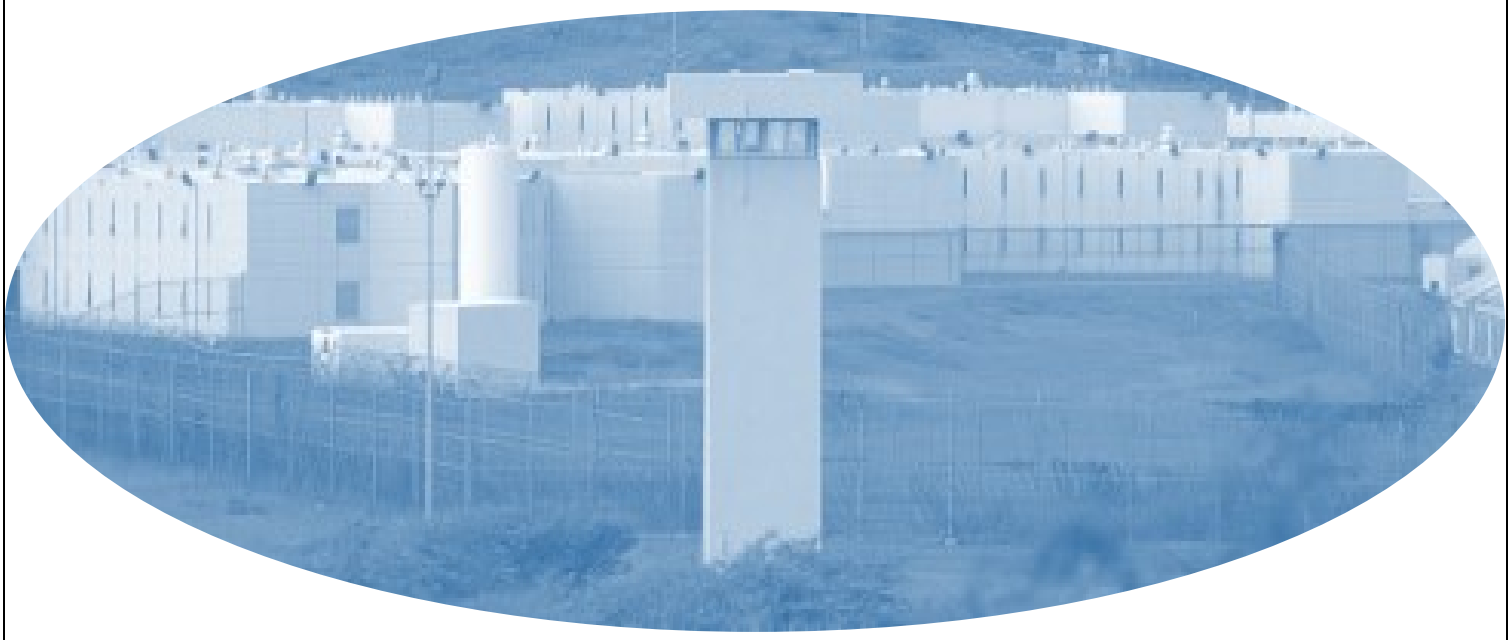
United States Virgin Islands

GOLDEN GROVE ADULT CORRECTIONAL FACILITY

St. Croix, VI



SEVENTH COMPLIANCE MONITORING REPORT

2013 Federal Court Settlement Agreement
In re: United States of America v. The Territory of the Virgin Islands (86/265)
Submitted May 31, 2015
Kenneth A. Ray, M.Ed., Monitor

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

"Progress is the attraction that moves humanity"

Marcus Garvey

Kenneth A. Ray, MEd, Monitor

TABLE OF CONTENTS

Topic	Page
Cover ……	**NA**
Table of Contents ……	**1**
Purpose……..	**2**
Executive Summary & Findings Overview……..……	**2**
Section IV. Safety and Supervision Compliance ……	**6**
Section V. Medical and Mental Health Care Compliance …….	**42**
Section VI. Fire and Life Safety ……	**70**
Section VII. Environmental Health and Safety ……	**78**
Section VIII. Training …….	**87**
Section IX / X. Implementation / Monitoring……	**89**
APPENDIX A	
Compliance Assessment Methodology …….	**93**

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 U.S. Virgin Island officials in developing action plans to systematically develop, prioritize, implement, and evaluate policies, procedures, and administrative and operational changes and improvements that ensure consistent substantial compliance with the Agreement and the provision of constitutional care and custody of prisoners incarcerated at the Golden Grove Adult Correctional Facility & Detention Center, St. Croix, Virgin Islands.

EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

The seventh onsite compliance monitoring assessment was conducted during weeks of March 2-5, 2015 and April 23-25, 2015 due to scheduling conflicts with the monitoring team caused by weather-related delays, and included an onsite Court status conference on Thursday, March 5th. Prior to this site visit, the Monitor coordinated communication between the Parties and monitoring team in preparation for the onsite assessment.

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

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

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

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

The Monitor 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 in accordance with this Agreement;
2. the above documents are promulgated and staff are adequately trained on those documents and related performance expectations; and,
3. those documents are adequately and effectively implemented. Implementation includes evaluation that implemented policies, procedures, and training are performing within the expectation of this Agreement.

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

This assessment found reasonable cause for the Monitor to reverse two Provisions from Partial Compliance to Non Compliance. Provisions IV.B.1a (Contraband) was downgraded due to decreases in security searches, Provision IV.D.a (Security Staffing) was downgraded as a result of occupied housing units continuing to not be staffed and continued inadequate shift supervision staffing levels. Consequently, overall assessment ratings are slightly lower from the previous assessment. 110 (92%) of the 120 Provisions are now rated in Noncompliance; 10 (8%), Partial Compliance; and, none are rated in Substantial Compliance. The score card below shows current compliance ratings.

GGACF SEVENTH COMPLIANCE ASSESSMENT SCORE CARD

Areas of Compliance Per Agreement	Total Provisions	Non Compliance	Partial Compliance	Substantial Compliance
IV. Safety and Security	**59**	**55**	**4**	**0**
V. Medical, Mental Health, & Suicide Prevention	**36**	**36**	**0**	**0**
VI. Fire and Life Safety	**10**	**10**	**0**	**0**
VII. Environmental Health and Safety	**11**	**5**	**6**	**0**
VIII. Training	**4**	**4**	**0**	**0**
Total Substantive Provisions	**120**	**110**	**10**	**0**
Percent Compliance	**100%**	**92%**	**8%**	**0%**

SEVENTH ASSESSMENT FINDINGS OVERVIEW:

Compared to all previous onsite assessment, this visit was well organized and attended by Territory, BOC, and GGACF officials and staff. Acting Director Benjamin took charge of our initial meeting and set very professional expectations for his staff to fully cooperate and collaborate with the monitoring team and USDOJ. The GGACF compliance coordinators ensured timely access to the facility and available documents, though several requested documents required post-visit follow up and submission, and staff could not find the requested Supervisor's Logbook for January 15, 2015, to February 27, 2015. All GGACF staff participated openly and seemed to answer all questions honestly. Access to the facility was much more fluid and timely. Officials from the VI Fire Service also participated and provided valuable information with regard to a forthcoming mutual agreement with BOC to provide facility fire safety compliance support. Counsel from the Governor's office, BOC, and GGACF attended the March visit in its entirety to provide timely counsel and support to the process. The Territory, BOC, and GGACF officials and staff are commended for the extra effort given to ensure a more effective and efficient assessment process.

An equally important aspect of the monitoring process, however, is the monitoring team's regular review of BOC and GGACF documents. The Territory must submit certain documents to the Monitor and United States on a monthly basis, and under the Settlement Agreement must also notify the Monitor and United States immediately if certain events occur, such as inmate deaths.

Generally speaking, progress toward overall compliance remains very slow. Although the Territory presented various new plans and intentions for improving the pace and substance of compliance, 92% of Agreement provisions remain in noncompliance. This is primarily due to these factors:

1. The Territory's failure to finalize and approve all policies and procedures required under the Agreement by the court-ordered March 30th deadline.
2. Inadequate correctional and supervisory staffing levels.
3. Lack of staff training and accountability to ensure compliance with basic security and correctional practices.

These factors permeate facility-wide operations. Inadequate staffing levels continue to create substantial safety, security, and health risks to inmates and staff. Occupied housing units continue to operate without correction officers for entire shifts at a time. Dangerous and nuisance contraband volume remains very high. Assaults on officers and inmates continue to be a very serious problem. Most staff uses of force against inmates are not properly documented or reviewed and administrative investigations have ceased altogether since the resignation of former GGACF Warden Donald Redwood, who simultaneously served as the facility investigator, on October 18, 2014. Most incident reports are submitted incomplete and provide no consistent method for developing an effective incident tracking and management system. Inmate disciplinary and complaint systems remain broken. Disciplinary due process hearings are infrequent, resulting in numerous Due Process Violations. The inmate grievance log remains incomplete and demonstrates continued problems in timely resolution of inmate complaints; there are often no responses to inmate complaints. Facility hygiene, lighting, and structures remain marginal due primarily to inadequate maintenance staffing levels. Mentally ill inmates languish

in isolation conditions and problems with inmates accessing medical and mental health services continue. Many inmates are held in administrative and disciplinary segregation for extraordinary periods of time—some indefinitely—and without an adequate review process prior to or during such detention. The inmate classification system remains invalid and mostly unreliable.

Despite continued noncompliance and ongoing problems, some very serious, it appears the Territory has renewed its commitment to compliance. Significant and impressive improvements to the medical building have been accomplished. Additional medical and mental health staff hired, and several new correctional recruits were observed. New equipment security equipment has been purchased and issued to staff and the new security camera system is being tested in preparation for full activation once the camera room is completed and operational. Although significant and extensive work remains to resolve this federal order, these accomplishments deserve positive recognition as each contributes positively to this ultimate goal.

Finally, we note that there does not seem to be a system in place for ensuring that the respective GGACF department heads receive our monitoring reports in a timely manner, if ever; therefore, they are incapable of providing follow-up actions. For example, the current Fire and Life Safety Officer had only received our report a few days prior to our on-site visit. We urge the Territory to distribute this report to all department heads immediately upon filing, and promptly schedule internal meetings to discuss the findings, how to address them, and any questions or concerns they may have."

IV. SAFETY AND SUPERVISION

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

A. Supervision

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Territory remains committed to finalizing, approving, and implementing policies and procedures required under this provision. Substantive progress is anticipated once these policies are promulgated and staff are appropriately trained.

Progress remains noncompliance due to 1) inadequate staffing levels (discussed in proceeding sections), 2) inadequate supervision and oversight of staff and housing-unit safety and security, and 3) mixing violent with non-violent prisoners. Additionally, the facility's broken prisoner disciplinary and grievance systems concomitantly and deleteriously limit consistent control of dangerous and disruptive prisoner conduct while affording only anemic resolution to prisoner complaints and victimization. However, the Warden changed the shift schedule in an attempt to address the staffing needs indicated in the NIC Staffing Analysis. New Shift hours are 6am to 2pm, 2pm to 10pm, and 10pm to 6am. Future staffing assessments will provide Territory officials in information about the effects of this change with regard to attaining and maintaining adequate and durable staffing levels.

RECOMMENDATIONS: Previous recommendations remain appropriate

1. Apply the approved Housing Stratification matrix as designed
2. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
3. Refer to IV.F. regarding specific classification and housing policy recommendations.

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

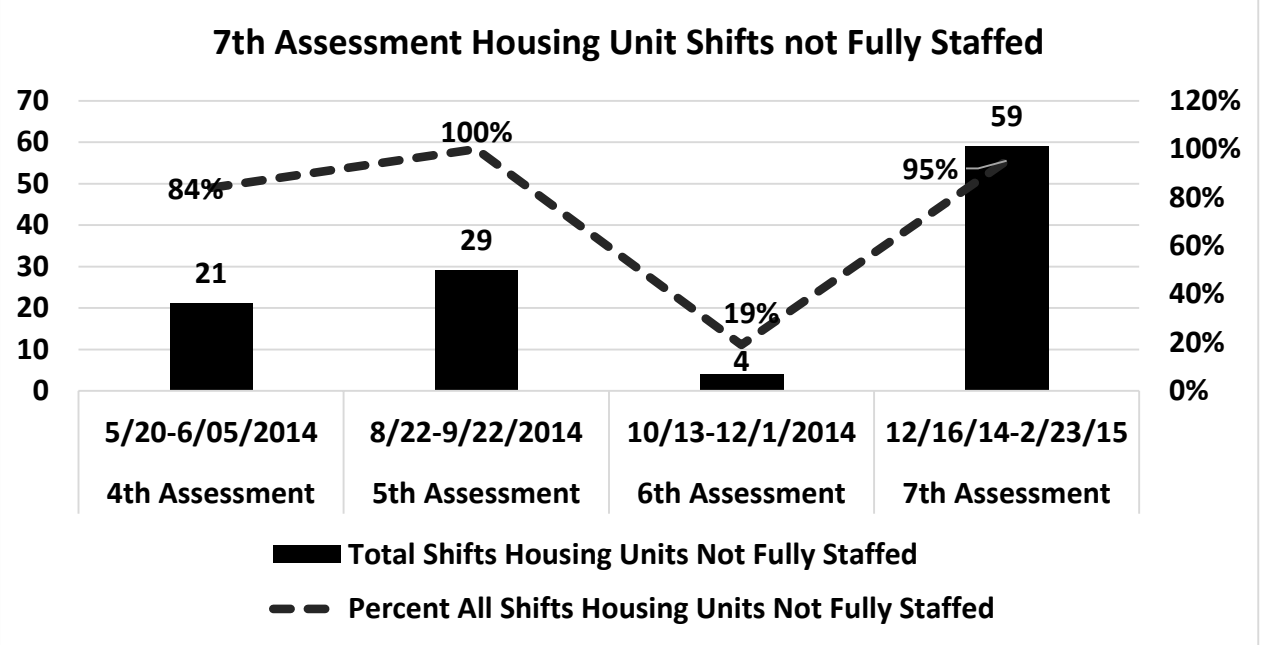
ASSESSMENT: NONCOMPLIANCE

FINDINGS: Revised Post Orders have not yet been promulgated to comply with this provision of the Agreement. Supervisor logs from 12/16/2014-02/23/2015 were analyzed to assess compliance with this provision and compared with previous compliance assessments.

This analysis assessed 43 work days and involved 62 housing unit work shifts for all 13 prisoner-occupied housing units. Fifty-nine of the 62 shifts (95%) were not fully staffed during this 43-day period. The table below compares assessments.

Monitoring Visit	4th Assessment	5th Assessment	6th Assessment	7th Assessment
Sgt. Log Book Date Range Reported	5/20-6/05/2014	8/22-9/22/2014	10/13-12/1/2014	12/16/14-2/23/15
Days Assessed	16	21	21	43
Shifts Assessed	25	29	21	62
Housing Areas Assessed	14	14	10	13
Total Shifts Housing Units Not Fully Staffed	21	29	4	59
Percent All Shifts Not Fully Staffed	84%	100%	19%	95%
Total Shifts Housing Units Fully Staffed	4	0	17	3
Percent All Shifts Housing Units Staffed	16%	0%	81%	5%
Assessed Shifts x Housing Areas Assessed	350	406	210	806

The graph below illustrates compared shifts not fully staffed.



This analysis finds a peculiar and relatively significant increase in the percent of shifts not fully staffed compared to previous assessments. Supervisor logs again document serious housing unit staffing shortages on several shifts for the period assessed. Staffing improvements were documented for housing units H, K, L, and 9B. Notably, the treatment building houses medically infirm inmates but was reported as not staffed on three (3) shifts. This is very troubling, especially considering that one inmate housed in the treatment building is physically immobile and has serious mental illness. The table below compares percent of housing units not staffed.

7th Assessment Analysis of Housing Unit Staffing Levels	4th Assessment Shifts Not Fully Staffed	Percent	5th Assessment Shifts Not Fully Staffed	Percent	6th Assessment Shifts Not Fully Staffed	Percent	7th Assessment Shifts Not Fully Staffed	Percent
A DORM	5	20.0%	3	10.3%	0	0.0%	21	33.9%
RSAT	14	56.0%	19	65.5%	Closed	Closed	51	82.3%
Intake	16	64.0%	27	93.1%	Closed	Closed	54	87.1%
X or X-Ray	1	4.0%	2	6.9%	0	0.0%	4	6.5%
G	0	0.0%	2	6.9%	0	0.0%	2	3.2%
H	1	4.0%	0	0.0%	0	0.0%	1	1.6%
I	0	0.0%	2	6.9%	Closed	Closed	Closed	Closed
J	1	4.0%	3	10.3%	Closed	Closed	Closed	Closed
K	1	4.0%	1	3.4%	4	19.0%	4	6.5%
L	2	8.0%	1	3.4%	4	19.0%	3	4.8%
9A	3	12.0%	2	6.9%	0	0.0%	0	0.0%
9B	3	12.0%	1	3.4%	1	4.8%	0	0.0%
9C	0	0.0%	0	0.0%	0	0.0%	0	0.0%
9D	1	4.0%	0	0.0%	0	0.0%	0	0.0%
TB Treatment Bldg	0	0.0%	0	0.0%	0	0.0%	3	4.8%
# Times Housing Unit Not Fully Staffed	48		63		9		143	
# Times Housing Fully Staffed	302		343		201		663	
Percent	86%		84%		96%		82%	

Estimated total hours housing units were understaffed are calculated to assess duration of real and potential risk to staff and inmates. As shown below, most housing areas operated understaffed for many hours during the period assessed.

