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 noted in the previous report, the Territory has not completed the required PREA self-audit. PREA draft polices have been submitted to USDOJ and this Monitor for review and comment. However, the Territory has not yet resolved the issue of the 24/7 hotline.

Also as noted in the previous report, 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**. However, the Territory has informed this Monitor that this position has been filled and the investigator began working on August 24, 2015. 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: The Territory has yet to provide evidence that the current classification system has been validated. However, draft classification policies and procedures have been submitted to this Monitor and USDOJ for review and comment according to the revised Schedule.

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 stated in F.1.a above.

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 noted in the above Classification section. Additionally, the previously reported incident in this report involving a violent inmate-on-inmate stabbing demonstrates how the current inmate classification system is easily and quickly disabled when officers do not maintain control of cell keys, fail to maintain adequate prisoner management, and are not continuously attentive to security duties when prisoners are unsecured in their housing units.

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: See previously discussed classification findings.

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: NONCOMPLIANCE (Downgraded from Partial Compliance)

FINDINGS: The current incident reporting system remains inadequate for complying with this provision. As previously noted in this report, the quality of incident reports remains problematic and the incident reporting log system does not consistently capture all reported incidents. Additionally, Disciplinary Committee monthly reports continue to report problems with missing and late submission of incident reports. Interviews with the sergeant responsible for the prisoner discipline program continues to state the same problems with incident reporting practices and quality oversight.

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: Examination of Segregation Review documents for April thru June 2015 continued to evidence noncompliance with this requirement.

Virtually all of these documents fail to include information about what alternatives were discussed and considered for segregation placement when the segregation review process was completed. Additionally, most of the documents examined omit required information about when and/or why the prisoner was placed in segregation, and whether the reasons for being placed in segregation remain valid. Most of the documents fail to record a prisoner's prospective release from segregation date, and much of the narrative required by staff performing the review is absent. Staff signatures are often missing and/or illegible, and there is routinely no information documented with regard to whether previous follow-up recommendations were accomplished. Many of the documents show that the segregated prisoner "refused" to

participate in the review process and the document includes not information about the prisoner's well-being or health status.

This document examination leaves an impression that GGACF officials give little to no priority to ensuring that prisoners held in segregation are provided constitutionally-required attention and care. As noted in previous reports, it continues to appear that prisoners are placed in disciplinary and administrative segregation for excessive time periods and without due process. A comparison of the prisoner mental health case log and segregation log indicates that inmates with mentally illness remain in segregation/isolation for very long time periods. This practice is a direct violation of the conditions of this Agreement and dangerously detrimental to the health of these prisoners and must cease.

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 Logs and incident reports provided for March through June 2015 demonstrates continued significant and problematic deficiencies with Provision compliance. This examination again found the following document 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 stated in previous monitoring reports, 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. A simple document quality assurance and compliance accountability process should be implemented and minimally include the following steps:

1. Officer completes an incident report
2. First-line shift supervisor reviews the report for completeness, accuracy, and legibility
3. First-line approves, signs, and forwards reports that meeting requirements above, deficient reports are immediately returned to the author with specific written and/or verbal instructions for correction
4. Shift commanders should review and approve only reports meeting the requirements in step two
5. Shift commanders should return to reports first-line shift supervisors that fail to meet the above requirements with verbal and/or verbal instructions for correction
6. The chiefs, Security Administrator, Asst. Warden and Warden should review all reports for quality assurance and operational management purposes.

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: As stated in previous reports, a formal and regular administrative process as indicated remains nonexistent. Effective implementation of this process first requires substantial improvements in the current incident reporting systems and reporting review process. 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: As stated in previous monitoring reports, the Evidence Log should include incident report numbers to cross-reference incident reports and evidence (i.e. contraband). This revision to the Evidence Log will help to provide efficient and timely matching of incident reports to evidence, and make the Evidence Log a very useful tool for tracking and managing facility incidents for planning, implementation, and evaluation strategic contraband control policies.

RECOMMENDATIONS: Previous recommendations remain appropriate

1. Refer to similar recommendations regarding contraband.

d. Central tracking of the above incidents.

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Central Control officer is the primary keeper of the GGACF incident central training process. The Central Control officer is notified of incidents, issues an incident number and records incidents on the Incident Log. A significant problem with tracking centralization system is that it assigns several consecutive incident numbers to a single incident depending on how many officers are involved. This practice leads to errors in incident and evidence tracking, and impairs using the incident log as an efficient and accurate information / data source.

Each incident should be assigned its own tracking number regardless of how many officers or inmates are involved in a single incident; this method is similar to a law enforcement incident-based reporting system and works very well. It is much more simple and efficient to determine incident volume for a given time period using the last incident number for that time period then having to count every entry on the incident log. Each incident report written by staff for a single incident would contain the same incident number, and all evidence logs/reports, use of force reports/reviews, medical reports, etc. would use the same incident number for tracking and documentation management purposes. The Territory should seriously consider revising its current incident numbering practices as described.

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.
3. Implement a quality assurance process that consistently ensures incident log accuracy and completeness.

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.

Prompt incident reporting remains a serious problem. Prisoner Disciplinary Committee reports examined continue to report problems with staff and supervisors using the appropriate incident report form, submitting error free and/or complete incident reports, and/or turning in reports. The Disciplinary Committee sergeant reports she continues to have problems receiving completed reports from which to make reliable disciplinary action decisions.

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 to address staff noncompliance with adopted policies and procedures.
4. Initiate corrective action against supervisors and staff who continually fail to submit and/or approve deficient, late, or no incident reports as required by policy and this Agreement.

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: The Territory has submitted draft us of force policies and procedures to this Monitor and USDOJ for review and comment. The Territory integrated USDOJ comments into the draft policies. The USDOJ rejected the revised document citing structural and content problems and provided additional comments and recommendations.

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:

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: Use of force reporting remains problematic. Examination of incident reports for this reporting period continue to describe events involving physical force by staff against inmates but required use of force review documents are not completed. This problem was reported in the 7th Report and must be corrected by the Territory.

