National Commission on Correctional Health Care.
4. Develop a food service training program that includes inmate and staff training records and ensure that all training is well-documented.
5. Policies and procedures developed should include controls for the use of caustic, toxic, and hazardous materials used in the kitchen. Material Safety Data Sheets should be posted conspicuously.

k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: No improvement was observed in the housing units during this assessment. Several cell sinks remain inoperable, inmates do not have consistent access to drinkable water following lock-down; they have no access to water at all when locked down and there are no officers working in housing units.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Refer to recommendations regarding sanitation and this provision.
2. Develop and implement a corrective action plan that ensures inmates have consistent and reliable access to safe drinking water.
3. Ensure that all inmates are provided consistent access to sanitary drinking water.

VIII. TRAINING

Defendants will take necessary steps to train staff so that they understand and implement the policies and procedures required by this Agreement, which are designed to provide constitutional conditions.

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

a. **The content (i.e. curricula) and frequency of training of uniformed and civilian staff regarding all policies developed and implemented pursuant to this order;**

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Required policies and procedures have not yet been submitted to this Monitor for review. Additionally, the BOC training director was (once again) not available during this assessment to review this provision and discuss progress. No records have been provided to this Monitor evidencing compliance with this provision.

The following discussion from the previous report regarding training curriculum remains appropriate to remind Territory officials of content and processes involved in developing efficacious training curricula:

Training curriculum is a total package of learning activities designed to achieve the objectives of the training program. In a competency-based system, the objective, or desired end, is that trainees will acquire the specific knowledge and skills (competencies) they need to do their jobs. There are three primary components to be examined when evaluating any training curriculum. They are:

1. *the content or information to be transmitted*
2. *the organization of the curriculum which includes*
   - *structure, format, and sequencing*
   - *the training methods used*

Training Content

Compliance requires that content include specific information, facts, attitudes, and skills to be transmitted by the training program. In a competency-based system, which is defined as "Training" in the Agreement, these are formalized in the competency statements containing measurable training outcomes. The following principles relate to training content:

1. *The scope and depth of the content of any curriculum are determined by the competencies the curriculum is designed to teach.*
2. *Content should transmit a theoretical framework and conceptual rationale for the training.*
3. *Content should reflect best standards of practice.*

4. *Content should communicate a values orientation.*
5. *In an in-service training program, the content must be applicable to direct practice.*
6. *The content of a curriculum must be congruent and complementary both within and between sections.*
7. *Content must clearly distinguish knowledge competencies and knowledge application competencies.*

Structure and Format

This refers to the construction of individual sections, and the organizations of the parts of the curriculum into an integrated whole. It includes the design of each section to achieve objectives, the sequencing of sections and activities, establishing time frames, and designing linkages between sections.

The sequence of activities within each section and within the curriculum as a whole should be concordant with the natural learning process and measureable learning outcomes.

Knowledge and skills that are conceptually related, or that are performed together on the job, should be taught together.

Providing a broad overview of the content early in the sequence provides a conceptual framework within which trainees can organize the parts. This facilitates retention and understanding.

Principles of sequencing are: from simple to complex, from the universal to the exception, and from fundamental to more refined applications:

1. *Repeating key concepts in different contexts facilitates understanding.*
2. *Relating sections within a curriculum helps develop logical linkages between previous and current training content, and identify different situations in which similar knowledge and skills are applied, which helps to reinforce retention and promote generalization.*

Planning adequate time to cover the content to the desired level of depth is essential. Compression of content into an unrealistic time segment limits the effectiveness of the training. It can't be done faster than it can be done.