Estimated Number of Hours Housing Units not Fully Staffed by Unit Classification	4th Assessment	5th Assessment	6th Assessment	7th Assessment
A DORM (Male Detainee Protective Housing)	40	20	0.00	**94.64**
RSAT (Juvenile Housing)	112	100	Closed	**302.64**
Intake (Male Detainee Protective Housing)	128	176	Closed	**390.64**
X or X-Ray (Female Detainee & Inmates)	8	16	0.00	**32.00**
G (Male Inmate Med/Max/Long Term)	0	16	0.00	**0.00**
H (Male Inmate Min/Med)	8	0	0.00	**0.00**
I (Male Inmate Protective Housing)	0	0	Closed	**Closed**
J (Not on Classification Matrix)	8	20	Closed	**Closed**
K (Male Inmate Protective Housing)	8	12	32.00	**32.00**
L (Male Inmate Admin/Discipline Seg)	16	8	32.00	**24.00**
9A (Male Detainee Admin/Discipline Seg)	24	8	0.00	**24.00**
9B (Male Detainee Med/Max)	24	16	8.00	**0.00**
9C (Male Detainee Min/Med/Special Needs/ MH/Med	0	0	0.00	**0.00**
9D (Male Detainee Min/Med/Special Needs/ MH/Med	8	0	0.00	**0.00**
TB Treatment Bldg.	0	0	0.00	**24.00**
Total Hrs. Housing Units Not Staffed	384.00	392.00	72.00	**923.92**

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Rapidly implement the NIC Staffing Analysis recommendations.
2. Complete the draft staffing, as required under the Agreement that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff.
3. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff working overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.
4. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.
5. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.
6. 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.
7. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues are detected and resolved in a timely manner.
8. 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: This assessment found operable two-way radios in all housing units assessed. However, as discussed in the previous report, officers must carry radios with them at all times; a few radios were observed unattended on counters (not in chargers) in officer stations. Officers should always keep radios attached to their duty belts at all times while on duty. Additionally, officers should never leave radios unattended and accessible to prisoners. An X-dorm portable radio was observed sitting on the officer desk with the office door open while the officer was in the day room talking to prisoners and 7th tour participants. This can be easily corrected with an appropriate written directive and compliance monitoring by shift supervisors. Additionally, one officer stated they did not know what the radio's "red button" did. This Monitor recommended this officer ask a supervisor for that answer. This provision is otherwise ready to advance to Substantial Compliance once policies and procedures are implemented according to the terms of the Agreement.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Finalize, approve, and implement all related policies and procedures.

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

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: GGACF remains inadequately staffed to ensure consistent, timely, and thorough management of housing units, including special housing areas. Inadequate staffing levels prevent housing officers from conducting adequate cell security and contraband checks. Lack of adequate housing unit staffing affords very little, if any, time for officers to perform thorough searches of prisoners entering and exiting housing units, which is evidence of ongoing high volume of dangerous and nuisance contraband reported on the monthly Evidence Logs.

Shift supervisor staffing levels remain inadequate to ensure supervision consistency and a continuum of leadership and staff guidance. For example, a minimum of three (3) shift supervisors are required to provide effective shift supervision. However, examination of 62 shifts recorded in supervisor's logs from 12/17/2014 through 2/23/2015 found most shifts staffed with only two supervisors. Approximately 70 percent of the 62 shifts examined were staffed with two or fewer supervisors. Thirty shifts were staffed with two supervisors (48.4%), 13 shifts with one supervisor (21%). Approximately 30 percent of shifts were staffed with three or more supervisors as shown below.

Shift Supervision Staffing	N	%
4 Supervisor Shifts	2	3.2%
3 Supervisor Shifts	17	27.4%
2 Supervisor Shifts	30	48.4%
1 Supervisor Shifts	13	21.0%
0 Supervisor Shifts	0	0.0%
Totals	62	100.0%

These shift supervision staffing levels clearly demonstrate that GGACF is unable to:

1. Provide consistent and effective continuum of housing unit staff supervision and leadership.
2. Provide supervisory monitoring of staff compliance with policies, procedures, and Agreement requirements.
3. Ensure housing units are consistently managed in accordance with industry standards.
4. Provide minimum levels of staff on-the-job training, coaching, counseling, and guidance.
5. Provide consistently reliable supervisory response to multiple concurrent facility crises.

Safety and security risks to staff and inmates increase for each shift not adequately staffed by supervisors; in this case increased risk involved 43 of 62 shifts according to supervisor logs examined. Timely implementation of the Staff Plan could positively remedy this problem, especially if required additional supervisor positions are filled as a high priority.

RECOMMENDATIONS: Some Previous Recommendations Remain Appropriate

1. Refer to recommendations regarding Post Orders.
2. Ensure housing units and cell blocks are consistently staffed at levels required to ensure staff and inmate safety and security, and according to inmate risks and needs.
3. Create a schedule for regular rounds by medical and mental health care staff for each shift to ensure that special needs inmates (suicidal, mentally ill, medically infirm, vulnerable, etc.) are monitored more frequently and by qualified health care staff.
4. Create a schedule for supervisory rounds, by shift, to ensure that supervisors routinely inspect general and special housing units to ensure compliance staffing requirements, policy and procedures, and to interview inmates presenting problem conditions. Supervisors should also ensure that all safety and security equipment is present and functional during these inspections and immediately replace any nonfunctional equipment. The supervisory rounds forms should be filled out at the end of each round and collected in a central location and submitted to the Monitor and USDOJ on a monthly basis.
5. Repair all broken lights in housing units and cells, issue flashlights to staff for cell inspections, keep all housing unit doors locked, repair broken control panels to improve unit security.

B. Contraband

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

a. Clear definitions of what items constitute contraband;

ASSESSMENT: NON COMPLIANCE (Downgraded from Partial Compliance)

FINDINGS: Draft policies and procedures have not been completed. This provision is downgraded from Partial Compliance to Non Compliance due to ongoing high volume of dangerous and nuisance contraband combined with decreased GIST facility search activity, according to staff interviewed during this onsite visit. GGACF officials reported that facility

shakedown searches have not been conducted since shift scheduling was changed February 8, 2015. This is very troubling. High volume of dangerous and nuisance contraband creates very high safety and security risks for staff and inmates that must be remediated.

RECOMMENDATIONS:

1. Finalize, approve, and implement the new policy according to the terms of this Agreement once approved.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Dangerous and nuisance contraband continues to permeate the facility and housing units with little abatement. Examination and comparison of evidence logs demonstrates very serious safety and security risks as shown in the chart shown below. This assessment found several items of contraband very troubling due to extreme risks the items pose to staff and inmates. Specifically, the evidence log examined for this assessment documents seizure of a handcuff key, two "combat knives", one machete, and a "16 inch metal shank". The presence of these weapons exaggerate risks and can only be eliminated with adequate staffing, diligent and regular prisoner and facility searches.

GGACF Contraband Seizures	6th Report (10/3-12/3/2014	7th Report 12/25/2014 - 4/15/2015	Combined Total
1. Days Reporting	60	111	171
2. Weapons (Knives, Shanks)	21	28	49
3. Cell Phones	32	16	48
4. Drugs, Alcohol, Paraphernalia	9	11	20
5. Handcuff Key	0	1	1
6. Money	3	3	6

As stated in the previous report, continued introduction and high volume of contraband is indicative of inadequate searches by staff of inmates and structures, which is symptomatic of inadequate staffing levels, staff supervision, and training. The high volume of dangerous contraband continues to place inmates and staff in constant and extreme risk of harm. Additionally, tours of housing units revealed evidence of fire ignition sources such as "burning wicks" and housing unit floors scorched by fire. It is obvious that prisoners continue to possess contraband for starting fires, which is further discussed in the Fire and Life Safety Section of this report. For example, during this visit we observed a prisoner returning from an outside medical visit through R&D, holding a large tote bag, but this prisoner was not searched. Additionally, an R&D logbook entry dated 1/21/2015 (p.70) documents a prisoner was found carrying drugs. GGACF officials must increase their efforts to eliminate the introduction and presence of contraband without delay.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Continue positive efforts in searching people before entering the facility.
2. A "stop and check" protocol for inspecting staff packages after initial entry into the facility must be developed and implemented.
3. Provide handheld metal detectors for contraband inspections at facility entry points and as needed for on-campus inspection.
4. Be prepared to thoroughly discuss current vehicle, mail, and package inspection methods and process during the 8th onsite tour and assessment.
5. Train supervisors to provide on-the-job-training (OJT) and staff mentoring in the areas of adequate searches, contraband prevention and control, and basic inmate supervision and security.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above findings and discussion.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Refer to above, expand application of recommendations to provision c (i-iii) above.
2. See recommendations regarding staffing levels.
3. Ensure inmates are systematically and consistently searched each time they enter and exit maintenance shop areas, kitchen areas, and any area and/or building containing items that can be used as contraband.
4. Always search prisoners each time they enter and exit housing units.
5. Always search all containers entering and exiting the facility, buildings, and housing units.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No change was found since previous reports. Previous recommendations should be implemented.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Additional staffing were assigned to the public entrance during this assessment period. This was accomplished by rotating newly hired corrections recruits to this post to search the persons and belongings of the monitoring team and USDOJ participants. This Monitor also observed similar searches of the public and a few officers at this entrance. This Monitor did not experience any delays in being escorted for facility tours and inspections.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Continue to ensure timely and consistent escorts for the monitoring team and USDOJ officials during all onsite visits.
2. Continue to maintain adequate supplies of visitor identification cards and ensure that all visitors conspicuously wear badges at all times while inside the security perimeter.

C. General Security

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: There was no substantive improvement with this provision. Inmates continued to wear and possess personal clothing, including polo shirts, while in the housing units and in the outdoor areas of the facility. Previous recommendations do not appear to have been implemented.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

4. Consider acquiring correctional apparel that provides obvious recognition of the inmates' classification/status.
5. Ensure there is a consistently sufficient supply of uniforms for regular laundry exchanges and changes in an inmate's classification and/or status.
6. Consider developing a correctional industry for making uniforms onsite.
7. Select/make uniforms specifically designed to reduce/eliminate places to hide contraband and weapons.
8. Mark all uniforms with highly visible letters/numbers.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Identification badges were provided to the monitoring team for each day of the visit. However, there were prisoners again observed traveling in and out of housing units and the yard without visible identification badges.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Some housing unit doors were found closed and some open during this visit. Most housing unit gates were closed and locked but a few were closed and unlocked. Some of the officer station doors were locked, some unlocked. Maintenance reports demonstrate ongoing problems with cell door locks. Additionally, certain cells in the intake area continue to be padlocked and staff seemed to have considerable difficulty and delays in locating keys to these locks. This poses a clear and present danger to prisoners under emergency conditions. These observations demonstrate continued inconsistency in facility security that requires improvement monitoring and remediation by supervisors and GGACF management. The facility remains unsecured anytime basic locking and unlocking practices are not followed and monitored by supervisors.

Additionally, per the previous report, related training documents were not provided as requested. This Monitor renews the previous request for these training documents.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Provide Monitor requested training records showing a 95 percent minimum successful completion rate.
2. Repair/replace all broken locks and keys.
3. Develop, revise, implement, audit lock/key inventory.
4. Regularly inspect keys, locks, and electronic locking systems to ensure reliable functionality, detection of tampering, and timely repair/replacement.
5. Continue to ensure staff are adequately trained in the proper use of mechanical and/or electronic locking systems according to their post assignments.
6. Consistently sanction inmates for attempting to manipulate or manipulating any security locking system or device.
7. Secure access to keys and electronic locking control panels.
8. Keep security doors locked!
9. Replace or upgrade existing unit control panels to provide for remote electronic locking and unlocking of unit and cell doors.
10. Improve video surveillance of internal areas by placing cameras in all housing units and inmate locations, and add additional cameras to monitor external access points to ensure rapid detection of attempts to disable or damage locking devices/systems.
11. Increase perimeter and internal lighting to improve detection of sabotage to locking devices and mechanisms.
12. Supervisor should inspect all locking systems during each shift and report for investigation and/or repair any signs of lock disrepair, malfunctioning, or manipulations.
13. Consistently enforce security locking policies and procedures with staff and inmates.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above. Inspection and maintenance procedures have not been approved nor submitted. The maintenance program remains understaffed to provide timely and consistent repair/replacement of locks and locking systems.

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

FINDINGS: There was no change found from previous assessments. No documents were provided to demonstrate implementation of the recommendations below, and the requested documents were not provided. This Monitor was unable to assess progress.

RECOMMENDATIONS: Per the previous report

1. Territory officials should assess history of terminations, identify determining factors, and realign completion of pre-employment practices to avoid post-employment terminations.
2. This Monitor again requests inspection personnel of 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. These documents were requested for all previous visits but not provided. **Please have these documents at GGACF for the upcoming site visit.**
3. Ensure access to applicant and staff records is adequately controlled and protected, and that access to these records is based on a legitimate, work related "need to know" basis.
4. Ensure there is an adequate centralized information tracking system in place to support periodic supervisory review of staff records for professional development, counseling, and corrective action decision-making.
5. Make records available to the Monitor for inspection and verification of compliance.

D. Security Staffing

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

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

ASSESSMENT: NONCOMPLIANCE (Downgraded from Partial Compliance)

FINDINGS: As previously indicated, security staffing levels remain inadequate.

A draft Staffing Plan, based on the NIC Staffing Analysis, was submitted for review and approval on April 1, 2015. The plan demonstrates incorporation of realistic relief factors for all security levels, housing units and non-housing posts, and security supervision.

The following table from the Plan shows that 179 total security staff is required for adequate security and security supervision. An additional 80 security staff are required to meet plan requirements.

Security Positions	Staffing Plan 3/2015	2015 Budget Authorized	Actual Staffing as of 3/17/15	Staff Needed
Security Management	**6**	**6**	**4**	**2**
TC Command (Lt)	**5**	**4**	**2**	**3**
ATC Command (Sgt)	**13**	**7**	**5**	**8**
Officer	**155**	**117**	**88**	**67**
Total Security Staff	**179**	**134**	**99**	**80**

It must be noted that this staffing plan does not account for the closing of two housing units following prisoner transfers off-island. The plan will, therefore, require revisions if those housing units are reactivated with additional inmates.

The plan has been reviewed by this Monitor and the United States. The Monitor provided recommendations to the Territory for relatively minor substantive revisions via email April 23, 2015:

Good morning, Shari/Paula –

I have reviewed the proposed seven year staffing plan submitted April 1, 2015 and inserted two charts on pages 6 & 7 that clarify targeted staff hiring and levels for each of the seven years. I have no objections to the proposed seven year plan after considering various unique challenges faced by the Territory involving staff recruitment and retention. However, seven years is considerable longer than has been my experience monitoring cases. For example, in one case where I monitor for defendants I was only able to negotiate with the United States a three year term for hiring 53 officers. That said, I would like to expedite final approval of the plan within two weeks, if possible, and make every effort to resolve objections to the plan by the United States within that timeframe. … Thanks you. Ken

As stated above, the United States objects to a seven-year implementation duration as too long, considering ongoing serious GGACF safety and security problems. This Monitor agrees but also considers the Territory's reported unique challenges regarding staff recruitment and retention. The United States has requested dispute mediation by this Monitor, which has been tentatively scheduled for May 8, 2015 and later rescheduled to May 13, 2015. The United States requested that the Territory supplement the Staffing Plan by detailing specific efforts the BOC has already undertaken to recruit and retain staff, additional steps BOC has considered but has not yet taken to recruit and retain staff, identify individuals by name and title responsible for recruitment and retention strategies, identification of priority housing unit/facility posts, including indication of whether these posts are currently staffed. By May 28, 2015, the Territory stated that it intends to provide the supplemented Staffing Plan and the parties will schedule a follow-up conference to discuss this same. This Monitor will update the Court on this matter.

RECOMMENDATIONS:

1. Incorporate Monitor's recommendations into the draft plan.
2. Resolve the United States objections by Monitor dispute resolution or the court, if required.

3. Quickly implement the approved staffing plan without delay.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above. Also, the Monitor recommends the Territory consider the following timetables for the seven-year implementation. This schedule would be revised if the seven-year implementation period is changed due to mediation or Court resolution of this matter.

VI BOC/ GGACF Hiring Plan			Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total	
Security Positions	Staffing Plan 3/2015	Staff Needed	2016	2017	2018	2019	2020	2021	2022	2016-2022	Staff Needed
Security Management	6	2	1	1	0	0	0	0	0	2	100%
TC Command (Lt)	5	3	1	1	1	0	0	0	0	3	100%
ATC Command (Sgt)	13	8	2	2	2	2	0	0	0	8	100%
Officer	155	67	10	10	10	10	10	10	7	67	100%
Total Security Staff	179	80	14	14	13	12	10	10	7	80	100%

VI BOC/ GGACF Hiring Plan			Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Total
Security Positions	Staffing Plan 3/2015	Actual Staffing as of 3/17/15	2016	2017	2018	2019	2020	2021	2022	2016-2022
Security Management	6	4	5	6						6
% Staffing		67%	83%	100%						
TC Command (Lt)	5	2	3	4	5					5
% Staffing		40%	60%	80%	100%					
ATC Command (Sgt)	13	5	7	9	11	13				13
% Staffing		38%	54%	69%	85%	100%				
Officer	155	88	98	108	118	128	138	148	155	155
% Staffing		57%	63%	70%	76%	83%	89%	95%	100%	
Total Security Staff	179	99	113	127	140	152	162	172	179	179
% Staffing		55%	63%	71%	78%	85%	91%	96%	100%	

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Draft policies and procedures have not been finalized or approved but the Territory reports having selected a qualified vendor to assist in completion of these required documents, pursuant to the Court's April 20, 2015 order.

RECOMMENDATIONS: See above.

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

ASSESSMENT: See above

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

RECOMMENDATIONS: Refer to previous recommendations.

E. Sexual Abuse of Prisoners.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously reported, the Territory has not completed the required PREA self-audit. PREA draft polices have not yet been approved and implemented.