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: As stated above in (f), this Monitor cannot verify compliance with this provision. Incident reports continue to describe use of force against prisoners with no accompanying use of force review documentation.

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: According to GGACF officials, the Investigator position remains vacant and the vacancy has not been posted to fill. This position has been open for several months and must be filled without further delay. There appears to have been no administrative investigation and no criminal referral resulting from the November 10, 2014 incident, which was reported in the media and appeared to result in inmate injuries.

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. The Territory did not provide requested documentation necessary for the Monitor to assess compliance with this Provision.

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: Noncompliance with this provision is a cumulative result of noncompliance with the Use of Force section of the Agreement. Re-training and sanctions against staff for improper use of force cannot be appropriately determined without routine and adequate administrative review of force events. Compliance with this provision is contingent upon compliance with the administrative review provision.

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RECOMMENDATIONS:

1. Comply with Administrative Review provisions of this Agreement.
2. Develop and prepare to implement remedial use of force training

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 complaint system shows inadequate improvement for advancement to Partial Compliance. An examination of Grievance Log entries after March 26 through June 29, 2015 reveal the log remains incomplete and mostly nonresponsive to inmate complaints.

There were 19 inmate complaints recorded for the date range assessed:

Food Service – 6
Housing Conditions – 2
Medical – 4
Safety – 1
Staff Misconduct – 1
Appeal – 2
Other – 2
Blank – 1

There was no received date and time for one (1) food service complaint or documented responses for more than half (10/19) complaints, mostly (5) for food service complaints.
Only seven (7) complaints documented response dates and only three (3) documented dates that responses were returned to prisoners.

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: As stated above, examination of the grievance log shows missing data entries indicating untimely or no investigation of prisoner's complaints related to safety or health care. Additionally, the grievance log studied shows equally problematic responsivity to inmate complaints involving disciplinary action, food service, and housing conditions.

It is not possible to assess timeliness or prioritization of complaints required under this provision due to grievance log document quality and inconsistencies. Most of the response (back to the prisoner) dates are missing in most of the response summary information. This document demonstrates that prisoner health and safety complaints are not investigated timely or prioritized in practice.

RECOMMENDATIONS: Same as above

c. Corrective action taken in response to complaints leading to the identification of violations any departmental policy or regulation, including the imposition of appropriate discipline ainst 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

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 to identify patterns of individual staff and inmate problems, as well as systemic problems in need of correction.

K. Administrative Investigations

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

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The Investigator position remains vacant and administrative investigations cannot be performed.

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: Examination of the CV provided by the Territory of the recently hire Investigator infers this person is well qualified, but specific documentation of pre-service and in-service training was not apparent. Additionally, training on the new Use of Force policy would be pending final approval of the policy currently in draft-review status.

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: No change from previous Report.

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, pending completion of training prior to our report being submitted to the court.

MEDICAL FINDINGS: Progress continues to be made with regard to intake screening. The policies have been submitted and reviewed and approved by this monitor. There was introductory training; however, the formal training has yet to be completed. We would hope that this training is completed and proper documentation is submitted to the monitor before this report is sent out.

The staffing at the present insures RN availability to perform the screening Monday through Sunday from 8:00 a.m. until midnight. Therefore, the only shift uncovered by registered nurses is from midnight to 8:00 a.m. seven days per week. Two nurses have been identified who are qualified and are in the process of being hired to complete the staffing. When that staffing is completed there will be 24 hours a day, seven days a week at least one registered nurse onsite availability. As referred to previously, there was some introductory training and we were informed that the head nurse does review performance with the nurses and provides feedback regarding the quality of the performance.

We reviewed the records of seven intakes who entered within the prior two months before our visit. Only one record lacked an intake screen. In that record, there was documentation that the patient refused to participate in the intake screen. Two weeks later he did agree and this resulted in a negative screen, including both his vital signs and his TB skin test. We did not find in the record documentation of daily offering of the intake screen with refusal by the inmate. In fact, it was not clear that this had occurred. The six other records did include completed intake screens, including one patient identified with a history of recent suicidal ideation who was seen by the psychiatrist two days later. However, on the day of the intake screen the psychiatrist was called and placed the patient on suicide watch. After the psychiatrist completed her assessment the patient was released from suicide watch. We also found a record of a patient who entered and did not have the screen completed until two days later. Finally, one patient was screened who had a history of seizures and admitted to currently taking medications, but these were not listed.

The performance on the intake screen is consistent with noncompliance. However, if the formal training has not been documented as having occurred prior to the release of our report, it will have to be an assessment of noncompliance related to the training.

Patient #1
S.A. This is a 23-year-old who entered the facility on 5/1/15 and refused the intake screen. Finally on May 14, he agreed to the intake screen and was found to have normal vital signs, a negative TB skin test and a negative screen. The same day as his intake screen he also received a health assessment. There was no daily documentation of the offering of the intake screen nor the refusal by the patient from May 1 through May 14.

Patient #2
J. N. This is a 28-year-old who arrived on 5/2/15. He provided a history of physical and psychological abuse and a history of recent suicidal ideation. He was assessed as an acuity level 1 and, appropriately, the psychiatrist was called. The psychiatrist initiated suicide watch and then saw the patient when she was onsite two days later. At that time the watch was discontinued. He also had a health assessment the same day.

Patient #3
K. R. This is a 27-year-old who arrived on 5/9/15. It is not clear why his intake screen was not performed until 5/11, since, although he arrived on a Saturday, nurses were available to complete the screen both on Saturday and Sunday. His screen revealed a peanut allergy and headaches. He had normal vital signs. He had no chronic medical problems; however, he has a history of schizophrenia as well as bipolar disorder. He also had a history of tremulousness for two days. He was listed as an acuity level 1 because of his psychiatric problems and his mental health assessment was completed the same day as his medical screen.

