**United States Virgin Islands**

# GOLDEN GROVE
# ADULT CORRECTIONAL FACILITY

## *NINTH COMPLIANCE MONITORING REPORT*

**2013 Federal Court Settlement Agreement**
**In re: United States of America v. The Territory of the Virgin Islands (86/265)**
Submitted November 27, 2015

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**United States Virgin Islands**

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**Kenneth A. Ray, MEd, Monitor**

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## PURPOSE

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

## EXECUTIVE SUMMARY & ASSESSMENT OVERVIEW

The ninth (9th) onsite compliance monitoring assessment was conducted September 21-24, 2015 and included a focused and productive Court status conference was held on Thursday, September 24, 2015. Prior to this site visit, the Monitor coordinated communication between the parties and monitoring team in preparation for the onsite assessment.

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

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

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

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

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

1. Policies, procedures, protocols, and/or plans required of a provision are properly approved in accordance with this Agreement;
2. the above documents are promulgated and staff are adequately trained on those documents and related performance expectations; and,
3. those documents are adequately and effectively implemented. Implementation includes evaluation that implemented policies, procedures, and training are performing within the expectation of this Agreement.

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

**ASSESSMENT FINDINGS OVERVIEW:**

The Territory's progress toward compliance with this settlement agreement remains very slow and relatively steady despite setbacks and delays involving completion of scheduled policies and procedures. Although all medical, mental health, and suicide prevention policies and procedures are approved, all other policies and procedures have not received final approval. Delay in the completion of these documents primarily result from the Territory's limited resources combined with scheduling conflicts with the Territory's policy development vendor. Nonetheless, the United States and this Monitor have endeavored to consider these issues and have made every effort to maintain a collaborative process in an effort to support the Territory's progress without seeking court intervention. As a result, the parties have agreed to various schedule changes represented by the Territory as their best effort to comply with the agreement. Concomitantly, the Territory seems intentionally focused toward completion of the documents.

This assessment finds no factual basis to change any of the compliance ratings reported in the previous ($8^{th}$) monitoring report. For example:

- Training documentation for approved health care-related policies and procedures was not sufficient to demonstrate that 95% of staff required to complete the training did so with a minimum passing score of 80%;
- Security and safety related policies and procedures are not approved;
- Security supervisor and officer staffing levels remain inadequate to reliably protect prisoners and staff from real and potential violence and harm;

- Security supervisor levels are insufficient to ensure consistent and routine oversight and supervision of staff and housing unit operations;
- Dangerous and nuisance contraband levels remain very high throughout housing units enabling prisoners the ability to violently and seriously harm others;
- Prisoner disciplinary practices continue to impose disparate and excessive punishments;
- Prisoners with serious mental illness continue to languish in solitary confinement with little or no out-of-cell time. Segregation review documentation remains unable to adequately demonstrate the existence of a meaningful and consistent review process;
- The prisoner classification system remains invalidated;
- The required staffing plan has not been approved or funded;
- The fire safety/suppression system remains inoperable;
- The incident reporting system, as well as most documentation process, continues to lack a quality management process to reliably record and track incidents;
- The inmate complaint system (grievance process) remains untimely, disorganized, and inadequately documented to clearly demonstrate prisoners have reliable access to a meaningful compliant resolution mechanism.

**GGACF NINTH COMPLIANCE ASSESSMENT SCORE CARD**

| Areas of Compliance Per Agreement | Total Provisions | Non Compliance | Partial Compliance | Substantial Compliance |
|---|---|---|---|---|
| IV. Safety and Security | 59 | 56 | 3 | 0 |
| V. Medical, Mental Health Suicide Prevention | 36 | 36 | 0 | 0 |
| VI. Fire and Life Safety | 10 | 10 | 0 | 0 |
| VII. Environmental Health and Safety | 11 | 5 | 6 | 0 |
| VIII. Training | 4 | 4 | 0 | 0 |
| Total Substantive Provisions | 120 | 111 | 9 | 0 |
| Percent Compliance | 100% | 92.5% | 7.5% | 0% |

# NINTH MONITORING REPORT
# GOLDEN GROVE ADULT CORRECTIONAL FACILITY
# UNDER DEPARTMENT OF JUSTICE AGREEMENT

## IV. SAFETY AND SUPERVISION

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

### A. Supervision

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** On July 24, 2015, the Territory submitted to the monitoring team and USDOJ draft policies, procedures, and related forms pertaining to housing unit security levels that include stratification for the classification of prisoners. The stratification "matrix" includes all housing units and classification designations. Corrections Corporation of America (CCA) has been assisting the Territory in the development of policies and procedures. USDOJ has been reviewing and commenting on these policies and procedures. The Monitor and his team have been providing suggestions and recommendations on these policies and procedures at the Parties request. Final approval and implementation of these policies and procedures is pending review.

The Territory's greatest challenge continues to be in ensuring prisoner safety and security, ensuring adequate and consistent housing unit staffing levels, consistent prisoner supervision and monitoring, and staff supervision. The best written policies and procedures are to no avail without sufficient staff and staff supervision to carry them out. For example, examination of the Incident logs, incident reports, Evidence (Contraband Logs), Daily Staffing Rosters, and interviews with inmates and staff continue to report the active presence of very serious and dangerous safety and security risks and adverse events. As stated in previous reports, prisoners and staff remain dangerously exposed to actual and potential risk of harm due serious staffing level shortages and staff and prisoner supervision and control.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Apply the approved Housing Stratification matrix as designed and with previously recommended revisions. Specifically, previous recommendations involved making physical and programmatic changes to Kilo (K) unit so as to eliminate isolated conditions of mentally ill inmates.
2. Review current population to verify accurate risk/need classification levels and housing, reclassify and appropriately house as indicated by review process findings.
3. Refer to IV.F. regarding specific classification and housing policy recommendations.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** GGACF administration requires shift supervisors to complete and submit three forms to document shift staffing levels and supervisor inspections. The following forms are required to be submitted for each of the three daily shifts:

1. Shift Roster
2. Overtime Verification Report
3. Shift Supervisor Rounds (inspection form)

The Shift Roster is intended to record the following information for each of the three shifts:

1. Shift date and time
2. Supervisor names
3. Post (where staff were assigned to work i.e. housing unit, Patrol, etc.)
4. Officer Name
5. Time In (time officer began work assignment)
6. Time Out (time officer departed work assignment)
7. Names of officers working overtime
8. Total number of posts

Shift rosters are important documents for assessing and measuring shift staffing levels, overtime patterns, and compliance with this and related provisions of the agreement. Unfortunately, however, an accurate and reliable assessment of staffing levels is once again impossible because approximately half (49%) of the staffing rosters (including overtime and rounds forms) for the reported period were missing and not provided to the Monitor. The chart below lists dates each month documentation was missing and descriptive data about this ongoing problem.

**June:** 1, 2, 3, 5, 6, 7, 8, 9, 10, 17, 23, 24, 25, 26, 27, 28, 29
**July:** 1, 8, 15, 17, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31
**August:** 3, 4, 5, 6, 7, 9, 10, 13, 14, 15, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31
**September:** 5, 11, 12, 18, 19

**Shift Roster / OT / Rounds Forms**

| Month 2015 | Days in Month | Dates Missing | % Missing |
|---|---|---|---|
| June | 30 | 17 | 57% |
| July | 31 | 16 | 52% |
| August | 31 | 22 | 71% |
| September | 30 | 5 | 17% |
| Totals | 122 | 60 | 49% |

As previously stated, revised Post Orders that comport with this Agreement and draft policies and procedures have not been submitted for review and approval by the United States or this Monitor. The former Warden previously issued written directives to shift supervisors requiring inspections of all housing units each shift and requiring them to document those inspections on Shift Supervision Rounds form. This form lists all facility areas to be inspected by supervisors each shift, including housing units, intake areas, non-housing unit buildings, visiting, medical, chapel, kitchen, etc. There are "Date" and "Comments/Concerns" columns to record this information. The bottom of the form provides clear and direct instructions for supervisors to conduct rounds. These instructions denote areas requiring daily (per shift) and weekly (per shift) rounds. All housing units, medical, Receiving and Discharge, and Roving Patrol areas require supervisors to conduct daily inspection rounds. The instructions also direct supervisors to:

- Sign and/or ensure that the officer sign in (RED INK) is preferred
- Talk to staff and inmates in each area visited and note any major concerns/issues
- Account of these items while on post: Post Order Manual, suicide cut-down tool, flashlight operational, radio operational, telephone operational, logbook completion, officers' view into the cells **not** obstructed
- Ensure: High sanitation level, Officers have tools to perform duties, keys secure, etc.
- Any deficiencies should be indicated that addresses [resolves] the issue

Examination of Shift Supervisor Rounds inspection documents for June through September 2015 again found significant problems demonstrating 1) noncompliance with this and related provisions of this Agreement, 2) failure of GGACF supervisors and management staff to monitor and ensure accurate completion of these documents, and 3) lack of a meaningful quality assurance process.

In addition to missing documentation for this assessment period, documentation examined revealed the numerous other problems and deficiencies:

- Only 8 dates had all 3 shift rosters.
- Rounds inspection documents did not record the shift except in a very few cases.
- Rounds inspection documents were either an exact copy of a previous inspection that had been copied repeatedly, or inappropriately completed by documenting "nothing new to report" (there is no comparison document nor is this appropriate documentation); and such poor documentation gives the distinct impression rounds were not initiated or completed in these instances.

- Duplicate copies throughout the date stacks. This is time consuming for the reviewer, wasteful to the printer, and draws attention to management's lack of attention to detail.
- Legibility of documentation is sometimes a problem.
- Lack of signatures on several of the documents. On at least one occasion the overtime verification document had no signature at all, no date, etc.
- Missing dates, cut off dates and shifts due to poor copy technique.
- At least one Roster lacked any documentation in the column for Time Out.
- July 7 was a troublesome stack, with 2 staff rosters for the 6-2 shift, different people assigned, same units, and same shift. Along with this, the 6-2 shift OT Verification also presented with 2 documents with different people, similar times. It is noted that on one of the rosters and one of the OT verification for the 6-2 shift, the date July 7 had been written atop the date July 5.

This document examination seems to clearly demonstrate extant noncompliance with this provision. More importantly, this document review confirms for this Monitor that there remains virtually no management oversight process in place to accurately verify whether supervisor rounds are being either consistently performed or performed as directed by the previous Warden.

Examination of Supervisor Logs, Housing Unit Logs and Shift Rosters continue to evidence continued non-compliance with requiring that at least one officer is assigned to each occupied housing unit. These records document supervisors finding housing units without officers for the entire shift, officers reporting late to housing unit assignments, and "extreme staff shortage." Staff shortages are routinely reported in Shift Rosters as the primary cause for overtime, with as many as 75 percent of a shift working overtime. The staff shortage and lack of supervision is exemplified in the IT supervisor's July 2015 monthly report whereby he reported that in May 2015 a camera was not working in Gulf Unit. He reported that "In May inmates managed to enter the Officer's station in Gulf Unit, climb up into the ceiling, remove a cover from a connection box and cut the wires leading to the cameras. The wires were patched, but one of the cameras shorted out and was destroyed. This left the unit with only one functioning camera."