Training Methods

Training methods are the strategies used to transmit the content and to promote learning and retention. In an in-service training curriculum, the training methods must be appropriate for use with adult learners in an applied setting. The method that is best suited to achieve the objective of the section should be selected accordingly:

1. *Use presentation to quickly transmit factual information.*
2. *Use discussion to promote greater exploration of the information and to develop understanding.*
3. *Ask questions of trainees or use exercises that feed information back to the trainer to determine how well trainees understand the content.*
4. *Use experiential exercises to develop self-awareness.*

5. *When trainees have prior knowledge or preconceived ideas about the content, use an activity that challenges mindsets and motivates trainees to rethink their own beliefs.*
6. *Use exercises and simulations to promote application of the content to job tasks, and to develop trainee skills.*
7. *Use activities that identify solutions to potential barriers in the workplace and action planning to promote TOL from the workshop back to the job setting.*
8. *Present the same concepts using a variety of learning strategies to help ensure that trainees with different learning styles can assimilate the knowledge. Hearing, seeing, modeling, and then practicing the training content also reinforces learning for individual trainees.*
9. *As determined appropriate, training should be conducted in housing units or other locations where the information is applicable.*

Ultimately, this provision asks for a/the training "curriculum," which has not been provided as required and possibly does not exist, based on the training documents provided. The documents provided, as stated above, would not qualify as curriculum by definition. The training materials provided appear to be outdated reading materials involving a blend of some basic and special topics. The materials provided are considered "canned" resources purchased off the internet from Lockup USA, a company that specializes in producing correctional training videos that includes study reading materials. A review of that website (http://www.lockupusa.com/). This During the previous assessment, this Monitored accessed and reviewed several training videos for corrections and non-corrections staff. Although the website allowed only partial viewing of training videos, their content appeared to provide meaningful training information for basic and in-service training purposes. However, neither the videos nor supplemental reading materials qualify as curriculum but are considered training supplements that would support a written curriculum if it exists. The Monitor has provided Territory officials curriculum document samples for review and consideration.

Training Materials

Training materials must support the overall curriculum and expected learning outcomes. This can be achieved:

1. *Ensure that training materials include all updated policies, procedures, regulations, forms and documents.*
2. *Ensure that training materials are current and related to subject outcomes.*
3. *Ensure that the materials are appropriate for adult learners and support trainee learning styles and abilities.*
4. *Ensure that training materials support Agreement requirements and Provisions.*

RECOMMENDATIONS: Previous recommendation remain appropriate, also:

The Territory should reach out to the University of the Virgin Islands' Graduate School of Education (Curriculum and Instruction) for assistance in developing adequate training curricula. This Monitor has done this with other universities and found such assistance invaluable and very inexpensive.

1. Written training policies and procedures should be developed and implemented to govern pre-service, in-service, and ongoing training or corrections and civilian staff. The following are a few recommended elements for training program policies and procedures:

   A. Training program mission statement, goals, objectives, and operating procedures;
   B. Written, understandable, and measurable;
   C. A training program written code of professional standards and ethics;
   D. Employees participate in formulation of policies, procedures, and practices;
   E. The training program is adequately staffed with qualified training and support staff;
   F. There is a written organizational plan that depicts training program structure, lines of communication and authority;
   G. Training records management and control;
   H. Descriptions and roles of the agency, public, and private training agencies and/or organizations involved in training development and implementation;
   I. Authorization and description of off-site training facilities;
   J. Regularly scheduled meetings between training leadership and agency leaders for program coordination and management purposes;
   K. A system for monitoring training program methods, content, and outcomes;
   L. Training program funding and space;
   M. Training program role in staff recruitment, selection, training, re-training, promotion, dismissal;
   N. Prohibitions against and consequences resulting from staff and student misconduct related to training functions and activities;
   O. Adequate equipment and supplies are available to develop, prepare, administer, and evaluate training program and services;
   P. Appropriate accommodations are available for disabled and/or impaired students;
   Q. Training curricula and plans are developed, evaluated, and updated based on a valid assessment of staff performance that identifies current job-related training needs;
   R. Ongoing formal evaluation of pre-service, in-service, and specialized training program conducted and/or sanctioned by the agency;
   S. Adequate reference materials are available to program staff and learners;
   T. All courses provided include attendance records, lesson plans, instructor name, course evaluations, methods for demonstrating topic proficiency and test results; records of certificates or completion verification;
   U. Methods that protect the integrity of testing and assessment processes;
   V. Courses are based on competency-based curriculum supported by appropriate materials and course resources;
   W. All instructors are qualified to teach course topics; instructors teaching uses of force, first aid, weapons use, etc. are currently certified to instruct such courses;
   X. Use of force training includes non-physical, physical, and appropriate use of authorized weapons, force levels, justification, etc.;
   Y. Training topics, content, proficiency, and hours/weeks of training is established for pre-service, in-service, and specialized training;
   Z. Firearms training covers use, safety, and care of firearms and the legal and ethical constraints on their use. Training includes knowledge and performance, and is assignment specific (e.g. use of weapon in various settings, conditions, areas);
   AA. Chemical agent training covers the use and handling of chemical agents, as well as the treatment of persons exposed to a chemical agent;

BB. Emergency responders are available to timely respond to training incidents involving injury.