Patient #4
A. P. This is a 26-year-old who arrived on 4/6/15. His screen revealed a history of seizures, although the most recent seizure occurred four years earlier. He gave a history of being on medications but there were no details such as the name of the medication, the dosage, the frequency or, for that matter, the pharmacy. He was listed as an acuity level 2 but was released the following day.

RECOMMENDATIONS:

1. Complete the training on the policy.
2. Complete the filling of the RN positions on the midnight to 8:00 a.m. shift seven days a week.
3. The head nurse should continue to provide feedback to the nurses performing the nurse screen regarding their performance and a special emphasis should be given to daily documentation of offering of the intake screen for patients who refuse.

MENTAL HEALTH FINDINGS: Nursing staff continue to perform intake mental health screenings in a timely fashion, within 24 hours of intake. Positive mental health findings do initiate referral to the mental health staff by security and medical intake screeners. The mental health intake screening components have been integrated into the form. The policy has been reviewed by all

parties. The health services administrator has trained on the draft policies and there is now an approved formal schedule to complete final training on all health policies.

RECOMMENDATIONS:

1. Complete final training on health policy.
2. Track data to support evidence of successful implementation of the policy and demonstrate adequacy of the quality of the screening process.

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

ASSESSMENT: NONCOMPLIANCE

MEDICAL FINDINGS: Most of the records we reviewed were patients who were released early. In the few records that should have had physical assessments, the performance was problematic. We are very encouraged by the soon-to-be addition of the new Medical Director beginning. In fact, we talked to her over the phone and the following day met her at the facility. We were impressed with her, as she appeared both knowledgeable and committed. She had previously worked in the system about seven years prior to our visit. Several nurses had worked with her previously and were universally enthusiastic about her return. She indicated that she is committed to be fully engaged and intends to work full-time for the correctional system. She committed to three days onsite at Golden Grove and two days a week at the St. Thomas facility. In a few records of patients who have been in the system a long period of time, I have seen assessments performed by her and have been favorably impressed. We would expect and hope that she will bring stability, predictability and leadership to the clinical side of the medical program. The former Medical Director, whose contract was allowed to lapse, has been on site inconsistently and unpredictably, which created problems for both the patients and the staff. Examples of problematic health assessments follow.

Patient #1
This is a 27-year-old who arrived on 5/9/15 but had his intake screen on 5/11. He indicated no chronic problems except mental health problems. He complained of tremulousness times 2 days and was assessed as acuity level 1 based on mental health issues and he had both a mental health screen and assessment on 5/11. His health assessment was performed three days later, but despite normal vital signs including blood pressure he was assessed as having hypertension.

Patient #2
This is a 23-year-old who arrived on 5/7/15 late at night and had his nurse screen on 5/8. He entered with a history of asthma and a peak flow was performed, which was 325. He was listed as an acuity level 1 for medical reasons but he should have been listed as an acuity level 2. He was referred for a chronic care visit. His TB skin test was negative and his health assessment was performed one day after intake. However, there was no adequate asthma history. He was found to have wheezing bilaterally and the rescue inhaler was ordered to be given four times per day rather than as needed. There was also no order for a chronic care follow-up visit. The rescue inhaler frequency of use is used by clinicians to determine how well-controlled the disease is. Ordering the rescue inhaler to be used four times a day whether or not it is needed is incorrect practice.

RECOMMENDATIONS:

1. The Medical Director position was filled in August.

MENTAL HEALTH FINDINGS: Ms. Murray, the Mental Health Coordinator, has been tracking completion of psychosocial assessments via an intake log, which she has developed. She described her current process as pulling the daily booking records to verify whether new intakes are still on site. The nurse will complete the initial screening within 24 hours and the mental health assessment will be performed within 48 hours (first business day for weekend bookings). If there is an urgent need the nurses will notify the psychiatrist any time of day for bridging orders on medications and other instructions. Nurses utilize the same acuity scale as used for general medical health screenings. Level I is urgent/emergent and level II is routine.

A copy of the assessment log tracking intakes was reviewed from the end of April through the month of May, 2015. Twenty-seven (27) inmates were booked into the facility during that timeframe. Eight detainees did not receive an initial mental health evaluation because they were quickly released from the facility. One inmate's assessment was delayed due to security issues. Assessments were completed within the required timeframes.

The service continues to develop new mental health and psychiatric assessment forms that will better guide this process. In the time being, they are documenting their assessments and initial plan in the medical record.

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 pending completion of training prior to the release of our Eighth Report.

MEDICAL FINDINGS: We have used this section to address medical sick call, focusing on the acute part of the section. A separate section deals with chronic care needs. The sick call log was more conscientiously utilized and there were few to no blank spaces. We selected records from the previous month and we are pleased to report that patients were seen timely. There were, however, some issues with performance. This is not unexpected in my experience of reviewing correctional

health programs. The head nurse has begun to review and discuss with specific nurses issues regarding their performance.

Patient #1
This patient submitted a request on 5/30/15 complaining of bloody stools for one day but he has had it previously. He also complained of a skin abscess on his face. At the time of his sick call visit he was found to have a significantly elevated blood pressure of 140/112. The physician was called and the patient was sent to the ER to have not only the hypertension addressed but also the facial abscess and the gastrointestinal problem. The ER records were available but had not been placed into the medical record. There has been no follow-up with a clinician.

Patient #2
This is a 50-year-old who complained of a toothache on 5/14/15. The nursing assessment contained no pain scale, no description of the nature of the pain, but did describe a minor swelling in the right lower jaw. This patient was provided over-the-counter medications and referred to the dentist. We were told the dentist saw the patient; however, there was no note in the medical record.

Patient #3
This patient also complained of tooth pain on 5/21/15. This was after the patient had seen the dentist. Again, there was no dental note in the chart. There was documentation that a phone order for antibiotics and Motrin had been given, but there was no order in the medical record. On the other hand, the medication administration record revealed that medications had been received. For all phone orders there must be a written order in the medical record.