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Immediately correct documentation problems shown above.
2. Use a standardize Shift Roster form that includes **ALL** locations and designate "CLOSED" for all locations that are out of service.
3. Rapidly implement the NIC Staffing Analysis recommendations.
4. Complete the draft staffing, as required under the Agreement that reflects the NIC Staffing Analysis and provides concrete steps for hiring sufficient staff.
5. Cease the practice of allowing staff to work high amounts of overtime and ensure that staff working overtime have adequate time away from the facility before returning to work to ensure they are adequately rested.
6. Create a fast-track basic officer training program that ensures recruits are adequately trained on salient correctional topics.
7. Seek Court relief to remove any barriers to rapid remediation of facility safety and security deficiencies that expose people to harm.

8. Subsequent to policy and procedure development and revisions, conduct a complete review of existing specific and general post orders to ensure they are:
   a. post specific;
   b. accurately represent post staffing needs and post resources needed to operate the post safely and consistently;
   c. are numbered, cross-referenced with policies/procedures, and formatted in a manner that makes them easy to interpret and apply;
   d. maintained at each post, kept current, and easily accessible;
   e. regularly reviewed, revised, updated;
   f. consistently enforced;
   g. known to staff through pre-service, in-service, and ongoing training.
9. Develop a plan that provides for regular review of all log books by supervisors to ensure staffing and other unit safety and security issues are detected and resolved in a timely manner.
10. Ensure that all posts are staffed according to post complexity and dynamics, risks and needs.
11. GGACF upper management must monitor compliance with any written instructions to subordinate supervisors if compliance with such orders are expected to be followed.
12. Create and implement one, standardized, shift staffing form for supervisors to accurately record shift staffing levels.

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** All officers (including recruits) require functional radios in their possession at all times while assigned duties within the security perimeter. Compliance with this requirement helps to ensure safety of staff and prisoners. However, prisoners and staff are exposed to extreme danger when all on-duty staff are not assigned radios.

During this inspection, we observed that officers assigned to housing units and other areas of the facility had functional hand-held radios.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Finalize, approve, and implement all related policies and procedures.
2. Timely repair and replace nonfunctioning radio and telephone communications equipment throughout the facility, and add additional communications equipment where indicated.
3. The Monitor will continue to review radio equipment inventories and functionality during each onsite assessment.
4. Ensure adequate supply of radio batteries to enable officers to carry radios on their person at all times. **The GGACF Warden did issue written directives to all staff requiring compliance with this recommendation.**
5. Ensure all persons carrying radios are fully trained to understand and operate all radio functions proficiently.

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

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

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

**FINDINGS:** Despite the fact the Shift Roster documents prevented accurate assessment of staffing levels for this reporting period, the Monitor was able to determine that staff remains inadequate. This is because 1) staffing levels are not equivalent with the requirements determined by the Staffing Analysis, 2) housing units continue to operate without staff, and 3) overtime remains extremely high.

Shift Staffing reports continue to evidence constant understaffing in housing units and patrols. Contraband detection and prevention efforts are substantively ineffective due to staffing shortages and evidenced by documented constant high levels of dangerous weapons inmates possess and use to violently attack others, drugs and alcohol, and nuisance items found throughout housing units.

Identical to previous reporting, current staffing levels make it literally impossible to ensure that officers make all required rounds per shift while also attempting to monitor prisoner flow for contraband and supervise prisoners not locked in their cells. Supervisor Shift Rounds reports examined for June through September cannot verify adequate housing unit inspections and staff supervision. However, Shift Rosters report shifts having only one on-duty supervisor at times, making it impossible for a lone supervisor to inspect all housing units and security areas, monitor staff, and respond to various scheduled and unscheduled duties and events.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

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

5. Repair all broken lights in housing units and cells, issue flashlights to staff for cell inspections, keep all housing unit doors locked, repair broken control panels to improve unit security.

## B. Contraband

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

**a. Clear definitions of what items constitute contraband;**

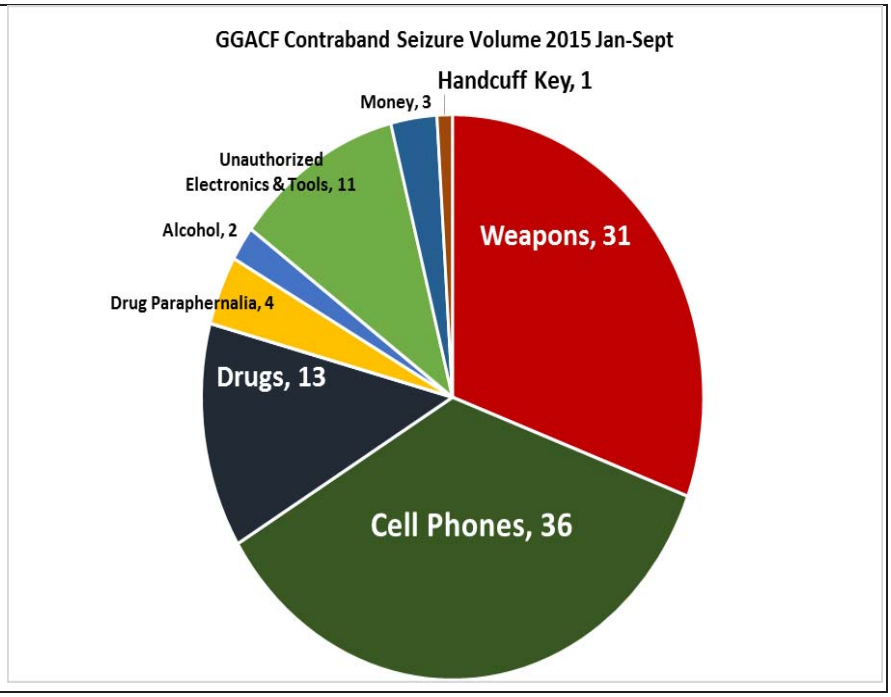
**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The movement and presence of nuisance and dangerous contraband remains seemingly unfettered by GGACF management staff efforts to control it. Weapons, cell phones, and drugs remain at the top for contraband confiscations and present the highest risk for staff and inmates. The chart below shows volume of contraband confiscations for 2015.