CC. Access the American Jail Association, American Corrections Association, and National Institute of Corrections training libraries for more resources for designing, developing, implementing, and evaluating policy driving training curriculum for adult learners.

2. Training plans should be developed for all revised and new policies and procedures required under this Agreement. These plans should include methods for determining content proficiency as defined in this agreement. The use of pre and post tests and visual demonstration of applied topics should be used in measuring topic competency.

b. Pre-service training for all new employees;

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

FINDINGS: Similar findings as discussed above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

FINDINGS: Similar findings as discussed above.

RECOMMENDATIONS:

1. Provide the Monitor all training program policies and procedures.
2. In the absence of training program policies and procedures, develop such policies and procedures.

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

IX. IMPLEMENTATION

1. **Defendants will begin implementing the requirements of this Agreement immediately upon the effective date of the Agreement. Within 30 days after the effective date, Defendants will propose, after consultation with the Technical Compliance Consultants ("TCCs"), a schedule for policy development, training, and implementation of the substantive terms of this agreement. The schedule shall be presumptive and enforceable until the Monitor is appointed.**

FINDINGS: The Territory has failed to meet many deadlines in the Court-approved schedule. On July 11, 2014 the Territory requested from this Monitor a 90-day extension to all deadlines that were not yet missed (i.e., deadlines that were after July 11, 2104). The Monitor approved this request but later modified that decision in part, requiring new timelines for any items pertaining to provision of adequate staffing. The Monitor required that those items be completed in 45 days. The United States is seeking Court resolution regarding the Territory's failure to meet deadlines prior to July 11, 2014, for which no modification request was submitted.

2. **Upon appointment, the Monitor will adopt the schedule as proposed or as amended by the Monitor after consultation with the parties and the TCCs. Either party may seek a modification to the schedule by making a request to the Monitor, or the Monitor may modify the schedule as necessary. If the parties disagree with each other or with the Monitor and cannot resolve it with the Monitor, either party may submit the dispute to the district court.**

FINDINGS: As stated above.

3. **Defendants will implement every policy, procedure, plan, training, system, and other item required by this Agreement. Each policy required by this Agreement will become effective and Defendants will promulgate the policy to all staff involved in its implementation within 45 days after it is submitted to the United States, unless the United States or the Monitor provides written objections. The Monitor will assist the parties to resolve any disputes regarding any policy, procedure, or plan referred to in this document. If the parties still cannot resolve a dispute, either party submit the dispute to the district court.**

FINDINGS: The Territory submitted to this Monitor and the USDOJ several policy and procedure draft documents during this reporting period. However, following a review of certain documents, the Monitor rejected all submitted drafts without further review. In the Monitor's opinion, the documents reviewed were so devoid of basic document requirements and littered with formatting, spelling, and grammatical errors that reviewing and commenting on each document submitted was an inefficient and inappropriate use of the monitoring budget. This Monitor advised Territory officials to submit only documents that contained those basic elements and provided technical assistance for doing so.

4. Defendants will conduct a semiannual impact evaluation to determine whether the policies, procedures, protocols, and training plan are achieving the objectives of this Agreement and to plan and implement any necessary corrective action. The Monitor will assist Defendants in identifying and analyzing appropriate data for this evaluation. The evaluation and all recommendations for changes to policies, procedures, or training will be provided to the United States and the Monitor.

FINDINGS: The Territory submitted to this Monitor is semiannual impact evaluation report on April 15, 2014. The plan includes a summary of Major Initiatives as well as a descriptive narratives for each provision reporting progress efforts. These descriptions, however, do not describe evaluative impact outcomes as stated in this requirement. This is somewhat expected due to lack of progress in meeting substantive requirements of the Agreement. This Monitor will continue to assist the Territory to develop qualitative and quantitative measures for evaluating progress and compliance as requested.