Patient #4
This patient complained on 5/21/15 that his head was hurting and he was seen the next day. The history did not describe the severity, the location, what relieved, what exacerbated it, etc. The patient also had drainage from a lesion on his head. The nurse never obtained a culture from the drainage. The case was discussed with Dr. Park but we could not find a note written by him.

RECOMMENDATIONS:
1. Continue to instruct staff on the need to conscientiously complete the sick call log.
2. Continue to provide counseling feedback to nurses regarding their performance in the sick call process. This feedback should include both positive reinforcement and constructive, corrective discussions.
3. Insure documentation of all phone orders as well as assessments.

MENTAL HEALTH FINDINGS: The mental health service has been maintaining a follow-up log for psychiatric visits. Even individuals who have no medications ordered are tracked on an as-needed basis. The current log contains 54 names with 46 being active clients. The service has developed a mental health statistical report that lists the names of every inmate or detainee currently followed by the service and inmates currently housed on the mainland or in hospital. That list contains a total of 64 names with 11 individuals in other prisons or in hospital. In reviewing the psychiatric chronic care visits, a few records demonstrated some opportunities for improvement as follows:

1. A 22-year-old male who arrived at the facility at the end of April was seen the following day by the psychiatrist for complaints that people could read his thoughts. He was diagnosed as Psychosis Not Otherwise Specified and was started on an antipsychotic medication. He was scheduled to return within one month. It is recommended that inmates unknown to the service or who present with recent onset of significant symptomatology should have follow-up scheduled at least within 10 to 14 days of initiating a new regimen of medication, particularly for a psychotic disorder. This inmate developed a common neuromuscular side effect in reaction to the antipsychotic medication and was actually seen four days after initiation of medication because of that complaint. He was seen again by the psychiatrist on May 14, 2015, with a return to clinic noted as two weeks. At the time of this review on June 10, 2015, he had not yet been seen again. Issue: 1. Initial follow up was too far in the future; 2. Additional follow up was delayed.

2. A 26-year-old male was seen for tongue movements while on an antipsychotic medication that can precipitate these findings as a potentially permanent side effect. Medications were ordered for the inmate but no formal Abnormal Involuntary Movements Survey was completed, which has been recommended to be done by this reviewer a minimum of semiannually for all inmates on antipsychotic medications. Issue: The AIMS score allows for detailed documentation of the location and severity of the emerging movement disorders for future comparison for improvement or worsening of symptoms.

3. Chart reviews completed this visit again indicate a high frequency of the assignment of the diagnosis Psychosis, Not Otherwise Specified or Drug-Induced Psychosis, which is often attributed to acute intoxication by an unknown substance. Dr. Sang has been ordering some urine drug screens, which have been helpful in documenting the presence of an illicit substance. Issue: See recommendation 2.

RECOMMENDATIONS:

1. 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, independent agency or accrediting reviews.

2. It is recommended that the Medical Administration Committee, once formed and active, begin to address the security issue of access to substances that are inducing psychotic conditions that then require psychiatric services. This monitor has noted the odor of marijuana in multiple units during each auditing visit, including the prison side segregation unit. Although, during this visit this finding was less apparent and hopefully represents benefit from recent security inspections.

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 again spent some time with the pharmacist whose contract arrangements are apparently stable. The pharmacy area has been reorganized and we witnessed the presence of new pharmacy supplies for packaging the medications. The current arrangements at Golden Grove do not comply with the Pharmacy Practice Act, and the pharmacist has a plan in which she would be present onsite part-time to facilitate the correct packaging of the medications. The monitor had a discussion with her as to whether her plan would achieve compliance with the Pharmacy Practice Act. This is an area that needs to be discussed further. We did discuss if she could, whether she was onsite or at home, review the prescriptions and create the labels for the medications. From home, she would connect through an electronic system and be able to review the medications timely. However, commonwealth law requires an onsite pharmacist for proper dispensing. This is problematic and it is this issue that remains to be addressed.

We also observed medication administration with regard to the morning pass in the housing units. The regular LPN who performed the administration generally performed well, as did the officer who demonstrated respect for the inmates while at the same time insisting on the inmates adequately acquitting their responsibilities in the medication process. However, their first responsibility is to provide an ID card or wristband so that the nurse can correctly identify the patient. This did not happen at all. Secondly, they must bring a container filled with water in order to appropriately ingest the medication in front of the nurse. When this did not happen, the officer appropriately insisted and the patients complied. Finally, the last element is that the patients are expected to open their mouths after ingestion in order to demonstrate that the medication has been swallowed. The officer did insist on this, but the frequency with which the inmates appeared to be unaware of this requirement was extremely problematic. This must be done not only when the medical monitor is observing medication pass but it also must be done at every medication pass. The warden should issue a memo that describes to the inmates the rules for participation in the medication process. The rules include appropriate identification, providing a container filled with water for the process and opening their mouths for inspection after ingestion.

The nurse in this instance knew all the patients quite well and they clearly knew her. A few needed to be reminded to bring the cup of water to the door or to the gate. However, several inmates were surprised at the mouth check and two refused. If an inmate does not comply with the requirements of the medication process then the clinician should be notified and consideration be given to discontinuing the medication.

The nurse did document in a timely manner after the medication was administered on the medication administration records. This is an improvement from prior visits.

RECOMMENDATIONS:

1. The warden should issue a letter in which she lists the rules for participation in the medication process. Those must include: (1) identification by official means; (2) presenting a cup with water in it when one interacts with the nurse; and (3) facilitating visual inspection of the mouth after ingestion. Noncompliance with the rules can result in nonparticipation in the medication process.
2. Assign a consistent officer to accompany the nurse on the medication pass, whether it is mornings or evenings.

3. Provide either a card or a wristband that allows correct official identification for the inmates.
4. Continue to improve the pharmacy arrangements so that it is possible to comply with the Pharmacy Practice Act.
5. 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 MARS for the current month were inspected on June 9, 2015, for completeness. Eighteen (18) inmates currently receiving psychiatric medications demonstrated issues that were of significant concern. Rather than list each chart separately, a general summary will be given. On June 2 and June 3, multiple patients did not receive Cogentin, a medication frequently utilized to treat the common neuromuscular side effects of antipsychotic medications.