| 2015 | Weapons | Cell Phones | Drugs | Drug Paraphernalia | Alcohol | Unauthorized Electronics & Tools | Money | Handcuff Key | Tobacco | Ttl |
|---|---|---|---|---|---|---|---|---|---|---|
| January | 3 | 2 | 3 | 1 | 1 | | | | | 10 |
| February | 3 | 2 | 2 | 1 | | 3 | 2 | | | 13 |
| March | 7 | 8 | 2 | | | 2 | 1 | 1 | 1 | 22 |
| April | 2 | 8 | 1 | 1 | 1 | 5 | | | | 18 |
| May | 1 | | | | | | | | | 1 |
| June | 8 | 8 | 2 | 1 | | | | | | 19 |
| July | 1 | | | | | | | | | 1 |
| August | 4 | 6 | 2 | | | 1 | | | 1 | 14 |
| September | 2 | 2 | 1 | | | | | | | 5 |
| Totals: | 31 | 36 | 13 | 4 | 2 | 11 | 3 | 1 | 2 | 103 |
| % Seizures | 30% | 35% | 13% | 4% | 2% | 11% | 3% | 1% | 2% | 100% |

Weapons confiscated included pocket and combat knives, razors, a box cutter and machete; drugs, marijuana and crack cocaine; various cell phones, drug paraphernalia; unspecified money, alcohol, handcuff key, tobacco; and, a variety of unauthorized electronic devices and tools. The chart and graph below further illustrate this contraband activity.

| Jan-Sept 2015 | Contraband Seized |
|---|---|
| Weapons | Pocket Knives, Combat Knives Razors, Box Cutter, Machette |
| Cell Phones | Various |
| Drugs | Marijuana, Crack/Cocaine, |
| Drug Paraphernalia | Various |
| Alcohol | Unspecified |
| Unauthorized Electronics & Tools | Cell Phone Chargers, Speakers, PSP, MP3 Player |
| Money | Unspecified |
| Handcuff Key | Unspecified |
| Tobacco | Unspecified |




High levels of dangerous and nuisance contraband can only exist at GGACF when 1) officers are not consistently and routinely following basic security tenants, 2) officers are not in control of housing units, 3) supervisors are not making consistent and adequate rounds of housing units, 4) supervisors are making rounds but not ensuring compliance with this policy, and 5) chronic staff deficiencies preventing staff from conducting timely and consistent prisoner supervision and control.

Adequate staffing levels, vigilant adherence to contraband and prisoner security policies by officers, proper training, and diligent staff monitoring and supervision is the minimum requisite for successful implementation of new policies and procedures.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement the new policy according to the terms of this Agreement once approved.
2. Ensure supervisors comply with supervision rounds requirements.
3. Ensure corrections officers comply with contraband control and related security policies and protocol.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Refer to B.a. above.
It should be noted that GGACF lobby entrance security includes a more comprehensive search process.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

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

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Also refer to above contraband findings and discussion.

GGACF cannot consistently nor adequately provide necessary levels of prisoner supervision in any area of the campus with existing staffing levels. This is evidenced by the previously discussed examination of Evidence Collection logs and incident reports. The Monitoring team observed during this visit no pat-down searching of ANY prisoner entering or leaving housing units. None of the housing units are equipped with metal detectors as previously recommended and required in paragraph ii above. GIST staff confirmed again during this visit that regular and random searches are very infrequent but sorely needed. Official GGACF documents evidence that dangerous weapons, drugs and alcohol, cell phones, and nuisance contraband remains accessible to prisoners.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to above, expand application of recommendation to provision c (i-iii) above.
2. See recommendations regarding staffing levels.

3. Ensure inmates are systematically and consistently searched each time they enter and exit maintenance shop areas, kitchen areas, and any area and/or building containing items that can be used as contraband.
4. Always search prisoners each time they enter and exit housing units.
5. Always search all containers entering and exiting the facility, buildings, and housing units.

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** No change was found since previous reports. Above Contraband Provision findings and discussion adequately support no change in this assessment rating.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

Review and implement relevant recommendations for Contraband above, specifically B1b.

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Front desk admission security checks seem improved. On a positive development, the new Director had a walk-through metal detector installed at the main staff and visitor entrance to the facility.

Monitoring team briefcases were searched before each daily visit and we were required to empty our pockets. Additionally, the monitoring team was consistently provided identification for each day of this visit. This practice may not be as consistent as it appeared, however, according to Shift Rosters and the Shift Supervisor Rounds Report.

First, very low staffing levels logically suggest GGACF is forced to prioritize duty assignments to where security protection needs are greatest – the housing units and prisoner locations. Second, none of the different Shift Roster forms show "Visitation" as a post for recording staffing levels.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Continue to ensure timely and consistent escorts for the monitoring team and USDOJ officials during all onsite visits.
2. Continue to maintain adequate supplies of visitor identification cards and ensure that all visitors conspicuously wear badges at all times while inside the security perimeter.
3. Implement document quality improvement protocols to improve reliability of the two supervisor reporting systems used for this assessment to aid in demonstrating compliance.