5. Defendants may propose modifying any policy, procedure, or plan, provided that the United States is provided with the 14 days' notice in advance of the action. If the United States or the Monitor provides written objections, the Monitor will assist the parties to resolve any disputes regarding these items. If the parties still cannot resolve a dispute, the parties agree to submit the dispute to the district court.

FINDINGS: As stated previously.

6. Defendants shall provide status reports every four months reporting actions taken to achieve compliance with this Agreement, Each compliance report shall describe the actions Defendants have taken during the reporting period to implement each provision of the Agreement.

FINDINGS: The Monitor received from the Territory a status report dated May 15, 2014. The limited volume of information contained in this report supports this Monitor's conclusion that little progress has been achieved. The Monitor expects that these reports will be much more detailed going forward. Repeated, general responses to each provision will not be accepted. The Territory is expected to adequately assess its own progress towards compliance and what actions it is currently taking or it is expecting to take in the future with regard to each provision.

7. Defendants shall promptly notify the Monitor and the United States upon any prisoner death, serious suicide attempt, or injury requiring emergency medical attention. With this notification, Defendants shall forward to the Monitor and the United States any related incident reports and medical and/or mental health reports and investigations as they become available.

FINDINGS: Although the Territory notified the Monitor shortly after numerous serious incidents occurred, those notifications were devoid of detail and promised prompt follow up. However, the Monitor often read the details of these incidents in local Virgin Islands newspapers long before any details were communicated directly from the Territory. The Monitor requests that, when such incidents occur, the Monitor be kept up to date as new information is learned. The Monitor to this Agreement should not read about these incidents second hand.

8. Defendants shall maintain sufficient records to document that the requirements of this Agreement are being properly implemented and shall make such records available to the Monitor and USDOJ at all reasonable times for inspection and copying. In addition, Defendants shall also provide all documents not protected by the attorney-client or work product privilege reasonably requested by USDOJ. The parties will discuss a protective order for other documents over which Defendants may claim privilege.

FINDINGS: The Territory has provided numerous documents and information throughout the first year of monitoring. However, during most of the onsite visit previously requested records with either not timely made available and/or were incomplete, illegible, or not provided at all. Improvement in the timely production of complete and legible documents is essential to efficient and meaningful monitoring.

9. USDOJ and its attorneys, consultants, and agents shall have sufficient access to Golden Grove, prisoners, and documents to fulfill its duties in monitoring compliance and reviewing and commenting on documents pursuant to this Agreement. Except to the extent that contact would violate the Rules of Professional Conduct as they apply in the Territory of the Virgin Islands, USDOJ and its attorneys, consultants, and agents shall have sufficient access to Golden Grove's staff.

FINDINGS: Generally speaking, the Territory's adherence to this requirement remains troublesome. There have been ongoing delays in responsiveness to information requests by this Monitor and USDOJ, the HR/Training director is consistently not available to meet and discuss important non-compliance issues during onsite assessments, forms and policies are reportedly promulgated an implemented without review and comment by this Monitor and USDOJ, staff have reported feeling intimidated by Territory administrators for sharing information with USDOJ and the monitoring Team and report being ordered by the Director not to share information. This is a very troubling and seriously impairs both monitoring and compliance progress efforts. This must be remediated.

10. Excluding on-site tours, within 30 days of receipt of written questions from USDOJ concerning Defendants' compliance with the requirements of this Agreement, Defendants shall provide USDOJ with written answers and any requested documents unless the Defendants obtain relief.

FINDINGS: This Monitor is aware that several written requests progress of the Territory by USDOJ for documents, information, deadlines, clarification of progress have exceeded the 30-day response deadline imposed by this requirement. This Monitor has been unsuccessful in resolving this matter.

APPENDIX A
ASSESSMENT METHODOLOGY

This compliance assessment involved activities before, during, and following the onsite visit by the monitoring team and the Parties.