On further investigation, it was discovered that there are major pharmacy supply issues reportedly related to late payments to Diamond Pharmacy, as well as an extremely high cost for medications supplied. In an e-mail from Diamond Pharmacy to the Health Services Administrator on May 5, 2015, it was noted that the Bureau of Corrections was in arrears by a total of $351,000. Even in taking into account the fact that this number may represent pharmacy costs for both St. Thomas and St. Croix, this total cost seems incredibly high considering the small number of people at Golden Grove Adult Correctional Facility who are currently receiving medications. Apparently, the pharmacy had refused to supply additional medications until partial payment was received, which resulted in the on-site pharmacy being out of stock of Cogentin.

Another problem identified in this review was notation of frequent refusal of medications by multiple inmates that did not result in any written notification to the clinicians treating these individuals. An example of this miscommunication is a very recent notation by the psychiatrist when seeing an inmate that his medication compliance was fair. Yet, the inmate had refused every dose of medication for the entire first third of the month of June. This same pattern was noted with inmates receiving general medical medications for the management of conditions such as hypertension.

There is no specific section in this agreement that deals with the risk of heat intolerance caused by many psychoactive and general medical pharmaceutics. These medications generally disrupt the body's ability to perspire as a cooling mechanism and increase the chance of heat stroke, and rarely death. While on site, an Ambient Weather WS-HE01 Handheld Heat Stress Index, Dew Point Monitor with Temperature, Humidity Meter was used to measure the temperature and heat index in several units at approximately 4 PM on 6/8/15, with an outside temperature of 89.9 degrees Fahrenheit (Heat index of 99.9). Some units had multiple readings taken in different parts of the common area (Dayroom).

Unit	Cell	Temperature (Fahrenheit)	Heat Index
L (prison segregation)	7	90.8	99.5
L	Dayroom	90	98
K (housing for medically fragile and some mentally ill inmates)	Dayroom	89.8	98.7

K	Dayroom	91.7	105.6
G (general pop)	Dayroom	90.9	101.8
G	Dayroom	89.2	98
H	Dayroom	89.5	98.5
9B	Dayroom	91	99.9
9B	8	90.9	100.3
9B	9	90.7	100.4
9B	TV room	90.5	99.9
9B	17*	90.4	99.6
A (detention segregation)	Dayroom	90.4	100.1

*B17 was an upper corner cell that was currently unoccupied. Due to the lack of ventilation, it was noted that the heat index of 99.6, although equal to or lower than the other readings, was totally intolerable.

RECOMMENDATIONS:

1. The service needs to quickly implement reliable use of the medication refusal form to allow nursing staff to notify clinicians of any significant pattern of medication refusal so that prompt attention and counseling can be provided to their patients prior to any clinical decompensation. This process should also be tracked through quality improvement project to ensure that it is appropriately implemented.
2. The Bureau of Corrections should continue its efforts to identify more cost-effective suppliers of medications and make every effort to avoid lapses in providing prescribed medications to its inmates.
3. GGACF should develop a heat risk policy and ensure that all inmates have access to plentiful supplies of water and ventilation methods at all times. A list of inmates on medications that have heat related risks should be maintained and these inmates should have access to ice and water when the heat index indicates an elevated risk of heat related illnesses.

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: These medical record policy has been approved and training was completed on August 3rd as scheduled. We have seen some improvement in the organization of the records. However, we did find documents that should have been filed but had not yet been filed. Over the long term, the move to an electronic record would be appropriate and necessary.

RECOMMENDATIONS:

1.Complete the training with regard to the policies and procedures.
2.Continue to improve the organization of the medical records.
3.Improve the timeliness of medical document filing.
4.Begin to develop plans to implement an electronic record.

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: Maintenance of the mental health record continues to show benefit from the time of our early visits. However, charts remain in need of organization. Multiple records were noted to have documents which were not filed in chronological order. Some charts continue to remain disorganized with significant numbers of loose documents in the folder.

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. The mental health records should be scrutinized in organizing chronological fashion.

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

MEDICAL FINDINGS: This item was dealt with under letter (c), including recommendations for this provision. However, these policies and procedures were approved and training was completed by most of the medical staff on July 28, 2015.

RECOMMENDATIONS: See letter (c) findings and recommendations.

MENTAL HEALTH FINDINGS: Ms. Randolph, the RN assigned to the mental health team, described the general process for mental health sick call. A registered nurse will triage the request and then hand it to the Mental Health Coordinator. When a request is triaged as emergent or urgent the registered nurse will call the psychiatrist directly and later notify Ms. Murray. Ms. Murray also triages sick call requests prior to determining who should see the inmate and within what time frame. A most interesting finding in reviewing sick call requests was that in the past six weeks there were a total of 17 requests entered into the log. For the prior 15 weeks there were only eight. It is calculated that this represents more than a 500% increase in requests for service. Speculatively, this is most likely attributed to the increased availability of programming and mental health staff. This increase is regarded as a very positive finding.

A review of the sick call log from April 22, 2015 until the present time (a review of all records since our prior audit) was completed on June 8, 2015, with Ms. Randolph. Seventeen (17) records were

reviewed. All inmates who had submitted a sick call request received a face-to-face triage by a registered nurse within 24 hours, an excellent practice which exceeds national standards. Mental health staff also saw individuals who were referred within 24 hours and the response was appropriate in addressing the complaints and requests from the inmates.

This reviewer identified an additional inmate who had submitted a sick call request but whose name was not entered in the sick call log.

RECOMMENDATIONS:

1. Discrepancies between entries in the medical and mental health sick call logs need to be corrected so that both logs are accurate. Accuracy is essential in both ensuring that inmate needs are identified and resolved in a timely fashion as well as providing accurate data for quality improvement efforts.