## C. General Security

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Prisoners continue to be allowed to wear personal "street" clothes in and out of the housing units. Several prisoners were observed wearing non-correctional attire in day rooms, their cells, and in the yard.

We continue to observe that some on-duty security staff were wearing unmarked clothing and some wore unmarked lightweight jackets that covered their uniforms. Security staff reported having to purchase their uniforms (including shirts, pants, and shoes) themselves; one staff member reported receiving only one official shirt 3-4 years ago. Security staff also reported not receiving expected yearly allowances for clothing maintenance. Unlike specialized law enforcement staff, there is no value or understandable purpose in allowing uniformed security staff to wear unmarked clothing or to wear personal attire that covers portions of their uniforms. The security officer uniform is specifically marked to provide clear and obvious awareness of the presence of a security officer. As such, a marked security officer uniform should never be obscured.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Require inmates to wear issued institutional clothing ONLY.
2. Take timely and appropriate corrective action with staff who fail to enforce inmate uniform policies and inmates who refuse to comply with those policies.
3. Ensure that all staff wear their required GGACF uniform at all times, and take timely and appropriate corrective action with staff who refuse to do so.
4. Consider acquiring correctional apparel that provides obvious recognition of the inmates' classification/status.
5. Ensure there is a consistently sufficient supply of uniforms for regular laundry exchanges and changes in an inmate's classification and/or status.
6. Consider developing a correctional industry for making uniforms onsite.
7. Select/make uniforms specifically designed to reduce/eliminate places to hide contraband and weapons.
8. Mark all uniforms with highly visible letters/numbers.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Refer to previous findings and discussions pertaining to B.a, C.1.a. In addition, some prisoners were again observed either not wearing identification or not properly displaying their identification if it was being worn. During the onsite visit, the monitoring team and the USDOJ were given and required to wear visitor badges.

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

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

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

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

**FINDINGS:** Previously requested training documents demonstrating completion of staff training on this subject matter have not been provided to this Monitor. Additionally, some of the Shift Supervisor Rounds reports and Housing Unit Logs, as well as direct observation during our visit show several inoperable locking mechanisms throughout the facility stating:

- Detention R&D: "Sally Ports remain inoperable along with Exits and Entrances"
- K Unit: June 23/24, 2015 an officer reported that around 5:00 am an inmate in cell #8 could not be let out because the cell door could not be opened. It appears that the cell door was not unlocked until around 9:06 am. The responding maintenance person indicated that he does not do locks and was not trained to open any locks.
- Housing Unit slider doors inoperable.
- Housing Unit Sally Port doors inoperable

Inconsistent and incomplete use of these reports makes it very difficult to use these documents as a credible sources to advancing this provision, and it is logical that compliance with this provision is frustrated by inadequate maintenance staffing levels. The Director is working with Human Resources and Budget staff to permanently expand the work hours of the contract locksmith, which should result in better upkeep of locking mechanisms. It was encouraging that after many months of noting inoperable

Sally Port gates and other deficiencies with doors in R&D that they were finally being addressed and most of them already repaired, with the exception one entrance door.

However, even with an adequate locking system maintenance program, prisoners will continue to gain dangerous access to each other until security staff consistently practice good key control.

**RECOMMENDATIONS**: Previous recommendations remain appropriate.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Draft policies and procedures are in the process of being developed. However, these policies and procedures cannot, ultimately, demonstrate compliance until GGACF has sufficient staffing levels to ensure compliance. This is because these policies and procedures require a much higher level of routine attention to all housing unit locking mechanisms by housing unit officers and supervisors.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Employ and maintain adequate Maintenance staffing levels.
2. As requested in the previous two reports, develop an "all-locks" maintenance plan for review by the Monitor and incorporation into policies and procedures. The plan should include a complete inventory of all locks, locking mechanisms, date lock found non-functional, date

repair/replacement was completed, and a list of all locks and locking systems taken offline. The plan should include, at a minimum, the following elements and should use an Excel spreadsheet: Where the lock is specifically located – (Perimeter gate, housing unit 9A, cell #, emergency door, etc.), and lock number, lock type, condition, etc.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** This assessment did not review whether corrective action had been take regarding problems found in GGACF personnel folders during the previous visit. These issues will be reviewed during the December 2015 site visit. The problems identified during the previous visit included:

- Missing verification of training documentation
- No application and/or background investigation record
- Missing criminal background-check documentation
- No uniformity of folder content, disorganization
- Incomplete documentation regarding disciplinary action (i.e. notification of policy violation with no other information regarding disciplinary process or case disposition)
- Employer/reference background forms missing or not completed
- Missing Personal History statements
- Pre-service psychological assessments found in some folders but not others
- Missing fingerprint records
- Incomplete military status questionnaire

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. The employee folder/record system should be standardized and well organized
2. All folders should contain completed Applicant Personal History Statements, criminal history check verification documents
3. Medical records should be kept separately from the general personnel folder
4. Training records should be kept in a staff training folder and separate from the training folder
5. These records should be reviewed periodically for quality assurance purposes and remedial instruction and/or training provide to records staff where indicated.

## D. Security Staffing

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As stated in the previous report, the staffing analysis that included a calculated shift relief factor was completed but the staffing plan remains in development by the Territory. During the September 2015 compliance tour, the Monitor and parties set a deadline of December 31, 2015 for approval of the staffing plan. This is because the Territory stated that it needed additional time in order for the new BOC Director to research and revise the staffing plan. The Monitor and parties have agreed to set a late December deadline for submission of the Staffing Plan.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Finalize and approve required policies and procedures.
2. Finalize and approve the required Staffing Plan.
3. Quickly implement the approved staffing plan without delay.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** As stated in D.1.a above, the staffing analysis was completed but the staffing plan has not yet been approved. Once the Plan and related policies and procedures are approved and implemented, this provision could be advance to Partial Compliance.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

4. Finalize and approve required policies and procedures.
5. Finalize and approve the required Staffing Plan.
6. Quickly implement the approved staffing plan without delay.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** The Territory has submitted the final policy for the Monitor and USDOJ's review.