Pre-visit activities ensured involvement and input from officials and legal counsel representing the Territory (defendant) and the United States (plaintiff) in the planning of the site visit. Pre-visit activities included conference calls and exchange of relevant documents intended to maximize clarity and mutual understanding for assessment visit purposes and scheduling, and monitoring compliance expectations in general.

Pursuant to Section X.D.1 of the 2013 Settlement Agreement, the Monitor provided the following information to the Territory and U.S. Department of Justice officials for review and comment. This information intended to provide to the Parties: 1) the description of how compliance with the Agreement will be assessed; 2) how information necessary for on and off site assessment work will be gathered; and, 3) what information the Monitor will require the defendants to routinely report and with what frequency.

1. Description of how the Monitor will assess compliance with each of the Compliance Measures.

   In general, compliance assessment will include the following activities:

   A. Discussions and meetings with facility officials, staff, providers, and inmates.
   B. Discussions and meetings with community agency officials providing inspection or other regulatory oversight of GGACF.
   C. Discussion and meetings with officials and staff of contract providers and community agencies who provide services within and/or for GGACF and inmates held in its custody.
   D. Discussions and meetings with other pertinent staff, personnel, and community members, either as requested by the parties or who, in the determination of the Monitor, can provide relevant information for the purposes of monitoring.
   E. On-site tours of grounds, perimeter security barriers, perimeter access control and entrance points, all external security technology and methods, building and structural exteriors, roofs, and utility systems.
   F. On-site tours of all buildings, housing units, special environments, health care facilities, receiving and discharge areas, segregation units, all cell areas, food service and storage areas, utility closets and chases, utility technology and systems, fire prevention and suppression systems, life safety locations and equipment, other interior areas and location relevant to determine compliance.
   G. Examination of all security equipment and systems used for perimeter, external, structural, internal, and special security operations purposes.
   H. Examination of health care equipment, supplies, materials, technology and other material methods and processes used for inmate health care assessment, diagnosis, treatment planning, treatment (long and short-term), follow-up, and discharge planning.
   I. Examination of agency motor fleet including all cars, busses, trucks, vans, and any other motorized vehicle used for correctional operations purposes.

J. Examination of any and all available records, data, and/or information relevant to compliance and compliance monitoring not limited to the following:
- Administration
- Budget
- Personnel
- Operations
- Training
- Facility construction, renovation, repairs, and maintenance
- Equipment, supplies, and materials
- Inmate case files
- Medical and mental health screenings, assessments, evaluations, diagnoses, treatment plans, progress charts and notes, medication logs and records, drug formularies, appointment calendars, invoices, etc.
- Labor contracts
- Incident reports and logs
- Evidence / contraband reports and logs
- Use of force incidents and logs
- Inmate grievances and disciplinary records and actions
- Policies, procedures, protocols, guidelines, post-orders, logs, memos, and other documents and information that support accurate compliance assessment and progress determinations
- Employee complaints, grievances, claims, etc. directly or indirectly related to the compliance provisions
- Other information required to determine compliance and compliance progress

The information described above is intended to assist the Monitor to determine compliance and the degree to which each of the compliance ratings (noncompliance, partial compliance, and substantial compliance) apply to each provision assessed. Additionally, the Monitor will collaborate with the parties to develop metrics and core measures for qualitative and quantitative measurement of progress and compliance. Core measures and metrics should specifically pertain to the conditions set forth in the Settlement Agreement, and generally consider accepted standards and recommendations promulgated by the National Correctional Association, American Jail Association, National Commission of Correctional Health Care, American Psychiatric Association, American Nursing Association, ASIS International, National Fire Protection Association, Centers for Disease Control (CDC), OSHA, Territory regulations, and other nationally accepted standards for compliance assessment and management. Additionally, specific measures articulated in the Order of the Court dated May 14, 2013 [Dkt 742] (the "Order") shall be followed. The following compliance management terms are suggested for assessment and compliance monitoring:

- Compliance Control: Implies activities designed and intended to inspect and reject defective or deficient performance, processes, services, equipment, etc. when applied.
- Compliance Assurance: Implies activities designed and intended to identify performance and services that assure compliance when applied.
- Compliance Improvement: Implies activities designed and intended to correct and/or improve compliance in performance and services.