Additionally, a prisoner's October 20, 2014 complaint of sexual abuse remains not investigated due to the Investigator vacancy according to GGACF officials. **Failure to properly investigate and resolve such compliances violates PREA and federal law**. The Territory is encouraged to ensure it fully complies with PREA regardless of whether this vacancy is filled.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. GGACF should take advantage of the National PREA Resource Center at http://www.prearesourcecenter.org/, and the National Institute of Corrections at http://nicic.gov/ for qualified information about PREA compliance, training, and other related resources.
2. Review PREA and develop an action plan for the implementation of PREA requirements.
3. Appoint a PREA Compliance Coordinator as soon as possible.
4. BOC officials are encouraged to send at least one qualified staff person to USDOJ's PREA auditor certification training. All costs are covered by USDOJ.
5. Complete the PREA Self-Audit.
6. Review, revise, develop, train, evaluate policies and procedures that include, at a minimum, the following PREA topics:
7. Fill the Investigator vacancy immediately.

F. Classification and Housing of Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: In July 2014, the BOC Director advised this Monitor that Dr. James Austin was scheduled to validate the existing Classification instruments. During the September and December 2014 visits the Director advised that this work was temporarily delayed but would be rescheduled. BOC and GGACF officials could not provide an update on when this work would be completed as of this assessment. The existing classification instrument, therefore, remains invalid and unreliable; it must be validated without further delay to ensure all classification and prisoner housing, security, and program decisions are sound and reliable.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate.

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: As previously stated, notwithstanding the lack of validated classification instrument and policies, Territory officials provide adequate documentation demonstrating an adequate classification / housing scheme as previously requested by this Monitor. These documents include the following Provision requirements:

- Total Institutional Monthly Average Daily Population (Pre-sentenced and Sentenced Prisoners)
- Total Outside of Territory Contract Prisoners (BOC prisoners held off-island)

- Monthly Average Daily Population, Admissions and Releases
- Classification / Housing Stratification for all Currently Used Housing Units
- Custody Classification Level Volume Report (number of prisoners in each primary classification).
- Names of all prisoners by classification, conviction statues, and housing unit.

Again, these documents do not, however, clarify whether the Territory conducts regular classification reviews to ensure prisoners continue to be properly housed and separated from other inmates according to changes in their classification status. BOC officials have indicated that classification reviews are regularly performed based on the draft classifications policy. However, BOC officials also report that due to challenges, prisoners' classification may not be reviewed in strict adherence to the timelines. BOC officials have agreed to provide this information in the monthly routine monitoring document submissions.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Inmates should be housed and separated according to reliable classification process as previously discussed.
2. Pending completion of a reliable classification process, GGACF officials should use the Incident Log Report and other reliable information sources to target population cohorts for housing and separation that is more consistent with behavioral risks and needs.
3. Comply with the Settlement Agreement prohibiting housing seriously mentally ill inmates in isolation cells or locked-down housing units. 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: Same findings as above.

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: The prisoner disciplinary system remains broken and ineffective for ensuring access to due process and supporting prisoner control and order. Interviews with GGACF officials and examination of monthly Disciplinary Committee Reports demonstrate ongoing problems with the disciplinary process. These reports document the following problems continue:

- No set time for conducting disciplinary hearings
- Lack of staff to assemble a full hearing committee consistently
- Needed hearings are not being conducted
- Disciplinary program management staff are not receiving incident reports and other documentation required for fair, objective, and accurate decisions
- Shift supervisors are not reviewing incident reports for accuracy and completeness before submission for disciplinary review
- No resolution by GGACF management staff to the above previously reported problems
- Prisoner due process violations continue due to the above problems

Examination of monthly Disciplinary Committee Reports concur with these statements and show insignificant change in due process violations volume. Monthly committee reports indicate there were 100 reports submitted for review for July, August, and September 2014 with 50 due process violations (50%). February, March, and April 2015 reports indicate that 40 reports were submitted and 17 due process violations (43%). The reader is reminded to interpret these findings with caution because GGACF documents are known to be incomplete, inconsistent, and inaccurate. Nonetheless, these findings reliably demonstrate that GGACF prisoners remain without a constitutional disciplinary process.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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 committee reports.
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;

ASSESSMENT: PARTIAL COMPLIANCE - Previous Recommendations Remain Appropriate

FINDINGS: There remains no formal process for collecting, analyzing, or distributing data and reports as required under this provision. Incident logs and reports continue to document ongoing prisoner-on-prisoner and prisoner-on-officer assaults, gang activities, and other serious incidents. However, the absence of a formal incident reporting system prevents GGACF officials from effectively planning and executing sustainable remedial actions. Thus, staff and inmates remain precariously subject to many risks that are otherwise preventable with the

implementation of an effective and strategic incident prevention and management reporting system. GGACF officials will remain unable to accurately and consistently evaluate serious incident activity until a uniform incident reporting system is successfully implemented.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: A sample of completed segregation review forms were examined. These documents continue to demonstrate lack of attention to detail, completeness, and documenting whether reportedly needed medical and mental health services were followed-up and provided. Additionally, this sample clearly indicates excessive disciplinary sanctions and continued violations of the Agreement with regard to housing mentally ill inmates in what amounts to long term isolation.

Document omissions and deficiencies include the following:

1. Location of segregation and type (disciplinary, administrative)
2. Time of review
3. Specific date of placement
4. Projected date of disciplinary segregation release
5. Prisoner special needs, if any (physical handicap, mental illness)
6. Officer or staff remarks regarding review findings
7. Required follow-up for medical or mental health care
8. Reasons and circumstances that validate continued placement in segregation
9. Alternatives to segregation that were discussed and considered prior to segregation placement
10. Final action or instructions by the Review Committee

The following examples further demonstrate deficiencies in segregation practices and violations of the Agreement:

AS: Held in administrative segregation for five months for having "2 cell phones".

JP: Held in administrative segregation for three years for "misunderstanding". Reports needing clean bedding with no follow-up documented.
MW: Held in administrative segregation for one year, three months for "misunderstanding".
JW: Held in disciplinary segregation for three months for fighting. Report needing medical and mental health services with no documented follow-up.
PD: Held in disciplinary segregation for six months for fighting. Reports needed medical and mental health care follow-up not documented.
EV: Held in disciplinary segregation for fighting. Reports inmate as "poor wellbeing" but no health care referral or follow-up documented.
PS: Held in administrative segregation for two months. Reports inmate states "pain in left hand" with no medical referral or follow-up documented.
JW: Held in administrative segregation for two years for threatening officers. Reports need for medical services but follow-up not documented.

These few examples are repeated throughout the majority of the documents examined. The GGACF segregation review process is inadequate and non-functional. It is probable that some inmates are kept in segregation:

1. without being afforded their legal due process rights;
2. for unnecessary and/or extended periods;
3. without being provided adequate health care services;
4. without being properly and routinely monitored and assessed for physical and mental health needs;
5. without having their reported complaints, needs, concerns resolved;
6. with serious mental illness in violation of the Agreement.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

G. Incidents and Referrals

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Examination of incident reports provided by GGACF officials continued to demonstrate virtually no change in previously reported deficiencies:

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

As previously stated, the existing incident reporting system must be completely overhauled if it is to provide valid and reliable information from which to evaluate serious events in order to comply with this Provision or any provision requiring accurate and complete incident reporting to assess compliance levels.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

2. Develop a unified incident coding system for valid and reliable information and data collection, reporting, and analysis.
3. Establish regular monthly quality assurance meeting process involving all major department team leaders to review serious incident reports and recommend evidence-based remedial measures for eliminating/mitigating incident frequency and severity.
4. Train staff in applying adopted policies and use of forms, implement a continuous quality assurance protocol.
5. Require supervisors to carefully review all incident reports for completeness, accuracy, and consistency.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: A formal and regular administrative process as indicted remains nonexistent. Effective implementation of this process first requires substantial improvements in the current incident reporting systems. Furthermore, valid and meaningful incident data for tracking and management purposes relies completely on the quality of the incident reporting system, quality compliance monitoring, and timely data management.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

c. Requirements for preservation of evidence; and.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No substantive improvement from previous assessment.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No substantive improvement from previous assessment.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE -

FINDINGS: As previously stated, deficiencies in the incident reporting system, lack of reporting quality management, and the vacant Investigator position exacerbate making positive progress with this provision despite the absence of approved policies and procedures.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

H. Use of Force by Staff on Prisoners

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Approved policies and procedures have not been submitted. Furthermore, the Territory has not yet provided current training curricula for use of force as requested by this Monitor several times.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Finalize, approve, and implement draft use of force policies and procedures upon approval and once the revised implementation schedule is approved.
2. Ensure all force incidents are properly reported and document complete supervisory reviews of all reported force incidents.
3. Implement a continuous quality improvement protocol to ensure all incident reports and supervisory review of document are 1) complete, 2) accurate, and 3) comprehensive.
4. All planned uses of force must be monitored and controlled by an onsite supervisor.
5. GGACF must promptly and thoroughly investigate all inmate complaints of excessive force and take necessary corrective action to protect inmates and staff.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above. No improvement.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: See above findings.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated previously reported and stated above, no use of force training has been provided to staff as described in this Provision. **The Territory continues to be nonresponsive to this Monitor's several requests for all training curricula**. This Monitor requested these documents prior to each onsite visit and several times between visits. The Territory's non-responsiveness to the Monitor's request prevents the Monitor from adequately assessing compliance with this section specifically, and all Provisions involving training.
Simply stated, the monitoring team cannot do its job without this information.

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 of force requirements.
3. Provide this Monitor and DOJ with all current training curricula.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Same as above. No change.

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: Despite several incident reports documenting incidents involving staff use of force on prisoners, the Territory did not comply with this Monitor's request for documents; all use of force reports and administrative reviews of force were not provided. Inadequate documentation combined with the Territory's failure to submit required documents as requested demonstrates noncompliance with this provision.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Implement supervisory quality improvement review for all reports to ensure accuracy and completeness before approval.
2. As requested in the previous report, the Territory must develop a use of force tracking log that includes elements to verify that reports are submitted complete and timely.
3. Comply with Monitor's request for documents.

g. Supervision and videotaping of planned uses of force;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

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

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No change.

RECOMMENDATIONS:

1. Provide Monitor documentation of Compliance with this Provision.

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

ASSESSMENT: NON COMPLIANCE

FINDINGS: Examination of incident reports involving use of force by correctional officers continues to demonstrate chronic absence of required administrative reviews. For example, this Monitor found 22 reported uses of force where administrative reviews were not performed. Territory officials stated during this visit that this was due to a misunderstanding about this provision and the definition of force. This Monitor directed GGACF staff to the definition of force in the Agreement and these officials agreed to comply with this provision going forward.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Ensure that supervisor/administrative reviews of incidents involving use of force resolve problems related to reporting accuracy, completeness, and consistency.
2. Provide the Monitor documentation of Compliance with this Provision for ALL previous use of force incidents as requested.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Inadequate incident reporting, lack of administrative reviews and the Investigator vacancy prevent compliance with this provision. Territory officials document that no allegation

of any staff misconduct has been investigated since the departure of the Warden, who also conducted administrative investigations.

RECOMMENDATIONS: Same as above

l. Administrative investigation of uses of force;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above. Documentation requested to assess compliance with this Provision was not provided.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

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

As previously stated, it is impossible for GGACF to fully comply with this Provision until supervisors comply with use of force review requirements.

RECOMMENDATIONS:

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

I. Use of Physical Restraints on Prisoners

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

a. Permissible and unauthorized types of use of restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above

RECOMMENDATIONS:

1. Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above.

d. Required observation of prisoners placed in restraints;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above.

f. Required termination of the use of restraints.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above

J. Prisoner Complaints

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The inmate grievance log from 12/16/2014 to 03/26/2015 was examined for completeness and to assess complaint system efficacy. As previously reported, this document continues to be incomplete and demonstrates serious deficiencies. Numerous data cells in the document requiring data/information were left blank. These omissions involved information/data regarding inmate housing unit location, date and time received, staff response to complaint, response date, and date response was returned to the complaining inmate. Eleven (approximately 25% of complaints) recorded "no response". This is especially troubling considering that no response was given for complaints involving medical care, housing conditions, disciplinary sanctions, staff misconduct, need for personal hygiene products, and food service.

This record continues to demonstrate that GGACF prisoners have no reliable system for resolving complaints. The current system remains inconsistent and not responsive in resolving inmate health and safety concerns and must be improved quickly.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Conduct monthly administrative reviews of the inmate complaint reporting and tracking process to measure and verify program compliance, take timely and appropriate remedial and correction action.
2. Ensure tracking log is consistently completed and accurate.
3. Assign reliable and timely oversight of the inmate complaint process and logs to a staff person who will provide the process consistent, dedicated, and comprehensive attention.
4. Develop a valid and reliable tracking a quality management statistical report for monitoring inmate and facility needs and problems.
5. Ensure staff are available during onsite visits to allow this Monitor to adequately assess this Provision.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Only half (21/40) of the complaints examined recorded dates to assess timeliness of responses. However, this is not to suggest that proper investigations were conducted. Inmates waited from one (1) to 63 days for a response to their complaint. Seventy-five percent (75%) of these 21 complaints were returned to inmates ten (10) or more days after staff received the complaint. Such delay in responding to inmate complaints creates frustration among inmates and increases tension in housing units. Frustration and tension exacerbate safety and security risks to staff, inmates, and the facility. Unresolved inmate complaints involving health care concerns expose inmates to serious physical harm and the Territory to significant criminal and civil liability.

RECOMMENDATIONS: Same as above

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same finding related to administrative and use force investigations and reviews.

RECOMMENDATIONS: Refer to administrative and use of force investigation review recommendations, and:

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

FINDINGS: Same as above.

RECOMMENDATIONS: Same as above, and:

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

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

ASSESSMENT: NONCOMPLIANCE

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

RECOMMENDATIONS: Same as above.

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

K. Administrative Investigations

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: This policy remains in unapproved draft form. The Territory informed this Monitor during this onsite that the investigator's position remains vacant. On April 27, 2015, the Territory informed this Monitor in an email that "*there has been allegations of staff misconduct and matters requiring investigation but the Bureau does not have an investigator, hence no administrative investigations.*" This Monitor's responded the same date requesting further clarification but has not yet received a response from the Territory:

Good evening, Shari – I appreciate your response to both subjects. Please provide further clarification and related documentation in order for me to more clearly assess this situation relative to compliance with the Agreement.

Administrative Investigations:

You state that no administrative investigations have been conducted for known allegations of staff misconduct because the BOC does not have an investigator. Please provide the following information:

1. *Date the investigator position became vacant*
2. *When BOC first had knowledge the investigator position would become vacant*
3. *Action taken by BOC to fill the investigator vacancy, anticipated date vacancy will be filled*
4. *What, if any, level of administrative investigations have been initiated and the name of the person(s) performing this work since the investigator position became vacant*
5. *Action/plans for ensuring when allegations of staff misconduct would be investigated*
6. *Dates, nature and description of all non-investigated allegations of staff misconduct since the investigator position became vacant*
7. *Dates, nature and descriptions, and dispositions of all investigated allegations of staff misconduct since the investigator position became vacant*
8. *Dates, nature and descriptions of all staff discipline take by BOC since the investigator position became vacant*

The Territory responded on May 15th to this Monitor's above information requested in seriatim as follows:

1. Date the investigator position became vacant.

The position became vacant in May 15, 2014 when, the Chief Inspector (Donald Redwood), who performed administrative investigations, was assigned to be the Acting Warden of GGACF by former BOC Director Julius Wilson. During this period, the administrative investigator position was vacant.

2. When BOC first had knowledge the investigator position would become vacant?

Shortly before the then-Chief Inspector was assigned to Acting Warden of GGACF, BOC had knowledge that the position would be vacant.

3. Action taken by BOC to fill the investigator vacancy, anticipated date vacancy will be filled.

To provide context, the procedure for filling the administrative investigator position is as follows: 1) BOC sends a personnel requisition form to the Office of Management and Budget to get approval that there are available funds in the budget for the vacant position. 2) If the personnel requisition form is approved, BOC notifies the Division of Personnel of the vacant position. 3) The Division of Personnel publishes a vacancy announcement and interested candidates apply with the Division of Personnel. 4) The Division of Personnel then sends a list of eligible candidates to BOC. 5) BOC then contacts those candidates and provides the pre-

employment package which includes necessary paperwork for the medical and criminal background check. 6) Those that pass the background check are then interviewed and BOC untimely selects the successful candidate.

On or about May 5, 2015, Acting Director Benjamin signed the personnel requisition form and the same is with the Office of Management and Budget. At this time, BOC cannot provide an anticipated date when the vacancy will be filled until it receives notification from the Office of Management and Budget.

4. What, if any, level of administrative investigations have been initiated and the name of the person(s) performing this work since the investigator position became vacant?

Yvette Phillip, Administrative Assistant, who is responsible for processing grievances, has compiled preliminary a list of matters requiring investigation based on information disclosed in the grievances. The list includes the associated grievances. See attached. Based on the documents, Chief Herbert indicated that he would investigate at least one matter. The Territory will provide a follow-up response regarding the same.

5. Action/plans for ensuring when allegations of staff misconduct would be investigated

See response to Number 3. In addition, Acting Director Benjamin and Acting Attorney General Terri Griffiths met on April 28, 2015 concerning the need to conduct independent administrative investigations into the misconduct of staff and corrections officers at BOC. As a result of the April 28th meeting, BOC and DOJ intend to execute a Memorandum of Understanding identifying where the administrative investigator will be housed. The administrative investigator's office will be located in the VI Department of Justice, St. Croix office, in order to create clear lines of separation between the administrative investigator and the BOC personnel who will be the subject of investigation.

6. Dates, nature and description of all non-investigated allegations of staff misconduct since the investigator position became vacant

See response to Number 4 and see attached.

7. Dates, nature and descriptions, and dispositions of all investigated allegations of staff misconduct since the investigator position became vacant.