**RECOMMENDATIONS:** Once approved, implement required policies and procedures.

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

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:** Finalize, fund, and implement staffing plan.

**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. The Territory has resolved the 24/7 hotline. The Territory contacted the National PREA Resource Center to seek resources in reviewing the PREA policy and training program that will go along with it. The PREA National Resource Center has agreed to provide the training.

Also as noted in the previous reports, 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 hired Mr. Jim Warren to serve as the Chief Inspector for both GGACF and St. Thomas. Mr. Warren reports directly to the Director which is an acceptable reporting structure for investigations. Mr. Warren is also supervising the GIST officers. Mr. Warren has an extensive background in law enforcement. Mr. Warren is in the process of developing the office of Chief Inspector as well as working on old cases involving GGACF and St. Thomas. The Director is also in the process of hiring an additional investigator for the agency. When the Office is fully developed, it should be capable of conducting required investigations of staff and prisoner sexual misconduct which is a major component of the PREA regulations. The Monitor is encouraged by these developments. Furthermore, several GGACF staff were recently trained on the fundamentals of PREA using approved NIC curriculum.

**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. Fill additional investigator position.

**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 is in the process of validating the current classification system. During this visit, James Austin, Classification Expert, was working in St. Thomas in reviewing and refining their classification system. Territory staff reported that he will also be assisting GGACF staff with their classification system and ultimately in the validation process, which is very encouraging. 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 nonconvicted 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 staffare 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. Additionally, we continue to note the housing of mixed classifications of prisoners in housing units and cells, including maximum security inmates being housed in the same cell as minimum security inmates. This practice significantly deviates from industry standards and violates the Agreement and related legal requirements.

**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. Mental health staff must continue 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 direct mental health staff to determine if a different, less punitive housing placement is available.

4.

**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. During the September 2015 compliance tour, we observed housing unit doors left open and/or unlocked, and prisoner movement outside of assigned housing units with little or no supervision.

**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**

**FINDINGS:** See previously discussed classification findings.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Refer to recommendations related to grievance and disciplinary policies and procedures.
2. Ensure accuracy of monthly disciplinary committee reports.
3. The Territory must correct problems reported in the monthly disciplinary committee reports.
4. 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**

**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 from June through September continue 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. During the visit, the monitor and GGACF discussed necessary revisions to the segregation review form to capture this information. 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 immediately.** In addition, we received reports that sometimes prisoners in segregation are not let out of the cell at all during the day, because of a shortage of officers to supervise. The monitoring team recorded a heat index of 105.2 F at 4:50 pm in the segregation cell of a prisoner who reported not being allowed out of the cell previously due to lack of officers.

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. Although there has been a reduction in the number of mentally ill inmates in segregation/isolation, a comparison of the prisoner mental health case log and segregation log indicates that there are at least some inmates with mentally illness that 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. Continue to ensure inmates with special needs are monitored frequently as indicated by a security and health risk/needs assessment. A routine schedule for conducting these rounds must be 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:** The previous report documents the following continued problems with incident reporting and log quality management:

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

Incident reports and logs for March 3 through October 12, 2015 were examined to determine whether improvement to document quality was achieved. This examination found no substantive improvement since the September 2013 Baseline Report.

Continued problems with incident logs:

There were 89 incident log entries for the time period examined. There were no corresponding incident reports found for 24 of these log entries. The logs contained incomplete and illegible entries, missing information, entries that were out of chronological sequence, and some incident numbers that did not follow a logical flow. For example, an entry dated 10/2 has an ID number of 10-0023. An entry dated 10/3 has ID number 10-0103. It is not likely that 80 incidents occurred within 24 hours.

Continued problems with incident reports:

There were a total of 65 incident reports that correlated with 89 incident log entries (there may be multiple reports per same incident number, but those were all counted as only one (1) reported incident). An additional 30 incident reports were not list on the incident log. Continued problems with incident reports include:

- Duplicates
- Errors in incident numbers
- Missing names/names in error
- Illegible handwriting
- Blanks (e.g., date, incident numbers, reason for submitting report, etc.)

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; the Incident Log 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 carefullyreview all incident reports for completeness, accuracy, and consistency.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** A regular administrative process required under this provision has not yet been formalized. Such a process first requires wholesale improvements in 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. It is imperative that GGACF management staff implement a measurable document quality assurance and management process for the incident reporting system.

**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:** Findings described in G.1.a adequately articulate continued problems found with the incident central tracking and logging system.

**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. Prisoners continue to receive inordinate amounts of disciplinary segregation that is unprecedented in contemporary corrections ranging from a few days to over 500 days. The Monitor is encouraged by the discussions he has had with both parties regarding Mental Health involvement in the inmate disciplinary process. The Monitor was somewhat puzzled to hear from the Disciplinary Sergeant that overall detainees receive harsher disciplinary sanctions that sentenced prisoners. Hopefully, the revised Inmate Disciplinary policies and procedures will address this concern.

**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 previously submitted revised draft use of force policies and procedures to this Monitor and USDOJ for review and comment. The USDOJ rejected the revised document citing structural and content problems and provided additional comments and recommendations. The Territory submitted a revised draft on November 13, 2015, and the USDOJ's comments to that draft are due November 30, 2015.