- Compliance Management: Implies activities designed and intended to ensure targeted compliance outcomes.
- Domain: A core aspect of the organization's performance, such as *access* to care, *costs* of care, or *quality* of care (e.g., consumer level of functioning, relapse and recidivism rates, or consumer satisfaction).
- Performance Indicator: A defined, objectively measurable variable that can be used to assess an organization's performance within a given domain. For example, within the domain of consumer satisfaction, a performance indicator might be: "the percentage of consumers who state that they received the types and amounts of services that they felt they needed."

2. How information necessary for on and off site assessment work will be gathered.

Monitoring will involve gathering various forms of information both on and off site and not limited to:

- Communications with Territory and U.S. Department of Justice Officials as authorized in the Order
- On-site visits, tours, meetings, individual and group meetings and interviews
- Collection and examination of electronic, paper, and photographic records, information, and data
- Photographs taken during inspections (not to be used in any report without expressed written agreement of both parties)
- Online media information
- Online public records
- Electronic and standard mailing of information
- Email communication and phone consultations

3. What information the Monitor will require the Defendants to routinely report and with what frequency.

It is understood that the Territory will use existing records systems and processes to provide routine reports. However, new records and information systems and methods may become necessary to accurately report progress compliance and related performance. It is this Monitor's desire to assist the Territory in developing records and information methods and processes that yield accurate, complete, and efficient reporting of compliance efforts and progress. Therefore, it is assumed that the compliance reporting process will evolve throughout the life of the Order.

Compliance reporting should include statistical reports, narrative descriptions of compliance activities and progress, improvement plans, case reviews, incident reports, and other information and data that helps the parties and the Monitor understand compliance progress as well as to identify issues and concerns that challenge compliance efforts. As recommended in both previously reports, a monthly compliance report is proposed until the reporting system and compliance progress evolves to justify less frequent routine reporting.

Non-exclusive information required for the Baseline and subsequent visits and monitoring includes the following. Many of these documents were not provided at the Baseline and second

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

A) Corrections Information:

1. The most recent census report.
2. Last five (years) admission, release, average daily inmate population.
3. The housing unit floor plans for all facilities and housing units.
4. A copy of the facility's policies and procedures manual(s), including the facility's Use of Force policy. [If you have the policies and procedures in electronic form, we would request all of them prior to our visit. Otherwise, we request only the Use of Force policy prior to our arrival].
5. The Use of Force Log for the past twelve (12) months and a few sample Use of Force packages [we request only the Use of Force Log prior to our arrival]. Please indicate any use of force on an inmate on the mental health case list.
6. The Serious Incident Report Log for the past twelve (12) months.
7. The Inmate Disciplinary Log for the past twelve (12) months.
8. The Contraband Log for the past twelve (12) months.
9. The Administrative Investigations Log for the past twelve (12) months.
10. A copy of the Inmate Grievance Policy.
11. A copy of the Inmate Grievance Log for the past twelve (12) months.
12. All forms and documents used by staff for inmate intake, assessment, classification, release, housing, supervision, disciplining, etc. Generally speaking, any form, report, log book, etc. used in the course of a corrections officers work day.
13. Documentation reflecting the current classification system, including policies and procedures related to such classification system.
14. **Documentation reflecting any training facility staff has received, including any corrections officer training manuals, pre-service and in-service training completed by all staff over the past 36 months**.
15. **Current staffing schedules for security positions and shifts.**
16. Job descriptions for all non-health care staff.
17. Copies of any self-evaluation reports, grand jury reports, American Correctional Association surveys, National Institute of Corrections reports/evaluations, National Commission on Correctional Health Care reports/evaluations, or any other outside consultant reports regarding the facility.
18. Any questionnaires, intake forms, or inmate handbooks provided to inmates upon their entry to the facility or during their stay in the facility.
19. **The most recent Staff Manpower Report/Matrix that shows all authorized positions and which ones are vacant.**
20. **Reports and data showing turnover information and statistics for security, medical, mental health, and other staff positions budgeted and authorized for the previous 36 months.**
21. Any staffing improvement plan, applications for technical assistance, and Territory budget proposals/authorizations to address staffing shortfalls.
22. **Facility maintenance requests and work orders for the past 12 months.**

23. Records and/or lists of physical improvements, repairs, and renovation completed to correct security problems and deficiencies over the past 36 months.
24. Past 36 months of agency budgets.
25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.
26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.