Since the position is vacant, there have been no formal investigations and thus, no dispositions.

8. Dates, nature and descriptions of all staff discipline take by BOC since the investigator position became vacant.

See attached. (This attachment contains protected information that this Monitor is restricted from including herein per the Settlement Agreement).

As stated in the previous report, the investigator's position must be filled without further delay. It is the opinion of this Monitor that timely and qualified administrative investigations are crucial to operating a safe and secure correctional facility. The fact that alleged staff misconduct

and other matters remain not investigated is very troubling. Compounding this problem is that Use of Force Reviews remain essentially not done.

RECOMMENDATIONS: Same as previous report

1. Fill the vacant investigator position.
2. Supervisory/management staff must be consistently held appropriately accountable for adherence to agency rules, regulations, policies, and procedures.
3. The November 2014 housing unit riot must be thoroughly investigated and reviewed to prevent similar future events and to improve organizational planning, response, and management of these types of major incidents.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No substantive change since previous visit.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The current investigator position remains vacant. No documents have been provided to assess the Territory's intentions or efforts to fill this position.

RECOMMENDATIONS: Fill the currently vacant Chief Investigator position immediately.

1. Finalize, approve, and implement relevant policies and procedures.
2. Create a formal pre- and in-service training program to train staff who are involved in initial and/or administrative investigation.
3. 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.
4. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.
5. 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.
6. Provide the Monitor qualification documents for the newly appointed Chief Investigator for review upon his/her appointment**.**

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: It is impossible for the Territory to take staff corrective and/or disciplinary action without a fair and complete administrative investigation. The investigator's position must be filled.

RECOMMENDATIONS: Previous recommendations remain appropriate.

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

V. MEDICAL AND MENTAL HEALTH CARE

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

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

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: Although the assessment remains noncompliance, it is clear to the medical reviewer nonetheless that progress is being made. This is evidenced by the fact that all medical policies have been submitted to the monitor as well as the U.S. Department of Justice for their review. The medical monitor has worked very closely with leadership staff at the facility and has provided input to all of the policies related to this agreement. This reviewer has not yet seen the Department of Justice comments regarding the medical policies but we expect to have a conference call within the next week to discuss their recommendations. Revisions may be made after that conference call. In any event, I would expect the policy sequence to be concluded prior to our next visit.

With regard to the receiving screening process, within the last 1-2 months, RN staffing has increased such that there are now RNs onsite Monday through Friday from 8:00 a.m. until midnight. Also, on the weekends there is 8:00am to 8:00 p.m. coverage. We were informed at this visit that there are now plans to add additional nursing hours such that there in fact will be 24 hours seven days a week RN coverage. The program is now using a log for the intake process, although we reviewed with the Director of Nursing the necessity of nursing staff completing every field on every patient in order for the log to be complete. For all of the logs we have indicated blank spaces are in fact an error and should be reviewed as such.

In our review of seven randomly selected records of patients who entered the facility within the prior six weeks, each record contained an intake screen performed by a registered nurse. All of these screens were performed on the old intake screening form as opposed to the one we had recently revised, which I am told will be used in the future. All intake screens were performed timely except for one who was moved by custody out of the intake area on the same day he arrived. That intake screen was not performed until Day 4. It must be a custody policy that no detainees or inmates are moved from intake without having had a nurse intake screen. Among the problems we found with the professional performance included a patient receiving psychotropics without the presence of documented mental illness. We found a case with no TB skin test result in the medical

record. We also found a patient who entered but no acuity scale was documented. Finally, the most consistent problem we found was that the health assessment was either not done or when done was completed belatedly. The Director of Nursing was confident that the nursing performance with regard to the new screen would be improved and more consistent with the requirements by the time of our next visit. In fact, we discussed her responsibility to monitor and provide feedback to the staff on a weekly basis. This should be a key component of their quality improvement program. What follows are some of the specific cases reviewed.

Patient #1
MJ is a 26-year-old whose screen was performed on 2/26/15. His medications include an antipsychotic medication as well as a medication used to prevent side effects of the psychotropic medicine. The acuity scale appears to have been changed from 1 to 2. Given his antipsychotic medications, he should have been assessed as a level 1. On the day of the screen, telephone orders were received for the antipsychotic medication. The history part of the form left blank the questions regarding nervous conditions or mental illness. This patient was seen by the psychiatrist the next day; however, his health assessment has not yet been done.

Patient #2
JIC is a 20-year-old whose intake screen was completed on 2/21/15 and he had a completely negative screen. However, he had no health assessment.

Patient #3
EM is a 24-year-old who was booked on 2/11/15. He lacked a TB skin test result in the medical record and he was on psychotropic medication for mood swings. He also lacked a health assessment.

Patient #4
PG is a 27-year-old who was booked on 1/2/15. He was a federal transfer who had had a CT scan of the chest which was negative and a prior positive TB skin test. His acuity screen was not filled in and he was not screened until 1/6, four days after he was booked. We investigated this case and found that he had been moved by custody immediately after booking and this resulted in a delay of the nurse intake screen. Nurses are in the habit of calling the booking area and querying whether there are inmates there requiring a screen. When patients are moved prematurely the response from the officer is a negative response. It is not clear how medical was notified that a patient was in a housing area who lacked the booking screen. Custody should have a policy that precludes moving out of the intake area until the screen is completed.

Patient #5
AL is a 20-year-old who was booked on 2/6/15 and was assessed as an acuity level 2 on the basis of his history of hypertension. His blood pressure on intake was somewhat elevated at 154/86. His TB skin test was negative. Six days after booking, his intake assessment was completed and he was enrolled in the chronic care hypertension program. However, he should have had his health assessment by 2/9 and instead it was completed three days later.

RECOMMENDATIONS:
1. Finalize, approve, and implement relevant policies, procedures, and forms.
2. Given the plan to provide 24/7 RN coverage, fill those hours as soon as possible.

3. The Director of Nursing should begin a weekly review of the intake process, including timeliness of screen, completeness of documentation including TB skin test results and acuity assessment.
4. Regarding the quality of integrity of the professional performance, nurses should receive feedback when the documentation includes internal inconsistencies, such as a patient on psychotropic medication but no documentation of mental illness.
5. This ongoing feedback and review should be documented so that it can form a part of the overall quality improvement program.
6. After incorporating the input from the Department of Justice, finalize the intake policies.
7. Custody needs a policy that prevents movement from intake to a housing unit until the nurse intake screen has been completed.

MENTAL HEALTH FINDINGS: Nursing staff are performing intake mental health screenings in a timely fashion, usually within 24 hours of intake. Positive mental health findings do initiate referral to the mental health staff by security and medical intake screeners. A freestanding mental health intake screen has not been implemented at the time of this visit.

RECOMMENDATIONS: It is still this reviewer's recommendation that a one page intake mental health screen be implemented to improve clarity, comprehensiveness and identification of needs rather than have components of the screen contained within a multipage medical screening. Sample screening tools have been discussed with the staff during past visits and this reviewer remains available to assist in the form development whenever requested by the site staff.

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: We discussed with the Medical Director the deficiencies with regard to this area. In our discussions we made it clear that compliance with the performance as well as the timeliness rests solely on his shoulders. Noncompliance can only be corrected by his performing or arranging for another clinician to perform these assessments both timely and appropriately. In the seven records we reviewed we found one health assessment that was not performed timely and all the others lacked the health assessment. Clearly this is a serious deficiency. We believe nursing staff should inform the Medical Director whenever an intake health assessment is due and it is the Medical Director's responsibility to insure that the intake health assessment is completed timely and the professional performance is consistent with expectations.

RECOMMENDATIONS:
1. The nursing staff should begin contacting the Medical Director regarding the need to complete an intake health assessment and this should be documented in the medical record.
2. The Director of Nursing, as part of her review of the intake process, should track performance of and lateness of performance of intake health assessments and this should become part of the GGACF QI program.

MENTAL HEALTH FINDINGS: Ms. Ava Murray, LCSW, the mental health coordinator and Qualified Mental Health Professional (QMHP,) provided a log of intake screenings for the month

of April referred to Mental Health and all 4/6 medical records were available and reviewed. Screenings by medical were timely and complete. All but one inmate were released within a very short period of time. The remaining inmate did receive a comprehensive review by mental health and a referral to the psychiatrist.

Since the hiring of Mr. Nemuel Rosas, mental health professional (MHP), initial mental health assessments have been completed on a partial portion of the caseload. The facility's plan is to do an initial psychosocial assessment, per this component of the Settlement Agreement, on all intakes. Now that this requirement has been initiated, a request for clarity in the interpretation of the Settlement Agreement was indicated. A discussion which included Ms. Myrthil, USDOJ, and Ms. D'Andrade, Territory counsel, regarding the interpretation of "within three days of admission" as to whether this represents three calendar days or three business days occurred on the first day of the site visit. This reviewer will monitor based on the final decision of how to interpret this language by the parties.

Since the time of the December 2014 site visit there have been major additions to the mental health staff. A mental health coordinator and Qualified Mental Health Professional (QMHP), Ms. Ava Murray, LCSW, licensed in Florida and the United States Virgin Islands was hired and began work on April 7, 2015. Ms. Murray also has a registered nursing degree and received a master's in social work degree in 2006 specializing in palliative care. She is currently working fulltime. Specific to this provision of the Settlement Agreement, Ms. Murray has created a log to track intakes to the facility to monitor timeliness of assessments.

On February 9, 2015, Mr. Rosas, BSW, began work as a MHP on a fulltime basis. Mr. Rosas has three years of experience working in Puerto Rican prisons as well as inpatient psychiatric experience. He has begun doing the initial comprehensive assessments on all inmates on the mental health caseload but has not yet made it through the entire case list. The Settlement Agreement does require that all inmates in the facility receive a comprehensive initial mental health assessment and it will take some time to complete that task. He has initiated group therapy based on inmate needs for those people on Dr. Sang's psychiatric case list. Groups occur weekly for ½ to 1 hour with five or six attendees per group. Topics range from anger management, law awareness, independent living, family issues, and relapse prevention. Mr. Rosas is attempting to complete individual encounters with all inmates on the mental health case list (approximately 57 inmates).

Ms. Benita Randolph, RN, was hired on January 12, 2015, and assists the mental health team with tasks such as scheduling appointments and referrals, and reviewing psychiatric order transcriptions for accuracy.

GGACF is also in the process of recruiting a second QMHP to complete its complement of mental health professionals. The current staff members all appear very bright, capable and motivated. Their presence should make a dramatic difference in the quality and availability of mental health services to the population on both sides of the facility. Dr. Sang remains a stable and predictable clinical presence in the treatment building weathering transition in the general medical and dental clinics.

RECOMMENDATIONS:

1. This monitor remains available to assist GGACF in developing standardized mental health intake screening, initial behavioral health evaluation, and progress note forms for implementation in the coming months.
2. Technical assistance is also always available and encouraged regarding development of treatment programs at the facility.
3. Continue to track inmates entering the facility and monitor time from admission, screening, and initial psychosocial assessment. In addition, referrals to the psychiatrist should be monitored for time to completion.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: We have used this section to address medical sick call. Therefore, it focuses on acute care needs. Another section deals with chronic care needs. The sick call log has been modified in a manner consistent with our recommendations and it is being used. However, we did identify blank spaces in the log which should have been completed. The blank spaces include date or location of assessment and on occasion some of the identifying demographic information. We reviewed 10 records of patients who had requested acute care or sick call services. In general, we found the nursing assessments timely, although we did find one record in which the logbook documents the date of a nursing assessment but in fact the record lacked any nursing note. We found, as we would expect to find, some instances of opportunities for improvement in nursing professional performance, but the most consistent problem we identified was the absence of timely physician assessment related to nursing referral. Our expectation is that these referrals be scheduled by the nurses based on their clinical assessment of the nature of the urgency but that the least urgent be seen within one week. Unfortunately, commonly this standard was not met. On the other hand, the nursing assessments were overwhelmingly timely. We will describe some of the specifics of our findings.

Patient #1
RG This patient requested to be seen on 1/31/15 regarding discomfort urinating. He was seen by the nurse on 2/2 according to the log but we could not find any note in the medical record.

Patient #2
MP This patient requested, on 2/5/15, to be seen by the Medical Director. There is no documentation by the Medical Director of ever seeing him.

Patient #3
EM This patient requested to be seen on 1/28/15 regarding flank pain. He was seen by the RN on the same day and referred to the physician. However, the RN note lacked any questions regarding the relationship between the flank pain and any difficulty urinating, whether there was any blood in the urine or any other abnormalities associated with the flank pain. This information would be helpful to the physician in sorting out what might be the basis for the symptom. This patient was

seen by the doctor but not until two weeks after the referral. The physician ordered a urinalysis but this was not collected until more than two weeks later. These delays are not acceptable.

Patient #4
SR This is a 27-year-old who requested on 2/9/15 to be seen for a sharp pain in her head. She was seen by the nurse on the same day and a referral was made to the physician. Unfortunately, she was not seen by the physician until nine days later. Again, the lack of timely response is problematic.

Patient #5
CB This is a 35-year-old who on 1/29/15 complained of stomach pain and a headache. He was seen on the same day by the nurse. Unfortunately, the nurse did not perform a physical assessment. She did refer the patient to the physician but he was not seen by the physician until three weeks later, at which point the stomach problem had been resolved but the physician made no queries regarding the headache.

RECOMMENDATIONS:
1. The Director of Nursing, as part of the quality improvement program, should on a regular basis review both the timeliness and professional performance of the nurses and provide direct feedback with discussion for the nurses whose performance needs improvement. This review and feedback needs to be documented so that it can be part of the quality improvement program.
2. The sick call logbook must be filled out conscientiously and accurately. Thus, for every documented assessment in the logbook there must be an associated record of that assessment in the medical record.
3. The Medical Director is responsible for insuring that nurse sick call referrals to the physician occur within the required time constraints.
4. Both nurses and physicians should insure that each symptom on a request is addressed with the patient and that the documentation of the assessment includes the fact that some problems may have been resolved.

MENTAL HEALTH FINDINGS: In the 6th monitor's report this reviewer noted, "The psychiatrist has been seeing inmates on a regular basis for chronic care follow-up. However, this monitor continues to see notations in the medical record indicating that inmates have not been brought to the clinic for their visits due to the absence of security staff. Although it is reported that this occurs less frequently than last spring, it remains a major barrier to access to care for inmates with chronic health conditions."

In my meetings with staff, all reported few if any difficulties regarding transportation of inmates to scheduled therapeutic encounters. Staff have good cooperation with the newly assigned officer in the medical treatment building and improved organization and availability of transport officers.

Currently, the only mental health log of follow-up appointments at the clinic is for the psychiatrist. With the addition of new staff, it is encouraged that the mental health clinics also track inmates\detainees seen for general mental health services, special observation status, and segregation rounds in order to develop data to demonstrate quality, appropriateness and timeliness in the delivery of services. While on site, we did discuss the development of simple but effective tracking tools regarding inmates' status and well-being for segregation reviews by the mental health staff.

The psychiatric log was reviewed in its entirety and charts were selected for both focal and general review and will be described under specific sections of the Agreement. No chart reviewed demonstrated patients being lost to follow up or not being seen within a reasonable time frame as was the case during our early visits.

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

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 met for some time with the pharmacist and understand that because there is a new administration she must have a new contract with the Bureau of Corrections. She is in the process of contract submission. She is also awaiting compensation for the last three months of 2014. We discussed with her the plans to move forward. She anticipates that the equipment should be onsite within the next three to six months. The process will require a person working in essence full-time as a pharmacy tech; the current LPN who is quite conscientious could meet the requirements and obtain the appropriate credentials. This person would work under the pharmacist's supervision. The person would be responsible for receiving medications and following the pharmacist's instruction with regard to storage and maintenance as well as responding to new orders from the clinicians.

My discussion with the pharmacist included selecting pharmacy software that would allow the pharmacy technician to enter orders into the software, but those orders could not be carried out until review and sanction by the pharmacist, who would have a second level of privileges. I also discussed the possibility that the pharmacist should be able to technologically perform this function even from home and if that is the case, then at least five days a week there should be timely availability of prescription medications. This capability would have to be worked out with the information technology people at the Bureau. However, I believe that this would be the most efficient way to accomplish the tasks.

I did observe a medication pass and was chagrined to observe that detainees were surprised to be requested to open their mouths for inspection after they had ingested the medication. The officer accompanying the medication nurse on both the morning and evening passes, seven days a week must insure that inmates present themselves at their door with a cup of water and are clearly identified. They must take and ingest the medication in front of the nurse, swallow the water and then open their mouths for inspection to insure that the medication is ingested. It is critically important that officers understand their responsibility for this part of the process and that this occur

during all medication passes. The medical monitor has seen this work in jails and prisons all over the United States and invariably the patients are not the problem when custody enforces the requirements for participation in the medication process.

We also observed that the medication administration records are now brought with the nurse in a carrying bag. However, the nurse was not immediately documenting in the control room after each housing unit was completed. Nursing boards require that documentation of medication administration occur as soon as possible after the administration takes place.

RECOMMENDATIONS:

1. An officer needs to accompany the nurse on all medication rounds.
2. That officer's responsibility besides accompanying the nurse is to insure that all inmates present themselves at the door, carrying a container of water and that after receipt of the medication they immediately ingest it, swallow the water and open their mouths for inspection to insure that no pills are retained as contraband.
3. Nurses should document medication administration within the control room of a housing unit immediately after completing the administration for that housing unit.
4. The Director of Nursing should monitor the performance of the medication administration process as part of the quality improvement program.

MENTAL HEALTH FINDINGS: 100% of all mental health medication administration records (MARS) were inspected for completeness during this visit. The medication administration records did not indicate a problem with the administration of medication. However, no quality improvement data was available to dispute previous observations of medications being distributed without observation of ingestion. It was reported that the nurse administers medication and is also performing mouth checks.