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

ASSESSMENT: NONCOMPLIANCE.

MEDICAL FINDINGS: We interpret this as referring to a chronic care list and an ability to track the sequence of visits. In this area, progress has been made in developing lists for patients with each disease. We were provided with a list which, although we did not perform a thorough analysis, did appear accurate. There is also a newly assigned chronic care nurse who will be working with the chronic care patients. We reviewed nine records of patients who are enrolled in the chronic care program. All records contain problems. These problems included incorrect assessment of the degree of control, incorrect scheduling of the urgency of follow up based on the degree of control, delays in enrolling in the chronic care program as well as incomplete assessments by the clinicians. We will provide a sample of these types of problems.

Patient #1

This is a 77-year-old patient with prostate cancer, asthma and hypertension and status post pacemaker implantation. His initial hypertension visit was in July 2014, and his last chronic care visit was 5/21/15. The initial visit was not in the record we looked at. This patient is on three antihypertensive medications, aspirin as well as medication for hyperlipidemia. At his last visit, his blood pressure was 178/100 and the hypertension was correctly assessed as poor control. However, he was given a follow-up visit in 90 days. This should have been 30 days or sooner.

Patient #2

This is a 61-year-old patient whose baseline visits for hypertension and diabetes occurred in January of this year and his follow-up visit occurred in March of this year. He was assessed as having both his diabetes and his hypertension in fair control. Due to a low blood sugar his meds were stopped. He also should have been followed much more closely, as he was given a 90-day follow up visit and this patient should have been seen much more frequently until his condition was under better control.

Patient #3
121043 This is a 67-year-old patient with diabetes and hypertension. He had a baseline visit in July 2014. His most recent follow-up visit was in May 2015. However, at first we could not locate the May follow-up visit. After we located the document, it lacked an appropriate disease specific history for each disease. Only the hypertension was addressed at this visit and that was assessed as fair control, but the follow up was in three months rather than within 60 days.

Patient #4
930306 This is a 52-year-old with diabetes type 2 and hyperlipidemia. He had his baseline assessment in April 2014, and his most recent follow-up visit was in January 2015. In October, his hemoglobin A1c result was 7.2%. He has not had any lipid studies in over six months and he should have a repeat hemoglobin A1c. He also has not had an eye or a foot exam.

This program will await the hiring of the new Medical Director who can provide more appropriate clinical decision making.

RECOMMENDATIONS:
1. Have the Medical Director review the chronic care policy and guidelines so that she is familiar with the program. She is certainly capable and should modify it consistent with her clinical judgment.
2. Have the chronic care nurse insure that the guidelines will be followed by working with the clinician and reviewing the records and notifying the Medical Director when particular consultations or tests require ordering.

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. The current log tracks all items critical for ensuring predictable and reliable patient follow up.

RECOMMENDATIONS:
1. It is my understanding that the Mental Health Coordinator plans on also adding a tracking log for general counseling services, which hopefully will be in place by the time of the next site visit.

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

ASSESSMENT: NONCOMPLIANCE.

MEDICAL FINDINGS: See f (ii).

RECOMMENDATIONS: See f (ii).

MENTAL HEALTH FINDINGS: See section V.s.1.

Dr. Shansky for items v, vi, g. and h.

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, although training was completed on these policies July 28, 2015.

MEDICAL FINDINGS: We continue to find medical response bags in the housing units. However, the documentation that the response bags are checked twice daily is problematic. If everything is complete, a checkmark should be made and if something is missing, an X should be documented; the item written in that was missing should also be replaced. We found in a few housing units that staff were using an X to mark bags that were completely filled. Also, in many housing units the bags were inconsistently reviewed, as evidenced by the documentation. Our understanding is that medical and custody should review the bags simultaneously twice a day. It would be helpful to use breakaway plastic strips that if in place indicate that the bag has not been used and therefore it is still filled. We have been told by nursing staff that they tend to bring the health care unit emergency bag to the housing units because that has been historically their custom. That can continue; however, when there are simultaneous incidents in two different housing units, the second incident will require the use of the housing unit emergency bag.

We also reviewed five emergency care records that were sent offsite. The five records revealed one in which the clinician assessment was incomplete and two in which there was no follow-up visit by a clinician after return from the hospital. Those records follow.

Patient #1
R. R. M. This patient was sent to have a carotid Doppler exam on 5/11/15. The cardiologist found an abnormality and sent the patient to the emergency room without documenting an exam. The patient was followed up by a physician in June without any diagnosis.

Patient #2
E. S. This is a 25-year-old who on 4/22/15 complained of chest pain during an intake history and physical. The physician obtained an electrocardiogram which was abnormal and therefore he sent the patient to the hospital. At the hospital, the abnormality was determined to be old and the diagnosis was a variant of costochondritis. The patient was treated symptomatically but no follow up occurred.

Patient #3
B. D. This is a 28-year-old who on 3/3/15 complained of chest pain and was seen on a sick call visit by a nurse and referred to the emergency room after an EKG which demonstrated an abnormality. This patient was seen in the ER and provided treatment, specifically a steroid injection, but the patient was never followed up by a clinician at the facility.

RECOMMENDATIONS:

1. Complete the training of officers regarding the identification of emergency medical and mental health crises.
2. Custody and medical should work together to facilitate improved monitoring of the medical emergency bags in the housing units.
3. The person who is responsible for retrieval of emergency offsite documents should also insure scheduling of follow-up visits.
4. The facility should initiate drills or at least critically review actual incidents identifying both positive aspects of performance as well as opportunities for improvement.

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

RECOMMENDATIONS: None

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: There is a log being maintained; however, we had concerns about the accuracy, which we shared with the offsite service coordinator. One of the first records we reviewed in the log indicated that the patient had not only received the service but also that the report had been returned and the follow-up visit had occurred. In fact, none of this was accurate. We discussed with the offsite service coordinator the need to maintain an accurate and comprehensive log so that the QI program's monitoring would be facilitated. We have been told that the computer link with the hospital has been set up. We did not have the opportunity to assess its use. However, it did appear that many reports are now more commonly available. This is clearly a step forward. Both the unscheduled service coordinator and the scheduled offsite service coordinator should be able to use that computer to retrieve reports not returned from the hospital with the patient.