B) Medical and Mental Health Information:

27. A mock or blank chart containing all forms used, filed in appropriate order.
28. The infection control policies.
29. The names of inmates who have died in the past year, and access to/or copy of both their records and mortality review.
30. The names of any inmates diagnosed with active TB in the past year and access to/or a copy of their records.
31. To the extent not provided above, the policies and procedures governing medical and mental health care.
32. A staffing roster with titles and status, part time or full time, and if part time, how many hours worked per week.
33. The staffing schedule for the past two (2) months for nursing and providers, including on-call schedules for the same time period.
34. Job descriptions for medical staff and copies of current contracts with all medical care providers, including hospitals, referral physicians, and mental health staff.
35. Inter-local professional services agreements with health care providers, companies, to include health care policies under which those persons and/or entities provide inmate health care.
36. Tracking Logs for consults and outside specialty care services provided, chronic illness, PPD testing, health assessments, and inmates sent to the emergency room or off-site for hospitalization listing where applicable name, date of service, diagnosis and service provided.
37. A list of all persons with chronic illness listing name, location, and name of chronic illness.
38. A schedule of all mental health groups offered.
39. Minutes of any meeting that has taken place between security and medical for the past year.
40. Quality assurance and Medical Administration Committee minutes and documents for the past year.
41. A list of all emergency equipment at the facility.
42. A list of current medical diets.
43. Sick call logs (i.e., lists of all persons handing in requests for non-urgent medical care to include in the log presenting complaint, name, date of request, date triaged, and disposition) and chronic illness appointments for the past two (2) months.
44. A copy of the nursing protocols.
45. To the extent not provided above, a copy of any training documentation for security and medical staff on policies and procedures and emergency equipment.

46. A list of all the inmates housed at the facility by birthdate, entry date, and cell location.
47. To the extent not provided above, external and internal reviews or studies of medical or mental health services including needs assessments and any American Correctional Association and National Commission on Correctional Healthcare reports.
48. **List of all inmates placed in restraints, and all inmates receiving mental health treatments, under suicide watch, or taking psychotropic drugs.**
49. Current mental health case list including inmate name, number, diagnosis, date of intake, last psychiatric appointment, next psychiatric appointment, and any case lists of inmates followed only by counseling staff with last appointment date and follow-up appointment.
50. **Documentation reflecting any training that facility staff have received on suicide prevention, including certificates and training materials.**
51. All documents related to the any suicide occurring within the past year.
52. List of all persons on warfarin, Plavix, digoxin.

C) Suicide Prevention Information:

53. All policies and directives relevant to suicide prevention.
54. All intake screening, health evaluation, mental health assessment, and any other forms utilized for the identification of suicide risk and mental illness.
55. **Any suicide prevention training curriculum regarding pre-service and in-service staff training, as well as any handouts.**
56. **Listing of all staff (officers, medical staff, and mental health personnel) trained in the following areas within the past year: first aid, CPR/AED, and suicide prevention.**
57. The entire case files (institutional, medical and mental health), autopsy reports, and investigative reports of all inmate suicide victims within the past three years.
58. List of all serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) within the past year.
59. List of names of all inmates on suicide precautions (watch) within the past year.
60. The suicide watch logs for the past year.
61. **Clinical Seclusion logs for the past year.**
62. **Use of clinical restraint logs for the past three years**.
63. Any descriptions of special mental health programs offered.
64. **A list of all uses of emergency and forced psychotropic medications in the past year**
65. **A list of any use of force associated with the administration of psychiatric medications for the past year.**
66. **A description of medical and mental health's involvement/input into the disciplinary process and clearance for placement in segregation.**
67. **List of all inmates referred for off-site psychiatric hospitalization in the past three years**.

It is also understood that the above lists are not all inclusive and the Monitor retains the discretion to request additional information and documents deemed necessary for legitimate monitoring purposes and within the scope of conditions provided within the Agreement.

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

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

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

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