RECOMMENDATIONS: defer to Medical recommendations

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: With the hiring of the new full-time medical records technician, we did observe some records which were well organized, appropriately sectioned and contained documents in the appropriate chronologic order. For this the records technician is to be commended. However, this was not the case with all records. Some records, especially of inmates who have been housed for longer periods of time, remain somewhat chaotic. We look forward to our return in June and expect that the reorganization of the medical records will have been completed.

RECOMMENDATIONS: Complete the task of reorganizing the documents within the medical records so that they are contained in the appropriate section on the appropriate side and in the correct chronologic order.

MENTAL HEALTH FINDINGS: The maintenance of medical records is another area that has demonstrated remarkable improvement since the time of the December 2014 review. The facility

has hired a permanent full-time medical records clerk, Ms. Franklin, as of January 12, 2015. Almost all of the mental health records, which at the time of the last visit had not shown any reorganization, are almost all reformatted. Charts are now assigned a numerical number for filing and have tabs to organize the location of materials within the record. It was noted during the records review that many of the entries within the sections still remain out of chronological order. I did not note any loose filing within the records, which again is a major improvement. Ms. Franklin continues to work on improving and thinning the records and I am quite optimistic that the charts will be in excellent condition within the next several months.

Dr. Sang noted that she has set up a meeting with her staff to go over the development of forms for the different functions within the team in the near future.

RECOMMENDATIONS:

1. Once all records are appropriately organized and filed, a quality improvement tool needs to be developed to track compliance with this provision.
2. It is recommended that the mental health team contact this reviewer by e-mail once the new mental health forms are drafted for technical assistance prior to implementation. This process will hopefully avoid after the fact modification to ensure their completeness.

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 this provision.

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: Eight mental health sick call requests have been submitted by inmates since the December 2014 site visit. Of these 6 (75%) records were located and reviewed. There were some delays in time to resolution but no adverse outcomes. I did discuss with Ms. Murray and Ms. Charles some issues noted such as original sick call requests being placed in a folder for a provider and not making it into the medical record.

RECOMMENDATIONS: This process needs to be tracked more closely to prevent delays in resolution in the future.

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: We interpret this as referring to a chronic care list and an ability to track the sequence of visits. There is not yet a process to guarantee an accurate list is available based on new admissions added to the chronic care program as well as recent releases deleted from the chronic care program. The nursing staff will have to work with custody so that they receive a daily list of releases and can compare that list with the chronic care list. The chronic care tracking system should contain the names of patients, the date of referral into the chronic care program, the date of the initial baseline visit and then the dates of follow-up visits. Most systems set this up in an Excel-type format; however, it can be done manually as well. We reviewed five records of patients with chronic diseases, which we obtained from the chronic care list. We found problems with the timeliness of follow up as well as the documentation of the degree of control and the timeliness of the scheduling of the follow-up visits. We discussed with the Medical Director the desirability of reassigning the chronic care program to a clinician whose focus goes beyond a single subspecialty. The person performing chronic care certainly can be retained for patients whose disease is within his specialty. Of the five records we reviewed, at least three were problematic.

Patient #1
JH This patient is a 71-year-old with hypertension whose initial comprehensive visit occurred in August of 2013. The old forms were utilized, which did not allow for documentation of the assessment of degree of control. His next follow-up visit was one year later in September 2014 and his subsequent follow-up visit was four months later in January 2015. He has had no laboratory test results in his record since 2011. This patient is not being appropriately followed.

Patient #2
RM This is a 56-year-old whose initial baseline visit occurred in March 2014. He is assessed as having hypertension. At that time his blood pressure was slightly elevated at 161/87. This was assessed as fair control and he was given a follow-up visit in 60 days. However, that follow-up visit, which should have been in May 2014, contained no date. He has not been seen since and has no recent laboratory studies.

Patient #3
HR This is a 54-year-old with diabetes and hypertension whose baseline chronic care visit lacks a date. He was most recently seen on January 9, 2015, as a follow-up visit. However, there was no assessment of his diabetes despite the fact that he is on oral hypoglycemic agents.

The program remains disorganized.

RECOMMENDATIONS: The Director of Nursing should assign a chronic disease nurse who will be responsible for (a) maintaining the chronic disease tracking log, including adding new names and deleting released names, (b) working with the doctor to insure that follow up is consistent with the assessment of degree of control, (c) insuring that based on the guidelines, required laboratory studies are drawn and available in the medical record at the time of the scheduled visits, (d) insuring that where medications are ordered, patients continue to be seen without any disruption in the availability of their medications.

MENTAL HEALTH FINDINGS: The mental health clinic continues to maintain a tracking log for all patients followed by Dr. Sang that appears to be up to date during this review.

RECOMMENDATIONS:

1. No further recommendations at this time

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: See f (ii).

RECOMMENDATIONS: See f (ii).

MENTAL HEALTH FINDINGS: The only current provision for acute mental healthcare is referral to the local emergency department where Dr. Sang can retain the individual for up to 48 hours. She reports she has kept inmates for up to nine days at the hospital in a general medical bed. No inpatient psychiatric beds are available on St. Croix. St. Thomas's mental health unit has been reduced in bed size due to inadequate staffing and they have refused transfers from Golden Grove Adult Correctional Facility. Officers do accompany inmates when they are at the local hospital for security purposes.

One inmate was placed in full security restraints and the medical record did not indicate any well-being and circulation checks performed by medical staff. Even if restraints are not medically ordered, nursing staff should conduct frequent checks for positioning and circulation.

RECOMMENDATIONS: defer to Dr. Shansky's report

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: We are encouraged that in several of the housing units we visited, there was an emergency response bag, which appeared to contain appropriate supplies for an emergency medical response. We did not review all housing units. However, in the five or six housing units we visited, the emergency response bag was available under lock and key and it was appropriately supplied. With the increased availability of nursing staff, officers now have access to medical staff for a greater number of hours. There is an emergency response log which is being maintained. However, as with the other logs, there are some blank fields which must be completed. We reviewed four records from that log. Some aspects of the process appear to be working. However, the most consistent deficiency was physician follow up after an emergency send out. This is a responsibility of the Medical Director to insure his availability or some other appropriately credentialed clinician. We will describe several of the cases.

Patient #1
JE is a 21-year-old who was sent out on 2/1/15 to the ER at 7:42 a.m. for an acute asthma attack. We did not find a nursing note prior to the send out. The emergency room report was present and the patient returned on the same day at 2:30 p.m. The patient was given prednisone, a steroid medication, to reduce inflammation but five days after the medication expired Dr. Burton wrote an order for a second prednisone order. He did not, however, place the patient on an inhaled steroid. The patient was seen by the chronic disease doctor, who indicated the patient had no complaints but that he heard wheezing in both lungs. He also did not order inhaled steroids but only ordered pulmonary function tests. Four days later, the patient was again sent to the emergency room. That last emergency send out would probably have been prevented had the patient been started on an inhaled steroid. The patient has not been followed up since his return.

Patient #2
ES This is a 34-year-old who was sent to the emergency room on 2/22/15 as a result of left-sided chest pain. The emergency room documentation indicates that vital signs were normal and the patient was given an injection for the pain. A chest x-ray was done and the ER diagnosed costochondritis. There is a nursing note on return to the prison, but there has been no follow up by a clinician.

Patient #3
NW This is a 19-year-old sent out on 12/17/14 for a gluteal abscess. This patient had been seen by Dr. Burton and sent to the emergency room for an incision and drainage. These services were provided at the hospital and the patient returned and was seen by a nurse the following day. However, there has been no follow-up visit by a clinician to review the wound and insure that the problem has been resolved.

Patient #4
FC This is an 83-year-old who was sent out on 1/16/15 after complaining of dizziness after he had eaten. The emergency room note only indicates that the dizziness had resolved and there does not appear to have been any other diagnostic studies or treatment. This patient had no follow up until he requested to be seen for leg swelling, which happened about a month later.

RECOMMENDATIONS:

1. There must be, during the hours when nurses are on site, a nursing note prior to each emergency send out.
2. There must be a nursing note when the patient returns and the emergency room documentation must be available and reviewed by the Medical Director.
3. There must be a Medical Director follow-up visit within a few days of the patient's return in order to insure that the problem has been appropriately followed up and is being resolved.
4. Medical staff should, on a regular basis, document the presence of emergency bags in each housing unit. There should be a sheet available to review in which custody has already documented the presence of these bags that are fully supplied.
5. We would like to see documentation of training being provided to officers by the Medical Director regarding emergency response.

MENTAL HEALTH FINDINGS: see section V. i.

RECOMMENDATIONS: see section V. i., also, as stated in 5th Report:

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: There is a log which is being maintained; however, we did find occasional blank spaces. Over a two-week period of time, four patients had to be rescheduled due to unavailability of officers or the transport van. However, all reschedules were accomplished timely. We were informed that radiology procedures take up to two weeks to accomplish and receive the report. We are still awaiting a computer in the medical unit to allow access to the hospital records including consultation reports, ER reports, radiographic reports, etc. We understand the hospital has agreed to this; however, the local BOC IT person has not been able to meet with IT at the hospital. This must be accomplished as soon as possible.

In the four records we reviewed, the most common problem was follow up by a clinician after the service was received at the hospital. This again is a responsibility of the Medical Director. Specific cases will be provided.

Patient #1
JM is a 58-year-old for whom the chronic care doctor requested an ortho consult after he complained of right hand and knee problems. He was seen by ortho timely on 2/3/15 and diagnosed as having cervicalgia and imaging of the neck and shoulders were ordered. This imaging has still not been accomplished. There has been no follow-up visit with the clinician to discuss the plan with the patient.

Patient #2
CL is a 47-year-old whose problem was left hip tenderness and for which an ortho referral was requested. Ortho indicated that a CT scan for the hip was indicated to determine whether a procedure needed to be done. After the ortho appointment there was no follow-up visit with the clinician. The CT scan was accomplished but there has been no follow-up visit after the CT scan. We discussed this case with Dr. Burton, who indicated because the patient may need surgery off island, he has discussed this with several other specialists but he is waiting to hear from a third and if that specialist concurs (that the service must be obtained off island), he will make the arrangements.

Patient #3
BC is a 58-year-old referred for a renal ultrasound and then on to a nephrologist. These referrals were done on 12/19/14 as a result of the patient having a blood test consistent with early renal failure. The ultrasound was done on 1/8/15 and the results are consistent with mild renal scarring and mild bladder retention. There has been no follow up with the clinician after these procedures. The patient did see a nephrologist on 1/27, but the nephrologist never mentioned early renal failure and ordered a follow-up visit which did take place in February, but again never commented on the elevated blood test and the diagnosis of early renal failure. This case was poorly handled and discussed with Dr. Burton.

RECOMMENDATIONS:

1. Dr. Burton needs to insure that he is available for follow-up discussion with the patients after consultations or procedures.
2. The electronic link that would allow for accessing the electronic record of the hospital at the prison needs to be implemented. The IT person from the Bureau needs to work with IT at the hospital as soon as possible so that this link is functioning by the time of our next visit.

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 f (v).

RECOMMENDATIONS: This has been discussed under f (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 have reviewed the draft policy and procedure from the Medical Director on alcohol and drug treatment. Our only recommendation is that the policy and procedure should make it clear at what point, based on nurse monitoring, the nurse is obligated to contact the Medical Director for direction. This should be specified in the guidelines.

RECOMMENDATIONS: Modify the policy and procedure so that it is clear when the nurses must contact the Medical Director.

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: We now have received and reviewed the infection control policy and procedure and are comfortable with the latest draft. We are purely awaiting comments from the Department of Justice. On the other hand, when I was observing the medication pass, the registered nurse who was performing the medication administration also had a list of patients whose TB skin tests needed to be read. At that time she saw several inmates and read their TB skin tests. However, one of the inmates appeared to potentially have a positive skin test, which the nurse told me after feeling the degree of induration she would list as positive. The problem was she had not used a centimeter ruler in order to measure the size of the induration. Since the measured size of the induration is necessary to determine whether a skin test is positive and the results have to be documented in terms of millimeters of induration, I counseled her on the need to return and measure the size and then document on that basis. The TB skin test process requires that the Director of Nursing review the requirements for appropriate reading as well as documentation.

RECOMMENDATIONS: The Director of Nursing must train all nurses who will potentially either plant or read a TB skin test as to what the procedure requires, including documentation of all positives in terms of the number of millimeters.

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: There are no validated cases located by this reviewer of suicidal behavior or ideation to review GGACF's actions for this provision.

In the past, review of the unit logs, especially the segregation units, contained frequent notations by security staff of behavioral problems on their units. These logs were very helpful in being able to identify charts for review to ascertain whether appropriate and timely behavioral health checklist referrals were generated. However, inspection of the segregation unit logs this visit demonstrated a complete absence of any description of any unusual behavior on the part of inmates housed in the L and 9A units with identified or unidentified mental illnesses.

The mental health coordinator is beginning a log to track behavioral health referrals from security as well as sick call requests.

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

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Ms. Charles and Dr. Sang reported no instances of deaths, including suicides, suicide attempts nor adverse events since the time of this reviewer's visit in December 2015. No medical records examined documented a suicide watch. However, the United States discovered during the April 2015 site visit that at least one inmate had in fact died in January 2015. That death was not reported to the monitoring team as required by the Settlement Agreement. The Territory confirmed the death by letter dated May 11, 2015, in response to the United States' April 30, 2015 inquiry. The monitoring team has requested additional documentation about the inmate's death and will evaluate it once it is received. The monitoring team's logbook review uncovered at least one serious suicide attempt that apparently had not been communicated to medical mental health staff.

RECOMMENDATIONS:

1. An observation log form be developed for correctional officers' use whenever an individual is placed on close observation or 15 minute watch. This will standardize documentation facility-wide.
2. Once implemented, these should be reviewed by mental health staff regularly to ensure security's compliance with the policy.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: A suicide risk assessment instrument is not in place.

RECOMMENDATIONS:

Per previous monitor reports, a suicide risk assessment form should be developed and implemented as part of the intake screening process as well as any other follow-up services. One reference for correctional use can be located at: http://www.cdcr.ca.gov/realignment/docs/PRCS-MH-pre-release-planV2-11-20-2012.pdf

2. All mental health encounters should record the presence or absence of suicidal or homicidal ideation by the mental-health professional performing the service.

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

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: During this visit we learned that there was no cut down tool in the medical treatment building. This situation was corrected prior to the reviewer's exit. For a complete assessment of all units within the facility this reviewer defers to the report by the security monitors.

RECOMMENDATIONS: defer to Mr. Romero's or Mr. Ray's report

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Currently the monitor has not yet received nor approved an adequate training curriculum. Therefore, this provision remains noncompliant.

While on site, I did discuss this continuing deficiency with Mr. Benjamin and again requested a copy of the training curriculum be sent to me and Mr. Ray for review and approval. He assigned Ms. Andrade the task of obtaining and distributing that document. As of this report, the document still has not been provided to the monitoring team.

RECOMMENDATIONS: A complete training curriculum on suicide prevention needs to be forwarded to the monitors for review and approval.

(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: There has been no change reported in this area. Ms. Charles reports no suicide prevention training has occurred since last fall. They are waiting to bring on a significant number of new hires and will then schedule training. However, it is again noted that there is no curriculum yet approved by the monitoring team.

RECOMMENDATIONS: GGACF will submit their curricula for training officers and facilities staff in suicide prevention for approval by the monitoring team. Once approved, the facility will need to develop a training schedule for all staff. Effectiveness of the training will need to be demonstrated by the use of competency measuring tools and follow-up quality improvement studies.

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: By inspection, GGACF continues to operate without any suicide-resistant cells. Inmates requiring close observation are housed in the regular housing units. That placement would require that inmates be placed on constant observation. However,

even when inmates have been listed as on suicide watch in the past it has been noted that observation occurred on an intermittent and unpredictable schedule, if at all.

Construction of a small infirmary and suicide prevention housing area within the medical treatment building has come to a halt, reportedly due to finances and relocation of inmate workers to off-site facilities (the latter as a remedy to improve inmate officer-to-inmate staffing ratios). One physically disabled mentally ill inmate is currently being housed in a single cell fitted with a hospital bed and access to the bathroom facilities. We were informed that an officer is assigned around the clock to the treatment building to provide supervision for this inmate. However, as noted above (see Section IV.A.1.b), documents reveal that the treatment building was not staffed on at least three (3) shifts.

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

(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 has occurred since the time of the last site visit. A draft protocol had been submitted to the parties for review and approval. Therefore, this provision remains in noncompliance since there is not an adopted and approved policy in place, training has not begun and no measurement of efficacy of the training exists. And in fact, as mentioned previously, there is observable evidence that little if any observation is provided and documented currently.

The supervisor's log dated Thursday, March 19th, 2015, indicated one person had been brought in by VIPD on suicide watch per the person's attorney. The medical department had no records on this individual and it is unclear whether they were ever booked into the facility.

RECOMMENDATIONS: Complete the process of policy approval, implementation and monitoring.

(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: It was reported there have been no cases of suicide watch for this monitor to review and no final policy. However, the logbooks indicate that there may have been at least one serious suicide attempt and a suicide watch, neither of which were brought to the mental health staff's attention.

RECOMMENDATIONS: Complete the process of policy approval, implementation and monitoring.

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: Since the last visit, a full-time medical records staff has been added and in addition there have been additional hours provided of registered nurse staffing. The current staffing as of the time of our visit is one full-time Director of Nursing and three full-time registered nurses plus an additional two hours of registered nursing. We have been informed that in order to cover the gaps that preclude 24/7 RN staffing they will add one full-time nurse plus part-time hours. They currently have one eight-hour shift uncovered seven days a week, which equals 56 hours plus four additional hours on Saturday and Sunday. That adds up to 64 hours of additional registered nurse time that needs to be added. This would be in terms of full-time equivalents; 1.6 FTEs and they would be able to cover 24/7. I have been generally impressed with the quality of the nursing staff hired and was informed by the nurse who has been on site the longest period of time that in his several years on site this is the best group of nurses they have ever had on site.