We reviewed 10 records of patients sent offsite for scheduled consultations or procedures. The most common problem we found was an absence of a clinician follow-up visit or delays in obtaining services. This was particularly true for CT scans, and we were informed that the hospital CT scanner was broken. This basically compromises access to CT scans for the facility. We have been told that the hospital scanner has been repaired and we would therefore expect that the services should be available more timely. Specific cases that we reviewed will be described below.

Patient #1
An order was written for his infectious diseases consultation on 12/3/14. This is an ongoing consultation and the appointment was for 4/28/15. The visit demonstrated good control, although there was no CD4 count. The patient was given a six-month return visit, but there has been no clinician follow up. This is particularly striking since the patient's blood pressure was significantly elevated upon return. That blood pressure should have been followed up.

Patient #2
This prisoner's visit to urology was ordered on 2/25/15. The appointment was scheduled for 4/27. The patient was unable to obtain the visit because, prior to the visit, a CT scan had been ordered and the hospital scanner was broken. This delayed his access and continues to delay his access to urologic services.

Patient #3
This patient had an order for a gynecologic appointment on 3/25/15. The appointment was scheduled for 10:00 a.m. This was for a procedure in the gyn office which did occur, but there has been no clinician follow up since her return to the facility. This particular procedure may cause complications and in this instance the procedure was not accomplished, although the gynecologist made an attempt and it was not accomplished due to abnormal anatomic variation. This should have been discussed with the patient.

RECOMMENDATIONS:
1. The scheduled offsite service coordinator should insure the accuracy of the maintenance of the log.
2. The computer link to the hospital should be utilized to retrieve documents that are not returned with the patient.
3. Once the documents have been obtained, the scheduled offsite service coordinator should schedule follow-up visits with the clinician so that the clinician documents a discussion of the findings and plan.

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

ASSESSMENT: NONCOMPLIANCE, training on Hospital and Specialty Care policies and procedures was completed on July 23, 2015.

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: None

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: This item is completely under the purview of the Medical Director and is one of the responsibilities that she has inherited. She should review and make any changes or additions to the current guidelines and policy

RECOMMENDATIONS:

1. The new Medical Director should review and modify the clinical guidelines developed for intoxication and detoxification as she feels appropriate.

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

RECOMMENDATIONS: None

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

ASSESSMENT: NONCOMPLIANCE. No substantive improvement from previous assessment.

MEDICAL FINDINGS: This item requires two things. One is training for the staff, which has been planned, and two, the identification of an infection control nurse who will be responsible for and oversee the program. It would be useful for the designated nurse to attend an infection control training program, usually provided at a hospital. The Director of Nursing can identify the best available program for the designated nurse to attend.

RECOMMENDATIONS:

1. The training needs to be completed and documented as such for the staff.
2. The designated infection control nurse should be sent for appropriate training, especially as it relates to the role of the infection control nurse in the patient care setting.

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

RECOMMENDATIONS: None

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: Suicide prevention is a critical component of any mental health service due to the high risks of serious morbidity and mortality should there be a lapse in these procedures. Policy review is currently complete and the policies have been formally approved and adopted. Training for all staff including security will not begin until early 2016. Medical staff, based on chart review, is providing adequate support to inmates identified and placed on suicide watch. However, there are significant obstacles for the facility to provide adequate 24-hour safety monitoring for these inmates. Until such time as training and implementation is complete, this provision will remain rated as noncompliant (with rare exception) as compliance requires a multidisciplinary effort.

The few charts reviewed supported immediate referral and rapid evaluation by a mental health professional. The officers continue to complete behavioral checklist referrals and this is maintained in a log by the Mental Health Coordinator. There have been nine such referrals since April 21, 2015 and six of these were reviewed on-site. All six referrals received prompt evaluation within 24 hours by mental health professional and appropriate referrals to the psychiatrist when indicated.

RECOMMENDATIONS:

1. Continue to monitor and review future behavioral health checklist referral tracking logs.
2. Because security staff have not yet been trained with an approved curriculum for suicide prevention, this provision remains noncompliant. However, it is recognized that the security staff does an excellent job completing these forms when behavioral problems are identified.

(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: Currently there is insufficient documentation or data to demonstrate constant observation of inmates until they are evaluated by a qualified mental health professional.

RECOMMENDATIONS:

1. The facility will need to develop a means of documenting whether or not an inmate is maintained on constant observation until the time of the evaluation in order to demonstrate compliance with this provision.
2. Currently, documentation is scattered between an observation form and hit-or-miss notations in the officers' unit log. Implement approved Log of Suicide Watch (PCO) Rounds.
3. 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

MENTAL HEALTH FINDINGS: A suicide risk assessment instrument is now in place and was utilized for the two cases reviewed.

RECOMMENDATIONS:

1. Continue to utilize the suicide risk assessment tool and develop quality assurance data to demonstrate compliance with this provision.

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

ASSESSMENT: NONCOMPLIANCE

MENTAL HEALTH FINDINGS: All housing units will be toured during the September 2015 monitoring visit to assess compliance with this provision.

RECOMMENDATIONS:

(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, however it is forthcoming based on the training schedule. Therefore, this provision remains noncompliant.

RECOMMENDATIONS:

1. A complete training curriculum on suicide prevention needs to be forwarded to the monitors for review and approval.
2. Complete training for all staff on suicide prevention and particularly use of cut down tools to security staff.

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

ASSESSMENT: NONCOMPLIANCE -

MENTAL HEALTH FINDINGS: There has been no change reported in this area. A training schedule was adopted at the end of this site visit, which will begin February 1, 2016, and be completed no later than July 31, 2016.