The monitoring team brought up the concern regarding an entry in the L-Unit log book (Log Book dated June 3, 2015 at page 197) whereby an inmate claimed he was spitting up blood due to been assaulted by GIST officers during a shakedown around July 29, 2015. Certainly, this allegation should receive prompt attention and investigation by the Chief Inspector.

**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:** As noted above, the draft policy has not yet been approved and implemented.

**RECOMMENDATIONS:** Previous recommendations remain appropriate.

1. Implement policy and procedures once approved.

**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:** Implement policy and procedures once approved.

**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:** The training program cannot be revised to meet this requirement until the new policy is approved. This Monitor and USDOJ also must first receive, review, and approve preservice and annual training curricula.

**RECOMMENDATIONS:**

1. Implement new policy once approved.
2. 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**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Same as above.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Problems with incident reporting make it very difficult to assess whether events involving force are being properly reported. For example, incident report 07019015 (07/20/15) documents "Taser" was involved in this incident. However, the narrative is virtually illegible and no use of force review document was provided. Making this incident even more confusing is the fact that administrative documents clearly state no use of force events occurred during the month of July 2015. Again, **GGACF management must take intentional steps to improve the quality and accuracy of incident reporting and documentation**.

**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**

**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:** Implement policy once approved.

**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:** This policy has not been approved and a formal process for complying with this provision has not been developed.

**RECOMMENDATIONS:** Implement policy once approved

**l. Administrative investigation of uses of force;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as above.

**RECOMMENDATIONS:** Implement policy once approved.

**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. No central tracking system has been developed by GGACF officials; this system will not be of much value unless and until quality assurance managements measures, as previously discussed, are in place and determined to be effective.

**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:** This policy draft remains under review.

**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.

**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 remains problematic based on an examination of grievance log entries from July 20 through October 5, 2015. Additionally, the log records no receipt of any grievance between June 29th and July 20th. It seems very unlikely that prisoners submitted no grievance during this time period based on previously recorded submission patterns, as well as prisoner reports of frequently filling out grievances. For example, one prisoner advised Mr. Romero, Monitor's operations expert, that he had not been able to obtain a attorney visit for six months but had submitted numerous requests and grievances. This further demonstrates GGACF's compliance with this provision and how noncompliance violates this prisoner's access to the court.

Approximately 50 prisoner complaints were processed during this reporting period. The log documents responses to prisoner compliance in approximately 76% (38) of these complaints:

| Classification | Ttl Received | Response Documented | Response Rate |
|---|---|---|---|
| Appeal | 3 | 1 | 33% |
| Food Service | 7 | 6 | 86% |
| Housing Conditions | 2 | 1 | 50% |
| Medical | 8 | 4 | 50% |
| Other | 14 | 10 | 71% |
| Safety | 4 | 4 | 100% |
| Staff Conduct | 12 | 12 | 100% |
| Totals | 50 | 38 | 76% |

As described in previous reports, the time between receipt of a prisoner compliance and response to the prisoner can take several days to weeks in some instances. Additionally, many of the recorded responses do not describe the actual response to the prisoner but instead only what GGACF will do to deal with the complaint i.e. "…*will look into the matter*."

USDOJ provided extensive comments to the Territory's draft prisoner complaints policy on October 29, 2015. Among other things, USDOJ reported that the draft policy continued to lack provisions required by the Settlement Agreement (including provisions regarding corrective

action and evaluation of trends and individual and systemic issues), and that comments previously submitted by USDOJ to an earlier draft in March 2015 had not been addressed. Under the current schedule, the Territory's revised draft is due to the Monitor and USDOJ on December 4, 2015.

**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:** The grievance log cannot demonstrate compliance with this provision for several reasons:

1. The "Type" column is intended to prioritize a complaint as "emergency" or "normal". However, this column is often blank.
2. Response to "emergency" complaints can range from zero (0) to nine (9) days.
3. Descriptions of prisoner complaints often do not support designating the complaint as an emergency.
4. Response often do not articulate what, if any, emergency (or even urgent) actions were taken to resolve the complaint.

The inmate complaint system remains problematic and unreliable. The grievance log is inconsistently maintained and confusing on its face. **This issue has been discussed with GGACF management officials at each site visit with little or no substantive improvement accomplished to date. The Monitor and USDOJ were assured by GGACF management this matter would be corrected but records consistently demonstrate otherwise.**

**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 stastaff whose misconduct is established by the investigation of a complaint;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Documentation provided is inadequate for assessing compliance with this provision. The description of the prisoner complaint system discussed above is also suggestive of noncompliance with this provision.

**RECOMMENDATIONS:**

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**

**FINDINGS**: Same as above.

**RECOMMENDATIONS**: Same as above, and:

1. Develop and implement a formal andreliable 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 (Chief Inspector) position was filled and the Director is in process of filling another investigator position. However, it will take some time for the Office of the Chief Inspector to be fully developed and fully functional. However, these are certainly steps in the right directions. Also, please refer to the discussion/findings noted in paragraph E-1 of this report.

**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, but with the creation of the Chief Inspector's Office it is expected that this area of the Settlement Agreement will advance in compliance ratings in future inspections.

**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 is still 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:**

1. Fill the currently vacant Investigator position as soon as possible.
2. Finalize, approve, and implement relevant policies and procedures.
3. Create a formal pre- and in-service training program to train staff who are involved in initial and/or administrative investigation.
4. 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.
5. Provide training for administrative/leadership in the areas of administrative investigation oversight, coordination, and management.
6. 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.
7. 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**

**MEDICAL FINDINGS:** Once again, there has been an improvement in the performance of the intake screen. The policy, with regard to intake screening, has been reviewed and approved by the monitor. Formal training has been completed and testing has occurred. It is our perception that all of the required staff have been trained and that they have successfully completed the post-test exam. However, a summary document needs to be sent to the monitor for his review.