RECOMMENDATIONS: Complete the remaining hours of registered nursing so that coverage achieves 24/7.

MENTAL HEALTH FINDINGS: This area of the Settlement Agreement has shown measurable improvement. There are currently two mental health professionals and a psychiatrist. A registered nurse has been identified to assist the mental health team when needed and monitoring referrals, medication order transcription and laboratory studies. This service is not yet fully organized; however, with the very recent addition of the mental health coordinator I anticipate rapid and continued improvement in the quality and quantity of services available to the inmates at GGACF in the near future.

While on site, I had the opportunity to review the resumes for the new hires and ensure that licenses for Dr. Sang and Ms. Murray were current. As mentioned earlier, a third mental health professional position is open and recruiting is ongoing.

RECOMMENDATIONS: None at this time. Once policies are adopted facility should complete an annual staffing analysis and those analyses and plans will be reviewed by this monitor.

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: There has been rotation of assignment of correctional officers who work in the medical area. As far as we are aware, there have been no additional officers added and this has had its most significant impact with regard to access to offsite services for which four patients in the last two weeks have had to be rescheduled. This was either due to officer availability or van availability. We have identified previously that officer escort onsite will be required less when the exam rooms built in each housing unit are refurbished and appropriately equipped. We are pleased to note that the effort to accomplish this has begun and we visited the L and K housing units where the process has progressed the furthest. We also visited the G housing unit and in detention both A, B, C and D. The detention housing units were least advanced and L and K were most advanced. I will list the requirements for each housing unit exam room. They are as follows:

1. An air conditioner that is functioning.
2. About 4-6 inches of privacy screen on the windows from the bottom of the window up.
3. An exam table with necessary paper.
4. A large wastebasket in which the used paper can be placed.
5. A desk and two chairs.
6. A sink which includes functioning hot water.
7. Soap.
8. Hand sterilizer.
9. A full set of tiles on the floors which were especially a problem in the detention area rooms.
10. A complete set of ceiling tiles.
11. A redo of the cleaning process so that sanitation is adequate.
12. Cabinetry with a lock on it which can house medical supplies.

RECOMMENDATIONS:
1. Provide sufficient officer staffing and transport vehicle so that rescheduling can be eliminated.
2. Refurbish and supply all housing unit exam rooms according to the requirements listed in the above findings.

MENTAL HEALTH FINDINGS: There is no progress on this front due to the lack of submission of an adequate and an approved training curriculum by the monitor. Given the absence of any mental health programming plan, it remains impossible for the facility to determine what the adequate number of correctional officers are to properly supervise prisoners serious mental health needs.

RECOMMENDATIONS: None at this time. Once policies are adopted facility should complete an annual staffing analysis and those analyses and plans will be reviewed by this monitor.

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: I have listed the areas that I expect to see quality improvement activities at the time of our next visit. Those include the intake process, including the intake screen and health assessment as well as sick call and medication management and I am expecting to see documentation of QI activities in these four areas by the time of our June visit.

RECOMMENDATIONS: Perform documented QI activities with regard to the above listed service areas.

MENTAL HEALTH FINDINGS: Until policies are approved, trained to, and implemented this provision cannot be met. It is reported that since our last visit there still have been no meetings of the Medical Administration Committee or the Quality Improvement Committee. Hence, there were no meeting minutes available to review.

RECOMMENDATIONS: Essential monthly or quarterly management meetings should be occurring regardless of whether a draft policy has been adopted. Although it is useful for the medical director to be present this should not be an essential component blocking communication between medical staff and other department leaders. Failure to implement these critical committees delays essential communication between administration and medical and remains a major deficiency.

m. Adequate dental care;

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We have looked at and approved the oral care policy for which we are awaiting the DOJ comments and the completion of the process. I met with the dentist during this visit and discussed with him access, which he indicates has improved. We do not yet have documentation of this.

RECOMMENDATIONS:

1. The HSA should track both the availability of the dentist as well as the availability of custody escorts under the QI program.
2. The dental program should report to the QI program the number of scheduled patients and the numbers who arrive and the reason for non-arrival of patients.
3. The dental program should track the number of extractions as well as the number of restorations performed each month.
4. Develop adequate dental 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: We have seen a draft policy. We do believe an important part of the QI program is for an external review of all deaths to be performed by a non-involved physician in direct care to the patient.

The Territory has not complied with the terms of the Settlement Agreement which require notification of the Monitor and United States upon any inmate death. At least one inmate died in January 2015, but that fact was not brought to the Monitor and United States' attention as required. Instead, the Territory only confirmed the death in May 2015, in response to the United States' inquiry in April 2015, which based on the United States' independent document review. The monitoring team has requested but not yet received documentation relating to this death.

RECOMMENDATIONS: Make an arrangement with an external physician to perform an educational mortality review on all deaths.

MENTAL HEALTH FINDINGS: However, as stated in V.1.k, there has been another case of complicated aggressive behavior and management issues which has generated no documented comprehensive combined internal investigation or review by security and health services. Cases like this would benefit from routine special management meetings or even discussion in a monthly Medical Administration Committee meeting, per provision V.i.l, but none of these are in place.

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

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: My understanding is medical staff are to round twice weekly in order to insure access to services and to assess the potential for decompensation. I have not reviewed the segregation logbooks. I will begin at my next visit.

RECOMMENDATIONS: The Director of Nursing should, on a monthly basis, monitor the segregation logbook to insure that registered nurse rounds have been completed.

MENTAL HEALTH FINDINGS As of the time of this visit, no rounds by any health staff have been performed in segregated units. However, Ms. Charles assured me that as of May 2015, the mental health coordinator would be completing and documenting weekly rounds. A registered nurse will begin doing medical rounds twice a week as of April 21, 2015.

RECOMMENDATIONS: The mental health coordinator will keep documentation of weekly rounds and this provision will be monitored at the time of the next site visit.

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: There is no change in the findings for this provision since the baseline visit. Inmates with serious mental illness continued to be housed on a long-term basis in disciplinary segregation units. This reviewer also observed three inmates with serious mental illnesses being housed in locked cells for vulnerabilities secondary to their mental illnesses in a general population detainee unit. These inmates are allowed congregant out-of-cell unstructured time for two hours each evening.

Two of the three inmates appear to have developmental disabilities while the third appeared to be actively hallucinating and responding to internal stimuli. A chart review indicated that these three men all carried diagnosis of the major serious mental illness and were receiving antipsychotic medications. All three were housed in cells with no radios or reading material. One man known to eat plastic cups was noted to have the debris of several Styrofoam cups on the floor of his cell. Another inmate was actively smoking a cigarette that he states he had made from toilet paper. The smoke in his cell was so acrid that it was difficult to interview him beyond a few seconds without withdrawing from the cell. The prison is a smoke-free facility with no fire suppression system in place and yet no officer accompanying us requested that the inmate extinguish his makeshift cigarette, which is contraband. The third inmate told me that during his time out of cell he smokes cigarettes in the common area. During the day, while locked in his cell, he attempts to beg cigarettes from other inmates who are circulating within the dayroom area. None of these inmates had any access to structured mental health programming yet clearly would meet criteria for residential treatment placement with the requirements of a minimum of 10 hours of structured therapeutic activities per week. These men are currently only receiving services at an outpatient level of care that is insufficient to meet their treatment needs and only allowed out of cell time two hours per day (a requirement for SMI in segregation) despite the fact that they are not in administrative or disciplinary segregation, but rather protective custody because of their vulnerabilities.

Similarly, some inmates with serious mental illnesses continue to reside in segregation units because of the lack of availability of any other housing designed to meet both their security and mental health treatment needs.

The medical case manager attended a segregation meeting that should be occurring monthly since January but there is not documentation to support the regularity of these meetings. In reviewing her notes from all meetings that have occurred, any chart referencing a mental health need was reviewed. For one inmate there were two notes that he needed to be seen by the psychiatrist but the medical record does not document that either comment resulted in a visit.

RECOMMENDATIONS:

1. As per the provisions of this Settlement Agreement, inmates with serious mental illnesses should not be placed in isolation. However, it is also noted that the facility lacks any specialized programming unit to adequately accommodate the treatment needs of the seriously mentally ill population and is unable to currently provide any relief to the mentally ill inmates in segregation who require heightened programming and structure. The latter however does not relieve the Bureau of that obligation to develop, in a timely manner, the necessary treatment programs and housing requirements for these inmates. The lack of programming and appropriate housing has been an issue identified by this monitor for the past year and half. The Bureau of Corrections needs to develop a corrective action plan with specific recommendations for capital improvements and dates to remedy this deficiency.
2. As discussed with the mental health staff, a record should be maintained in order to prove that the practice of weekly mental health rounds in segregated units on the detainee and prison side.
3. During the time that inmates remain in segregation with serious mental illnesses, mental health staff should be aware that these inmates be offered a minimum of 10 hours a week of unstructured out of cell time by security. In addition, mental health staff is encouraged to develop supportive group or individual therapeutic activities, generally recommended being a minimum of 10 hours per week per inmate in order to support the inmate's mental state as well as assist inmates in acquiring skills to move them off the segregated status and sustain themselves in the general population setting.
4. Medical services needs to ensure that communications regarding inmate needs gathered in administrative or other meetings be formally entered on to a referral sheet to the clinic for improved follow up.

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: Without a policy requiring input by mental health into the disciplinary process and a form to communicate with the disciplinary committee, mental health will not be notified regarding disciplinary reports and therefore, cannot provide input.

RECOMMENDATIONS:

1. GGACF should develop a form which can be sent to the Mental Health Coordinator, completed by mental health staff and submitted to the disciplinary committee. The committee can use the same form to communicate back to the mental health staff outcome of the hearing proceeding.
2. GGACF needs to develop an effective policy and process to provide mental health review and input into the disciplinary process.
3. Mitigating factors discovered by the mental health professional must be considered by the disciplinary committee.
4. Mental health services should track the effectiveness of their input in mitigating sanctions or

terminating sanctions as appropriate.

5. Alternative housing and treatment services are an essential component in diverting seriously mentally ill inmates committing infractions due to their impaired judgment and mental processing. Again, it is recommended that GGACF provide appropriate staffing and housing alternatives for this population. (See V.1.p.)

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MEDICAL FINDINGS: We have discussed some progress made in the preparation for housing unit exam rooms to be appropriately equipped, cleaned and sanitized. The section k medical findings on officer staffing includes a description of what is needed. Additionally, nurses are now performing sick call in a room with only a desk and chairs. The room in the clinic area must be equipped with appropriate exam table, other examination supplies as well as, at a minimum, hand sanitation liquids.

RECOMMENDATIONS:

1. Complete the requirements found in the medical findings regarding officer staffing.
2. Appropriately equip the clinic space in which nurses are now performing sick call.

MENTAL HEALTH FINDINGS: The psychiatrist and MHP are using private offices in the treatment building. However, once the medical director and other medical providers are on-site running clinics, space may yet again be an issue.

RECOMMENDATIONS: Appropriate sound private office space with reasonable visibility by security staff needs to be made available to the psychiatrist and to any mental health professionals that are hired providing services in the medical treatment building.

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: Based on chart review, there remains a need for updated treatment plan, some of which have not been changed since 2013. However some of the difficulty may be due to the lack of mental health professional staff. Now that there are two new members to the team there should be improvement in the quality and quantity of treatment plans.

RECOMMENDATIONS:

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous visit.

MENTAL HEALTH FINDINGS: There remain serious deficiencies in meeting the requirements of this provision. As noted earlier with the hiring of additional mental health staff, approximately 5 weekly outpatient groups are being offered as well as an increased number of individual face-to-face encounters. However, the service has not yet had time to organize itself to develop and implement a comprehensive facility-wide treatment program.

RECOMMENDATIONS:

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

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

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous assessment.

MENTAL HEALTH FINDINGS: The psychiatrist continues to do an excellent job in obtaining vital signs including girth at the time of each visit.

Review of 3/5 records were available of those inmates on psychiatric medications that ordinarily would require blood testing and level analysis indicated a need for improvement in the ordering and tracking of these studies. No chart that fell in this category demonstrated adverse effects if studies had not yet been obtained.

A total of 38 inmates are currently receiving psychotropic prescriptions. Of these 68% were on antipsychotic medication and 73% of that group were receiving long-term injectable preparations. There is an unexpectedly low percentage of individuals being treated with antidepressant medication (16%).

There is no formal policy in place or protocol to establish laboratory practice guidelines for the psychiatrist to follow and for the Quality Improvement Process to track.

RECOMMENDATIONS: USVI BOC should develop its own set of practice guidelines to be used system-wide.

Please refer to the following previously provided suggested guidelines (these are not standards, simply suggestions).

LABORATORY GUIDELINES:

Lithium:
1. Initial (within 3 months of initiating drug)
2. U/A
3. CBC
4. SMAC
5. TSH
6. EKG if over 40
7. Level every one to two weeks after reaching dose of =/> 600 mg day until level stabilizes.
8. Once a plateau is reached levels should be obtained q 4 months.

Tricyclic antidepressants:
1. Initial same as above except a U/A is not required
2. Level every 6 months or sooner if clinically indicated (Dose exceeds daily recommended dose, etc.)

Atypical Neuroleptics:
1. At least quarterly weights, HgA1C and fasting lipids q six months especially for Clozaril, and Zyprexa.
2. AIMS (Assessment of Involuntary Movement Symptoms) initially and q 6 months

Anticonvulsants (Depakote, Tegretol):
1. Hepatitis screen within last three months
2. SMAC
3. CBC with platelet count
4. Monitor levels of Tegretol and Depakene until within a therapeutic range

Chronic use:
1. Level q six months
2. Follow up LFT's for Depakene

Beta blockers
1. Initial vital signs and follow up pulse and BP whenever dose is changed

Benzodiazepines
2. Baseline vital signs
3. Random UDS q 3-6 months or whenever clinically indicated

Psychostimulants
1. Baseline vital signs
2. Random UDS q 3months
3. Consider TSH whenever clinically appropriate.

Other reference sources on:

1. practice algorithms include the American Psychiatric Association's Practice Guidelines at www.psych.org; http://www.urmc.rochester.edu/psychiatry/links/practice-guidelines.aspx
2. AIMS http://www.cqaimh.org/pdf/tool_aims.pdf

(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 the sixth report.

Correctional officers at GGACF should be commended for continuing to comprehensively complete behavioral checklists to initiate referrals for mental health services.

RECOMMENDATIONS:

1. Continue to utilize the Behavioral Checklist process.
2. Conduct a facility quality improvement morbidity review that can be submitted to the monitoring team for review.

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

ASSESSMENT: NONCOMPLIANCE - No substantive improvement from previous visit.

MENTAL HEALTH FINDINGS: As noted above, there has been no change in this area since the sixth report.

There continues to be no improvement in this area. Inmates with serious mental health issues continue to be maintained in segregation and isolation (in the case of one individual) due to the lack of appropriate housing, programming, and coordination with security and classification.

RECOMMENDATIONS:

1. Facility leadership continues to fail to include critical medical and mental health staff in decisions regarding housing and programming of the seriously ill inmates. In addition, observations at the time of this visit indicate an ineffective or nonexistent system of communication by the facility leadership to health services leadership. It is strongly recommended that the Warden's office establish weekly communication meetings between the critical health services leadership (Health Services Administrator, Medical Director, Psychiatric Director, Director of Nursing, etc.) and that the Health Services Administrator coordinate monthly Medical Administration Committee (MAC) meetings occur, documented by minutes and attendance sign in sheets.

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. Draft policies and procedures were completed by the monitoring team in the area of Fire and Life Safety by the December 31, 2014 deadline and were provided to both parties.

FINDINGS: The Territory provided this Monitor draft Fire Safety policies and procedures during the July 2014 onsite technical assistance visit. However, during that visit the Fire Safety consultant advised the Monitor that he had revised these policies and would thereafter provide them. The monitor reported in his previous reports that he had not yet received revised policy drafts despite making a written request. The revised policies and procedures were not provided to the monitoring team during or after the December 2014 monitoring visit. However, the monitoring team completed a draft version of the GGACF Fire Safety policies and procedures and provided them to both parties by the December 31, 2014 deadline. The finalization, approval, staff training and implementation of these policies and procedures remains vital.

Inadequate housing unit staffing levels and contraband control practices continue to enable inmates to ignite various materials in the housing units as evidenced by our April 2015 inspection of the housing units. During this inspection, I observed lit wicks and smoke emanating from them in several housing units. Supposedly, inmates use the smoke from the lit wicks to ward off insects. However, aside from the contraband problem stemming from the use of wicks, it also creates fire hazards. It appears that staff have relented to the use of lit wicks by inmates and do not prohibit their use. Cigarette butts were observed on the ground in the recreation yard for the Gulf housing unit.

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

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

During our inspection, I also observed exposed electrical wiring throughout various areas of the Facility, including the kitchen, housing units, maintenance shops and electrical rooms. In the kitchen I observed boxes stacked in the dry storage area nearly up to the ceiling (should be stacked no higher than 30 inches below the ceiling). This was an identical finding from our last report.[1] These findings, in addition to previous findings, reveal the urgent need to develop and implement a comprehensive fire safety program at GGACF.