RECOMMENDATIONS:

1. GGACF will submit their curriculum for training officers and health staff in suicide prevention for approval by the monitoring team.
2. The facility will complete a training by July 31, 2016 for all staff.
3. Effectiveness of the training will need to be demonstrated by the use of competency measuring tools and follow-up quality improvement studies. Development of curricula and measures of effectiveness of the training were provided by the Monitor.

(vii) availability of suicide resistant cells;

ASSESSMENT: NONCOMPLIANCE - No Substantive Improvement from Previous Visit.

MENTAL HEALTH FINDINGS: 7th Report: 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 staffing ratios).

8th Report: No change. The absence of a suicide resistant cell and adequate supervision remains a serious deficiency.

RECOMMENDATIONS:

1. GGACF is encouraged to urgently complete renovations in the infirmary in order to provide appropriate and safe suicide and close observation cells. As expressed in the last 2 reports, 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.
2. Security staff will need to be present in the infirmary to monitor inmates on suicide prevention 24 hours per day.
3. Whenever an inmate is housed in the infirmary a nurse must be present 24 hours a day to complete the required monitoring of the patient every shift.

(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: The Mental Health Coordinator is maintaining a log that tracks suicide watches. Since the time of our last site visit two inmates have been placed on suicide watch and one inmate was listed as receiving chemical restraints. All three records were thoroughly reviewed.

1. Inmate 1 is a 26-year-old male who placed a sick call request complaining of auditory and visual hallucinations. He was seen that same day by the psychiatrist, who placed him on constant observation with 15 min. documentation on suicide level I. This inmate was seen daily by the psychiatrist until released from suicide watch two days later. He was assigned to a weekly group as part of his follow-up. He was also seen by the psychiatrist one week after being removed from suicide watch. A suicide risk assessment form was also utilized by the medical staff. And he was seen by nursing and behavioral health. Security staff only documented safety reviews hourly on the first day of suicide watch between the hours of 1500 and 2100. There were no further entries in the security logs whatsoever. When the C unit log was reviewed it was noted that while the inmate was supposed to be on constant 1:1 observation, he was allowed to go out to the rec yard with six other

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 continue to allow inmates/detainees to cover their cell lights, which is creating a fire hazard. This practice also creates real and potential serious security problems because staff visibility into cells is virtually completely impaired.

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 insect presence. Some inmates have lit "wicks" made, apparently, of toilet paper on their cell windows and floor, hoping that the smoke will deter insects. 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.

RECOMMENDATIONS:

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, similar to previous site visits, 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 from a sanitary standpoint, including mold problems and physical plant deterioration. We also observed that some showers have been repaired from our previous site visit.

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.

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

ASSESSMENT: NONCOMPLIANCE – 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 noncompliance with this Provision can jeopardize the health of staff and inmates.

In Housing Unit 9D there was a recent serious inmate on inmate stabbing whereby one of the inmates sustained blood loss. During our inspection we noted that even several days following

this serious incident, the cell and blood residue had not yet been cleaned or the cell sanitized. The delay in cleaning and sanitizing the cell created a bio-hazard risk to 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 below.

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, however, 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.

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 continue to observe worn out linens and dirty linen in many inmate cells.

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 have 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 previous inspections, 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. 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. Repairs were made to the flooring in order to eliminate the problem of standing water. Unlike previous site visits, we did not observe plumbing leaks. Overall, the kitchen was cleaner than from previous site visits. The dishwasher has not being working properly for a lengthy period of time. There is still an inoperable walk-in refrigerator that was cleaned from our previous site visit; however, there is still evidence of roach infestation that staff are trying to address. There is no hot water in the male and female inmate bathrooms to properly clean their hands. There is an additional hand washing sink located outside the bathrooms that did have hot water, but it takes a lengthy amount of time for the water to get hot. There are no documents to prove that food temperatures are routinely taken of prepared food. The kitchen doors are not rodent proof. We observed evidence of mold and rust in various areas of the Kitchen that staff are attempting to address; however, a permanent fix to the problem still needs to be made to the overall structure of the kitchen. There is no master

inventory of the utensils and dangerous implements. However, the kitchen officer is working on developing a chit check out system for the utensils and dangerous implements.

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 major 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. In previous site visits, inmates consistently complained of seeing particles of rust in the ice that is provided to the housing units. Since our last visit this area seems to have improved. However, a long-term solution to the problem still needs to be addressed.

In X-Dorm we had been reporting a consistent problem regarding the lack of drinking water for this unit. However, since our last site visit 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: Draft training policies and procedures remain under review and revision for final approval. These documents include required content listed in this provision.

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: The draft training policies and procedures include requirements for pre-service training for new civilian, correctional, and supervisory/management staff. These documents remain under review and revision for final approval.

RECOMMENDATIONS: Finalize and implement approved training policies and procedures.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: The draft training policies and procedures include requirements for in-service training for new civilian, correctional, and supervisory/management staff. These documents remain under review and revision for final approval.

RECOMMENDATIONS: Same as above.

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

ASSESSMENT: NONCOMPLIANCE

FINDINGS: Draft training policies and procedures generally include the required elements of this provisions. These documents remain under review and revision for final approval as scheduled.

RECOMMENDATIONS: Implement training policies and procedures once approved**.**

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: All medical, mental health, and suicide prevention policies and procedures have been approved. A new training schedule was filed with the Court on June 12, 2015 and implemented. On August 3, 2015, the Territory submitted proof of training for Group 1 policies and procedures as schedule.

On June 22, 2015, the new schedule for completion all security policies and procedures was filed with the Court. The Territory appears to remain diligent to its adherence to this schedule but is somewhat dependent on a private contractor who is providing consulting services at no cost to the Territory. A measure of flexibility with completion dates is agreed to by this Monitor and USDOJ so long as all documents are finalized and adopted by the Territory by October 30, 2015. The Monitor will work with the parties to develop a final training schedule for security policies.

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: This Monitor continues to monitor compliance with Court-ordered schedules.

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: As stated above.