The BOC did not renew the contract with the Fire Safety Inspector; however, they have assigned Officer Samuel to perform the fire safety duties for GGACF. Although Officer Samuel appears to be qualified in performing fire safety duties, he also is required to perform other duties associated with GIST. Officer Samuel reported that the VI Fire Marshal has not come to the facility to conduct a fire safety walk-thru, but is expected to do so shortly. The previous contract Fire Safety Inspector had reported that the facility provided copies of the Fire Evacuation Plans to the VI Fire Marshal; however, those evacuation plans only addressed the housing units. Furthermore, there is still no documentation available to demonstrate that even those limited evacuation plans were approved by the VI Fire Marshall. The fire evacuation diagrams within the Facility remain woefully outdated and offer no assurance that they would be effective in routing staff and inmates from a fire or smoke related emergency. In fact, some diagrams do not outline the appropriate route. A comprehensive fire evacuation plan that that would incorporate all areas and buildings within the confines of GGACF and the contents of the overall fire safety program, such as the fire safety policies and procedures, still needs to be developed and provided to the VI Fire Marshal for review.

Staff reported and documents reflect that the BOC is trying to secure an MOU or MOA with the VI Fire Service for helping GGACF come into compliance with the fire safety provisions of the SA. However, it must be expressed that the BOC/GGACF are the primary entities for demonstrating compliance with the fire safety provisions of the Settlement Agreement.

RECOMMENDATIONS: Previous recommendations remain appropriate. Additionally, the Monitor continues to request the reports for all drills and exercises conducted. It is also imperative that when the GGACF Fire Safety Program and the Fire Safety Plan are finalized and that they be provided to the Fire Marshal and with a copy to the Monitor.

1. Finalize and implement fire safety policies once approved and according to the Monitor's schedule.
2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.
3. Train all staff on this plan.
4. Install self-contained breath apparatuses (SCBAs) or an appropriate alternative at all locations where staff would need to search for or evacuate people.
5. Conduct and document quarterly fire drills for all shifts and document those activities.
6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.

[1] There does not seem to be a system in place for ensuring that the respective GGACF department heads receive our monitoring reports in a timely manner, if ever; therefore, they are incapable of providing follow-up actions. For example, the current Fire and Life Safety Officer had only received our report a few days prior to our on-site visit.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Almost Identical to previous Monitor's reports, we found that the Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, cell and housing unit sprinklers are non-functional and regularly used by inmates to support personal clotheslines. The primary fire detection and suppression system was designed to automatically detect and extinguish fires within most of the housing areas. However, the older housing units are not equipped with this system. The detection system does not function and the sprinklers are either broken or clogged by inmates. The only way to alert staff and inmates of a fire or smoke hazard is to use hand-held air horns that are located in the control rooms of the housing units. During this inspection, a maintenance officer had a difficult time locating the hand-held air horn that was found in a drawer in the maintenance office.

Adequate supplies of handheld fire extinguishers were found in housing units, kitchen areas, the medical unit, and shops. All devices were tagged showing current inspections and all gauges showed positive pressures. However, in reviewing the housing unit logs for 9A between January 1, 2015 and April 2, 2015, I noted entries in the log book whereby there was no fire extinguisher available between January 17, 2015 and approximately March 10, 2015. It also appears that there was no fire extinguisher in unit 9B between January 17, 2015 and February 21, 2015.

GGACF staff continue to indicate that sprinkler heads may be replaced in the "newer" buildings at some point in 2015. During our last inspection, we were provided with a letter, dated November 24, 2014, directed to the Department of Interior from the BOC Director requesting to allocate funding to aid in the replacement of the fire suppression system and for refurbishing the Kitchen at GGACF. However, the scope of work for the fire suppression system seems to only include the purchase and installation of fire sprinkler heads and related parts in areas of the Facility where there is a fire sprinkler system, but does not seem to address the need to install a fire sprinkler system such as in the old housing units where there is no fire sprinkler system. This needs to be clarified. The estimated cost for the fire sprinkler heads and related parts is approximately $89,700.00. Moreover, GGACF plans to continue to house individuals in the "older" buildings, and has no plans to update or install fire suppression equipment in those buildings. As reported in earlier monitoring reports, GGACF will never come into

compliance with these provisions if that remains the case. The acting BOC Director informed us that a grant with the Department of Interior has been approved for renovating the Main Control Center and related electronics, including fire and life safety improvements. The bid for this work is scheduled for bid with 30 days, according to the BOC acting Director. During our June 2015 inspection, it would be helpful to review the scope of work to be performed associated with this bid project.

During this inspection we also observed that medical department does not have emergency lighting and only 2 of the 5 manual smoke alarms had batteries. Also, in H housing unit, the emergency lights are inoperable due to lack of batteries.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Documentation demonstrating compliance with this Provision was not provided during this assessment. GGACF staff indicated that fire drills have not been conducted on a regular basis. The newly appointed Fire Safety Officer reported that the plan is to conduct fire drills in at least two (2) areas of the facility during each quarter. It is laudable that the new Fire Safety Officer plans to start addressing the necessity to conduct regular fire drills. As an example of the lengthy lapses in conducting fire drills, we were informed that in X-Dorm, the last fire drill occurred in 2012. Furthermore, staff and inmates confirmed that fire drills are not conducted on a regular basis. As reported in earlier Monitor reports, it is unclear when, if ever, full fire drills are conducted. The failure of GGACF staff to conduct fire drills on a regular basis of all facility areas continues to put inmates at risk of injury or death, should a fire break out that cannot be suppressed by the hand-held fire extinguishers present in the officer control pods of housing units.

Confusion still remains surrounding emergency key management. For example, some housing units had the emergency key to the fire exit doors available in housing control center. However, in another housing unit we were informed that the emergency key to the fire exits had been removed and taken to another area of the facility. Also, in the housing units that have cell slider doors (Units L and K); the tool used for opening cell doors is not readily available. We were informed by security staff that the emergency tool to manually open these doors is kept in the maintenance shop and tool room. However, there was no emergency tool located in the tool room. There was an emergency tool in a cabinet in the maintenance supervisor's office, but it uncertain how quickly this emergency tool could be accessed, especially after normal working hours and on weekends. There needs to be a clear and concise understanding by all security

staff as to where the facility emergency keys are kept as well as having the tool to open the cell slider doors readily available.

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

During this inspection we also observed that the cells in the intake area, which at times houses juveniles or high level protective custody prisoners, have padlocks on the cell doors. This practice, coupled by the fact that when inmates are housed in these cells where there is not constant and direct supervision, or a functioning smoke alarm system or fire sprinkler system puts the prisoners at a high risk of harm.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

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

There is not a written preventative maintenance program or a regular security inspection program in place for checking that cell locks are functional and are not jammed from the inside or outside of the cell, nor a system for ensuring that all facility remote locking cell mechanisms are functional. During this monitoring visit we observed evidence of inmates compromising the cell locks by inserting various materials in the locking mechanisms. We also observed numerous housing unit grills whereby the locking mechanism was inoperable and the grills left open.

There is also no position for a full-time locksmith at the facility. The part-time locksmith is only contracted for 75 days per year, thus the Maintenance Supervisor has to assume the duty of working on the locking system as well as supervising the Maintenance Department which is a daunting task. We also observed that the R&D entrance doors are still inoperable from previous monitoring visits.

RECOMMENDATIONS: Same as above.

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Although the previous Fire Safety Inspector reported that he was involved in training staff on fire and life safety procedures, we were unable to ascertain its' validity because as stated in the previous reports and in our current site visit, no records have been provided to verify that all staff have been trained and tested on safety procedures. It is also unclear if the newly appointed Fire Safety Officer duties will include testing of staff regarding fire and life safety procedures.

RECOMMENDATIONS:

1. Maintain records proving that staff have been trained and tested on emergency procedures. GGACF officials should create a statistical report showing percentages of staff who have and have not completed required testing.
2. Provide this Monitor documentation evidencing compliance with this Provision.

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

ASSESSMENT: NONCOMPLIANCE

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

During our previous monitoring visit we observed that GGACF has had the necessary equipment for installing a manual fire alert notification system stored in an office for about two (2) years. It appears that in order to install this system, the facility needs to provide the necessary electrical components. However, in light of the acting BOC Director's comments

regarding the fire safety upgrades as noted previously in this report, a fire notification system is contemplated in the project.

RECOMMENDATIONS:

1. Install and routinely test the stored file alert notification system without delay
2. See previous fire safety recommendations

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously stated, the fire evacuation policies have not been approved and full scale evacuation drills are not conducted.

RECOMMENDATIONS:

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

h. Fire suppression;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as previously stated. There is no functional fire suppression system, with the exception of the kitchen's cooking area. Also, as noted previously in this report, fire extinguishers are not always readily available.

RECOMMENDATIONS:

1. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.
2. Repair the automatic fire detection, notification, and suppression system.
3. Replace cell sprinklers with tamper proof mechanisms.
4. Monitor staff response to fires, ensure they comply with basic fire safety principles, and implement appropriate staff corrective action as needed.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The requirements for this provision are addressed in the draft Fire and Life Safety Policies and procedures that were provided to the parties in December 2014. Once approved, staff must be trained on them and they need to be fully implemented.

RECOMMENDATIONS:

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

j. Control of highly flammable materials.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Many inmate cells contain considerable personal property, thus creating a fire and safety risk. Flammable storage areas/cabinets in the Carpentry shops do not appear to be properly vented. The Monitor provided a draft policy and procedure dealing with the Control of Chemicals, Flammables, Toxic and Caustic Materials to the parties which substantially addresses this provision.

RECOMMENDATIONS: Same as above.

VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

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

FINDINGS: Documentation in the form of logbooks and memorandum was provided during this monitoring visit that demonstrated ongoing efforts of GGACF officials and maintenance staff to assess, improve, and monitor facility sanitation and hygiene. Draft policies were provided to this Monitor for review prior to the Court ordering the monitoring team to write draft operational policies. The Monitoring team reviewed and further revised these policies and procedures and provided them to both parties in December 2014. Yet, these policies and procedures were not finalized and approved by GGACF officials in accordance with the court-ordered March 30, 2015 deadline.

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

During our review of the Maintenance Department we observed that the Maintenance Supervisor maintains preventative maintenance schedules for various components of the GGACF physical plant, including the emergency generator.

However, during this inspection we continued to observe inoperable doors and grills, inoperable showers, mold in showers, non-functioning water fountains, plumbing leaks, security fencing breaches and cluttered electrical and mechanical rooms.

RECOMMENDATIONS: Previous recommendations remain appropriate.

1. Replace, repair, and install reliable sinks in all cells and housing areas that provide safe drinking water for inmates.
2. Prohibit allowing inmates to use toilets, sinks, and described clotheslines for cleaning clothes and linens.
3. Laundry exchanges of clean, institution issued linens and clothing, should occur at least twice per week.
4. Replace, repair, and install working shower heads and plumbing to provide reliable personal hygiene, adhere slip-resistance materials at shower entrance points to reduce fall risks, repair water draining to eliminate standing water in unit and cell floors.

5. Develop a mold control/mitigation plan that includes routine inspection and cleaning activities. Control access to related cleaning chemicals and train staff and inmates in the proper use and storage of those chemicals.
6. Develop and implement a sanitation management plan that monitors and mitigates sanitation problems and hazards.
7. Improve practices involving mattress cleaning and ensure inmates and staff involved in this program are trained in proper cleaning methods and use of materials and chemicals. Ensure mattress storage areas are sanitary at all times.
8. Repair all housing/cell windows to prevent penetration by insects.

b. Adequate ventilation throughout the facility;

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As stated in previous reports, ventilation throughout all housing units remains troubling. High summer temperatures and humidity make the housing units and cells constantly uncomfortable for breathing. High temperatures and poor ventilation can contribute to and exacerbate pulmonary illness, and potentially jeopardize the health of inmates on psychotropic medications (many such medications can cause harmful reactions when body temperatures are elevated). In housing unit 9 D we encountered an inmate locked in his cell who was visibly mentally ill and verified by the assigned officer. We observed other inmates in front of his cell arguing about a portable fan the inmate had in his cell. Apparently the fan belonged to another inmate who had lent it to this inmate and they were trying to get it back from him. A security supervisor verified that the fan did not belong to the mentally ill inmate and gave it back to the rightful owner. However, I observed that the cell where the inmate was housed was very hot, had no ventilation and the cell window had minimal airflow capability. We were informed that the inmate was homeless and could not afford a fan on his own, and the Territory does not provide fans to indigent inmates—even those who have a mental illness. The mentally ill inmate is also only allowed about one (1) hour of out-of-cell time on a daily basis. These are unacceptable living conditions for any prisoner and particularly for a mentally ill prisoner.

Most of the housing unit exhaust fans remain inoperable.

During our previous inspection the Monitoring team was provided with a draft proposal regarding a Detailed Energy Audit conducted by Energy Systems Group, dated November 10, 2014. This proposal includes measures to retrofit the lighting system, the air conditioning system, the PV Panels and for conducting plumbing upgrades at the Facility at an estimated cost of approximately $8,425,106.69. However, during this inspection we were informed by the acting BOC Director that there is no long term plan to address the ventilation issues. Certainly upgrades are necessary for the continued operation of GGACF.

RECOMMENDATIONS:

1. Timely complete an air quality assessment performed by a qualified provider.
2. Implement necessary improvements that reduce housing area and cell temperatures and increase air flow.

3. Medical and mental health staff should monitor all inmates for heat and airflow-related health risks. All inmates in segregation or who are locked in their cells should be monitored by medical and mental health staff for signs of health conditions.
4. Train all staff in detecting and responding to health conditions related to heat and air circulation contributors.
5. Install environmental health condition monitoring devices, e.g., temperature, humidity, and air quality readers. Require regular monitoring and recording of readings and take timely action to mitigate environmental conditions that create health risks caused by those conditions.
6. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Attention to lighting repair and replacement remains positive. However, security staff are allowing inmates/detainees to cover their cell lights, which is creating a fire hazard.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: Very little change since previous inspections. This provision remains in Partial Compliance but no decline in performance was found. Identical to our previous inspection, we noted that the overhead door to the storage area of the Kitchen is not properly sealed and rodents and vermin can easily infiltrate the Kitchen. Inmates in the housing units complained of mosquitos. Some inmates have lit "wicks" made, apparently, of toilet paper on their cell windows and floor, hoping that the smoke will deter mosquitoes. We also observed missing or broken screens on many facility windows.

The BOC has contact with a private vendor (Oliver Exterminating of St. Croix) to provide pest control services at GGACF.

The Monitoring Team developed a draft Vermin and Pest Control Policy and Procedure that was provided to both parties in December 2014. Yet, these were not finalized and approved in accordance with the court-ordered March 30, 2015 deadline.

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: There was no substantive improvements from previous assessments. Inspection of housing units, cells, kitchen, and medical areas again show consistent presence of personal hygiene and cleaning supplies. However, there were a number of inmate complaints in the Housing Units claiming they do not have sufficient quantities of cleaning materials to properly sanitize the showers. We observed that many inmate showers are in deplorable condition both from a sanitary standpoint, including mold problems and physical plant deterioration.

The Monitor provided the parties with draft policies and procedures for this area of Environmental Health and Safety. Yet, these were not finalized and approved in accordance with the court-ordered March 30, 2015 deadline.

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: NON COMPLIANCE – No substantive improvement from previous assessment.

FINDINGS: No substantive change from previous assessment.

There is no formal sanitation plan or protocols covering compliance with neither this Provision nor a formal training program for staff or inmates on this topic. Staff and inmates must be trained and demonstrate competence in handling bio-hazardous materials, provided and instructed on the proper use of bio-protective clothing and supplies, and supervisors must closely monitor biohazard clean-ups. Remaining in Partial Compliance with this Provision can jeopardize the health of staff and inmates.

Spill clean-up kits were available in the medical area.

RECOMMENDATIONS:

1. Develop, as part of medical infection control policies and facility sanitation plans, a comprehensive bio-hazard control plan that includes:
   A. OSHA and CDC standards and protocols for biohazard safety and exposure control;
   B. Written and enforced procedures and protocols for biohazard handling; cleaning, disposal, storage, inspections, and clean-up;
   C. Staffing and inmate training on the plan and proper handling and disposal of biohazards;
   D. Consistently maintain adequate supplies of feminine hygiene products and disposal bags for all bio-waste;
   E. Locate adequate supplies of bio-hazard disposal and clean-up supplies in or at all locations where biological waste and/or spills do and could occur;
   F. Provide appropriate clean-up apparel and training in the use of that apparel.
   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 bio hazardous 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: PARTIAL COMPLIANCE

FINDINGS: I did not see this area to be problematic during this monitoring visit. There were no inmate complaints regarding their mattresses and the ones I inspected were adequate. However, GGACF staff have not yet substantially addressed the Monitor's previous recommendations as listed below, including mattress care.

RECOMMENDATIONS:

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

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

ASSESSMENT: PARTIAL COMPLIANCE

FINDINGS: No substantive change since previous assessment. Implementation of approved policies and procedures, and a quality assurance tracking system will aid in advancing this provision to Substantial Compliance. Although chemical storage appears appropriate, there is no training program for staff or inmates responsible for handling and controlling these chemicals. Additionally, staff that supervise inmates and are allowed to handle these chemicals must be properly trained in that role and those responsibilities. This has yet to occur.

The Monitor provided the parties with a draft Control of Chemicals, Flammables, Toxic and Caustic Materials policy and procedure and incorporates this Provision. Yet, these were not finalized and approved in accordance with the court-ordered March 30, 2015 deadline.

RECOMMENDATIONS:

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: As previously reported, housing unit/cell inspection and inmate interviews found no substantive improvement. As stated in previous reports and found during this monitoring visit, inmates continue to routinely wash personal and issued clothing in cell sinks and toilets, and dry these items in their cells using clotheslines anchored to fire sprinkler heads, walls, window frames, bunks, etc. We also observed worn out linens and dirty linen in many inmate cells.

The Monitor provided a draft Inmate/Detainee Clothing, Bedding, and Linen Supplies policy and procedure to both parties in December 2014 that addresses the requirements of this Provision. Yet, these were not finalized and approved in accordance with the court-ordered March 30, 2015 deadline.

RECOMMENDATIONS:

1. Finalize, approve, and implement relevant policies and procedures.
2. Cease the practice of allowing inmates to wash personal and issued clothing in toilets and sinks.
3. Cease the practice of allowing inmates to dry clothing on make-shift clotheslines in their cells.
4. Routine and consistent replacement of damaged mattresses, mattress cleaning, cleaning of bedding.
5. Review, revise, develop, train, implement, and evaluate a comprehensive laundry management plan that governs total laundry operations.
6. Develop specific policies and procedures for handling, containing, and washing contaminated clothing, linens, and mattresses.
7. 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.
8. 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.
9. 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.
10. Staff and inmates involved in the laundry work program should be properly trained and supervised.
11. Laundry equipment should reliable and properly maintained.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: During our previous inspection, Territory officials reported the initiation of a major project to repair and clean-up the kitchen area. A scope of work for the project was submitted to the BOC Director on July 11, 2014. During this inspection, the acting BOC Director reported that the BOC received a federal grant last year for approximately $400,000.00 for GGAC kitchen improvements, but also included an outside project. The acting Director reported that he was trying to reorganize the grant disbursement to be used only for GGACF.

The physical plant of the Kitchen remains in a state of substantial deterioration as does the food service equipment. We found the flooring to be substandard with numerous broken tiles resulting in standing water and unable to properly clean and sanitize it. From our previous inspection, some minor repairs were made to the floor area in the dishwashing room. The dishwasher has not being working properly for a lengthy period of time. We observed plumbing leaks throughout the Kitchen. We observed inoperable ovens. There is an inoperable walk-in refrigerator that is unsanitary, along with a foul smell. There is no hot water in the male and female inmate bathrooms to properly clean their hands. There was an additional hand washing sink located outside the bathrooms that did have hot water, but it took a lengthy amount of time for the water to get hot. Paper towels present on the first day of our visit were missing the next. Food temperatures are not routinely taken of prepared food. The kitchen doors are not rodent proof. We found residue of rust in the ice that is provided to the housing units. We observed evidence of mold and rust in various areas of the Kitchen. There is no master inventory of the utensils and dangerous implements. New items/utensils are not properly labeled. We observed particles of ceiling tiles falling off in the dining room. However, the staff reported that the inmate dining room is no longer used for inmates to eat in.

RECOMMENDATIONS:

1. Review, revise, develop, train, implement, and evaluate food service program policies and procedures.
2. Ensure policies and procedures include, at minimum, the following elements:
   A. Meals that are nutritionally balanced, well-planned, and prepared and served in a manner that meets established health and safety codes;
   B. An adequate number of qualified food service employees and supervisors needed to monitor program quality and inmate worker supervision;
   C. Special menus that comply with various medical and religious needs and requirements;
   D. Maintain accurate accounting records;
   E. That menus are reviewed at least annually by a qualified dietitian to ensure meals comply with nationally recommended allowance for basic nutrition;
   F. Prohibitions of using food as a disciplinary measure;
   G. Involvement of independent outside sources to verify food service facilities and equipment meet government safety codes;
   H. Prescribes regular cleaning schedules including routine deep cleaning;
   I. Provide written utensil control methods similar to those used by the tool shop;
   J. Accident prevention program;
   K. Personal and environmental sanitation requirements;
   L. Food temperature monitoring and records keeping;
   M. Adequate health protections for all staff and inmates including health screens and prohibitions against working in the kitchen when ill;
   N. Requirements for daily monitoring of staff and inmate cleanliness practices, and that all bathrooms and wash basins are consistently supplied with antibacterial soap and hot water;
   O. All areas and equipment related to food preparation, distribution, and storage require frequent inspection to ensure they are sanitary, operational, and safe;

P. Water temperature on final dishwasher rinse should be 180 degrees Fahrenheit; between 140 and 160 degrees Fahrenheit is appropriate if a sanitizer is used on the final rinse. The person conducting inspections should be a qualified food service inspector;
Q. Stored shelf goods are maintained at 45 degrees to 80 degrees Fahrenheit, refrigerated foods are 35 to 40 degrees Fahrenheit, and frozen foods at 0 degrees Fahrenheit or below, unless national or state codes specify otherwise;
R. Food temperatures for hot foods should range between 135-140 degrees Fahrenheit and cold foods at approximately 41 degrees Fahrenheit;
S. Supervisory food service staff should monitor food service operations to ensure that that cooking, cooling, and food temperatures and delivery meet established requirements;

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

k. Sanitary and adequate supplies of drinking water.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: No improvement was again observed in the housing units during this assessment with the exception of X-Dorm.

The lack of constant reliable access to drinkable water further prevents GGACF from ensuring that inmates live in a healthy environment. 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. Inmates have consistently complained of seeing particles of rust in the ice that is provided to the housing units. As noted earlier in this report, we observed evidence of rust particles in the ice in the kitchen that was going to be used for housing unit distribution.

In X-Dorm we had been reporting a consistent problem regarding the lack of drinking water for this unit. However, GGACF officials have addressed this problem by installing portable water bottles in the dorm.

RECOMMENDATIONS:

1. Develop and implement a corrective action plan that ensures inmates have consistent and reliable access to safe drinking water.
2. Ensure that all inmates are provided consistent access to sanitary drinking water.

VIII. TRAINING

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

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: This Monitor has repeatedly requested, **since September 2013**, all pre-service and in-service training curricula and related documents. The Territory has not provided any such material.

During this visit this Monitor examined a Training notebook provided by a corrections recruit. This recruit indicated the contents of the notebook included all materials for the basic training program provided to recruits. The contents of this notebook included the following subject matter:

1. Employee Handbook
2. Sexual Harassment
3. BOC General Orders (which were out of date)
4. Outdated Rules and Regulations
5. Staff Dress Code
6. Outdate SOPs
7. Mental Illness (reportedly taught by an unqualified instructor)
8. The 1986 Consent Decree (which is no longer relevant to compliance with the current Agreement)
9. Two very outdated civil cases
10. Information on body searches and classification
11. The current consent Agreement
12. Suicide Prevention (reportedly taught by an unqualified instructor)

The recruit training program will require extensive and comprehensive revision if this notebook accurately represents the core basic training program. A comprehensive list of basic training topics was previously provided to the Territory for consideration. Additionally, only fully qualified instructors should be authorized to teach pre-service and in-service training courses.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

1. Implement training policies and curricula once approved.
2. Provide this Monitor and DOJ all requested training documents.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Same as above.

RECOMMENDATIONS: Previous Recommendations Remain Appropriate

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

IX. IMPLEMENTATION

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

FINDINGS: This Monitor completed and issued a revised Schedule as directed by the Court. Policy and procedure drafts were provide to the Territory on 12/31/14 as directed by the Court. This schedule has since become obsolete as a result of the Territory missing deadlines. The schedule will be revised in collaboration with the parties.

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: Same as 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: Virtually all policies drafts submitted by the Territory for review and comment were rejected by USDOJ and this Monitor as incomplete. Moreover, the Territory missed critical court-ordered deadlines for finalizing policies and procedures. As a result, policies and procedures have yet to be approved for training and implementation, rendering the latest court-ordered implementation schedule obsolete. The Territory intends to retained professional assistance to finalize and resubmit all deficient policies.

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

FINDINGS: There have been no semiannual impact evaluations submitted by the Territory. The reports submitted do not include evaluation of progress.

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: Same as number 3

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 recent Status Report largely provides inadequate information to reliably assess or evaluate progress toward compliance. The information provided does not link progress to compliance. Thus, following the last status conference, the Court ordered "that Defendants' sixth status report and similar future status reports filed with the Court shall include the expected progress on each item discussed at the preceding status conference with the Court together with the actual progress made by Defendants with regard to each item." ECF. No. 882 at 2.

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

FINDINGS: The Territory fails to promptly notify this Monitor and USDOJ of inmate deaths and injuries requiring emergency medical attention. A review of emergency room transfer logs reflect several transfers of inmates sustaining injuries but not notification was provided as required. Also, during the April 2015 onsite tour, the United States discovered an inmate death in January 2015 that had not been reported by the Territory. This Monitor has requested from the Territory additional information and records about these instances but has yet to be provided that information.

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: Generally speaking, most of the various administrative and operational records provided evidence continued noncompliance with this Agreement. Production of requested records is relatively slow and sometimes incomplete. In some cases, housing unit logbooks have gone missing or been destroyed. This Monitor believes, however, that the document production process is improving with new BOC administration and compliance team.

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

FINDINGS: The Monitor and monitoring team were provided adequate access to the facility during this visit. Yet, staff could not find the requested Supervisor's Logbook for January 15, 2015, to February 27, 2015, and the Territory still has not submitted requested training records.

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

FINDINGS: The Monitor believes that USDOJ continues to experience significant difficulty in receiving timely written responses to questions as required. The USDOJ requested information about the housing and supervision of juveniles and the use of the intake unit at the facility. The Territory's written response conflicts with facility documentation.

X. Monitoring

D.1. Monitoring Access: Within 30 days of appointment by the Court, the monitor will conduct the first site visit and submit to the parties for their review and comment a description of how the Monitor will assess compliance with each of the Compliance Measures, how the monitor intends to gather information necessary for the assessment, and what information the Monitor will require the defendants to routinely report and with what frequency.

FINDINGS: This Monitor complied with this requirement before conducting the Baseline visit in September 2013. This Monitor continues to provide the parties this information prior to, during, and following each onsite assessment.

D.2. Monitoring Access: With reasonable advance notice, the Monitor will have full and complete reasonable access to the Golden Grove Correctional Facility and Detention Center, all facility non-privileged records, prisoners' medical and mental health records, staff members, and prisoners, Defendants will direct all employees to cooperate fully with the Monitor, Reasonable advance notice must be provided to the Bureau of Corrections prior to conducting any on-site compliance reviews. Other than as expressly provided in this Agreement, this Agreement shall not be deemed a waiver of any privilege or right the Territory or Defendants may assert against a third party, including those recognized at common law or created by statute, rule, or regulation against any other person or entity with respect to the disclosure of any document. All nonpublic information obtained by the Monitor will be maintained in a confidential manner.

FINDINGS: The Monitor has consistently provided reasonable advance requests for documents and information that are essential for carrying out his duties required and authorized within this

Agreement. As previously discussed in this and previous reports, the Monitor (and the USDOJ for that matter) continues to experience significant delays in receiving requested documents and information and has not received some requested documents at all.

APPENDIX A
ASSESSMENT METHODOLOGY

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

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

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

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

   In general, compliance assessment will include the following activities:

   A. Discussions and meetings with facility officials, staff, providers, and inmates.
   B. Discussions and meetings with community agency officials providing inspection or other regulatory oversight of GGACF.
   C. Discussion and meetings with officials and staff of contract providers and community agencies who provide services within and/or for GGACF and inmates held in its custody.
   D. Discussions and meetings with other pertinent staff, personnel, and community members, either as requested by the parties or who, in the determination of the Monitor, can provide relevant information for the purposes of monitoring.

E. On-site tours of grounds, perimeter security barriers, perimeter access control and entrance points, all external security technology and methods, building and structural exteriors, roofs, and utility systems.
F. On-site tours of all buildings, housing units, special environments, health care facilities, receiving and discharge areas, segregation units, all cell areas, food service and storage areas, utility closets and chases, utility technology and systems, fire prevention and suppression systems, life safety locations and equipment, other interior areas and location relevant to determine compliance.
G. Examination of all security equipment and systems used for perimeter, external, structural, internal, and special security operations purposes.
H. Examination of health care equipment, supplies, materials, technology and other material methods and processes used for inmate health care assessment, diagnosis, treatment planning, treatment (long and short-term), follow-up, and discharge planning.
I. Examination of agency motor fleet including all cars, busses, trucks, vans, and any other motorized vehicle used for correctional operations purposes.
J. Examination of any and all available records, data, and/or information relevant to compliance and compliance monitoring not limited to the following:
    - Administration
    - Budget
    - Personnel
    - Operations
    - Training
    - Facility construction, renovation, repairs, and maintenance
    - Equipment, supplies, and materials
    - Inmate case files
    - Medical and mental health screenings, assessments, evaluations, diagnoses, treatment plans, progress charts and notes, medication logs and records, drug formularies, appointment calendars, invoices, etc.
    - Labor contracts
    - Incident reports and logs
    - Evidence / contraband reports and logs
    - Use of force incidents and logs
    - Inmate grievances and disciplinary records and actions
    - Policies, procedures, protocols, guidelines, post-orders, logs, memos, and other documents and information that support accurate compliance assessment and progress determinations
    - Employee complaints, grievances, claims, etc. directly or indirectly related to the compliance provisions
    - Other information required to determine compliance and compliance progress

The information described above is intended to assist the Monitor to determine compliance and the degree to which each of the compliance ratings (noncompliance, partial compliance, and substantial compliance) apply to each provision assessed. Additionally, the Monitor will collaborate with the parties to develop metrics and core measures for qualitative and quantitative measurement of progress and compliance. Core measures and metrics should specifically pertain to the conditions set forth in the Settlement Agreement, and generally consider accepted standards and recommendations promulgated by the National Correctional Association, American Jail

Association, National Commission of Correctional Health Care, American Psychiatric Association, American Nursing Association, ASIS International, National Fire Protection Association, Centers for Disease Control (CDC), OSHA, Territory regulations, and other nationally accepted standards for compliance assessment and management. Additionally, specific measures articulated in the Order of the Court dated May 14, 2013 [Dkt 742] (the "Order") shall be followed. The following compliance management terms are suggested for assessment and compliance monitoring:

- Compliance Control: Implies activities designed and intended to inspect and reject defective or deficient performance, processes, services, equipment, etc. when applied.
- Compliance Assurance: Implies activities designed and intended to identify performance and services that assure compliance when applied.
- Compliance Improvement: Implies activities designed and intended to correct and/or improve compliance in performance and services.
- Compliance Management: Implies activities designed and intended to ensure targeted compliance outcomes.
- Domain: A core aspect of the organization's performance, such as *access* to care, *costs* of care, or *quality* of care (e.g., consumer level of functioning, relapse and recidivism rates, or consumer satisfaction).
- Performance Indicator: A defined, objectively measurable variable that can be used to assess an organization's performance within a given domain. For example, within the domain of consumer satisfaction, a performance indicator might be: "the percentage of consumers who state that they received the types and amounts of services that they felt they needed."

2. How information necessary for on and off site assessment work will be gathered.

Monitoring will involve gathering various forms of information both on and off site and not limited to:

- Communications with Territory and U.S. Department of Justice Officials as authorized in the Order
- On-site visits, tours, meetings, individual and group meetings and interviews
- Collection and examination of electronic, paper, and photographic records, information, and data
- Photographs taken during inspections (not to be used in any report without expressed written agreement of both parties)
- Online media information
- Online public records
- Electronic and standard mailing of information
- Email communication and phone consultations

3. What information the Monitor will require the Defendants to routinely report and with what frequency.

It is understood that the Territory will use existing records systems and processes to provide routine reports. However, new records and information systems and methods may become necessary to accurately report progress compliance and related performance. It is this Monitor's

desire to assist the Territory in developing records and information methods and processes that yield accurate, complete, and efficient reporting of compliance efforts and progress. Therefore, it is assumed that the compliance reporting process will evolve throughout the life of the Order.

Compliance reporting should include statistical reports, narrative descriptions of compliance activities and progress, improvement plans, case reviews, incident reports, and other information and data that helps the parties and the Monitor understand compliance progress as well as to identify issues and concerns that challenge compliance efforts. As recommended in both previously reports, a monthly compliance report is proposed until the reporting system and compliance progress evolves to justify less frequent routine reporting.

Non-exclusive information required for assessments and monitoring include the following.

A) Corrections Information:

1. The most recent census report.
2. Last five (years) admission, release, average daily inmate population.
3. The housing unit floor plans for all facilities and housing units.
4. A copy of the facility's policies and procedures manual(s), including the facility's Use of Force policy. [If you have the policies and procedures in electronic form, we would request all of them prior to our visit. Otherwise, we request only the Use of Force policy prior to our arrival].
5. The Use of Force Log for the past twelve (12) months and a few sample Use of Force packages [we request only the Use of Force Log prior to our arrival]. Please indicate any use of force on an inmate on the mental health case list.
6. The Serious Incident Report Log for the past twelve (12) months.
7. The Inmate Disciplinary Log for the past twelve (12) months.
8. The Contraband Log for the past twelve (12) months.
9. The Administrative Investigations Log for the past twelve (12) months.
10. A copy of the Inmate Grievance Policy.
11. A copy of the Inmate Grievance Log for the past twelve (12) months.
12. All forms and documents used by staff for inmate intake, assessment, classification, release, housing, supervision, disciplining, etc. Generally speaking, any form, report, log book, etc. used in the course of a corrections officers work day.
13. Documentation reflecting the current classification system, including policies and procedures related to such classification system.
14. Documentation reflecting any training facility staff has received, including any corrections officer training manuals, pre-service and in-service training completed by all staff over the past 36 months.
15. Current staffing schedules for security positions and shifts.
16. Job descriptions for all non-health care staff.
17. Copies of any self-evaluation reports, grand jury reports, American Correctional Association surveys, National Institute of Corrections reports/evaluations, National Commission on Correctional Health Care reports/evaluations, or any other outside consultant reports regarding the facility.

18. Any questionnaires, intake forms, or inmate handbooks provided to inmates upon their entry to the facility or during their stay in the facility.
19. The most recent Staff Manpower Report/Matrix that shows all authorized positions and which ones are vacant.
20. Reports and data showing turnover information and statistics for security, medical, mental health, and other staff positions budgeted and authorized for the previous 36 months.
21. Any staffing improvement plan, applications for technical assistance, and Territory budget proposals/authorizations to address staffing shortfalls.
22. Facility maintenance requests and work orders for the past 12 months.
23. Records and/or lists of physical improvements, repairs, and renovation completed to correct security problems and deficiencies over the past 36 months.
24. Past 36 months of agency budgets.
25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.
26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.

B) 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.