There has been no change in the RN staffing since our last visit. That is, onsite there are sufficient numbers of nurses to perform appropriately the intake screen each day, Sunday through Saturday from 8:00 a.m. until midnight. There remains a gap of RN coverage between midnight and 8:00 a.m., seven days a week. The Territory is actively recruiting and we would hope that by the time of our December visit, a complete set of staff are in place to provide timely nurse intake screens.

We did identify a systemic problem, in that several patients arriving in the evening did not have their intake screen until the following day, including several that did not receive the intake screen until the following afternoon. It is not completely clear why this delay occurred. However, the nursing staff informed us since there is no appropriate space available in the intake area, the detainees must be escorted to the clinic. Custody partly confirmed this. Commonly, there is an absence of escort officers and this is the major reason for the delay. We discussed this problem with the Director and the Associate Director, and we accompanied the Associate Director to the intake area. A small room was identified that could be used by the nurse, sitting behind a half door, to quietly interview the detainee sitting less than a foot away. In order for this to be established, however, the door must be created. The bottom half of the door should be a collapsible shelf to benefit the nurse while documenting during intake and assist in obtaining the blood pressure. Once this room is established, there will be no further need for an escort officer to assist in the movement of detainees for the intake screening process.

We found a second record in which the inmate entered the facility on July 10 but did not obtain his intake screen until July 24. The nurses informed us that each morning they run a report from the offender tracking system that lists the names of individuals who have entered the system. However, this inmate's

name did not appear on this report until two weeks later, when they obtained the screen. There was an effort while we were onsite to identify when the entries were initially made into the offender tracking system but thus far, the timing of the data entry has not yet been determined.

We reviewed 10 records of detainees who entered the system during the months of June, July and August. Beyond the delays, we felt that the quality of the nursing performance had in fact improved. Even the assessment and application of the acuity scale had improved, and the results of the tuberculosis skin tests were all in the record.

We did clarify our interpretation of the new recommendations from the Centers for Disease Control with regard to determining a positive skin test. Although for the lower risk individual the definition of a positive test has been elevated from 10 mm to 15 mm, it is our view that, by definition, individuals entering a correctional facility come from the highest risk population and therefore the old definition of 10 mm induration should continue to be utilized. Below are some examples of health records reviewed.

**Patient #1**
This patient entered the facility on 7/10/15; however, his nursing screen was not completed until 7/24/15. His screen included a history of a gunshot wound affecting his rib cage in October 2014. His TB test was negative but he also complained of an upper eyelid redness and chronic back pain. He did see a physician, who completed the health assessment on 8/5. This delay was related to a paucity of physician hours in July.

**Patient #2**
This patient arrived on 8/25/15 in the early morning, but did not have his nurse screen until 8/26. His skin test was read as positive at 15 mm; however, on 9/2, his chest x-ray was read as negative. He did report a history of night sweats. I reviewed with the Director of Nursing that when the nurses perform the reading of the tuberculosis skin test and identify a positive skin test, they should immediately query the patient with the positive skin test about the presence of TB symptoms.

**Patient #3**
This patient entered the facility at 5:48 p.m. on 7/25/15, but did not receive his nurse screen until 3:45 p.m. on 7/26. He had a history of both asthma and hypertension. He did receive a peak flow test, which revealed a rate of 300 mm. Otherwise, his vital signs were normal and he was listed as an acuity 2. His TB skin test was also negative. This patient was not seen by a physician until 9/5 (due to the absence of physician hours) and there was no effort, either by the nursing staff or by the physician, to indicate the need for monitoring his blood pressure.

**RECOMMENDATIONS:**
1. Complete the revisions to the space identified within the intake area so that the nurse intake screen will no longer be dependent on the availability of escort officers.
2. Complete the filling of the RN positions on the midnight to 8:00 a.m. shift, seven days a week.
3. Assume that all inmates entering the system are designated as high risk and therefore utilize the definition of a positive test as 10 mm or greater of induration.
4. When the nursing staff identifies a positive skin test, insure that they query the patient with the positive test regarding TB symptoms and document in the medical record.

5. Continue to run reports from the offender tracking system in order to identify recent entries into the system.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** For the most part, nursing staff continue to perform intake screenings, which include a section on mental health, within 24 hours of intake into the facility (see above noted medical findings). However, looking only at screenings with positive mental health findings, there were two case exceptions identified during this site visit. In one case, the intake screening was delayed for approximately 2 weeks; the reported reason for this delay was that for some reason, the inmate wasn't entered into the 'smart jail' system; and I was told that the smart jail system is at least one of the ways that inmates in need of an intake screening are identified. In the second case, the intake screening was delayed because no corrections officer was available to accompany the inmate to the health unit so that he could be screened.

A positive finding on the mental health section of the intake screen does prompt an immediate referral to the mental health staff for a full mental health assessment. Positive findings on the mental health screen correlate fairly well with positive findings during the course of the fuller mental health assessment, meaning that there are only a small number of false positives on the mental health intake screen. However, it appears that some of those in need of mental health treatment or at least monitoring by mental health staff are being missed during the mental health intake screening process. For example, there are inmates who are later referred to mental health by corrections officers using the 'behavioral checklist', and now that mental health assessments are being performed on all new inmates, some additional number of inmates who were not previously identified at intake are being picked up through this process. Although the reasons for these false negatives at intake are still being explored, at least preliminarily it appears that there are several reasons. For example, it at least appears that there is some subset of new admissions that are either unwilling or unable to reveal mental health issues during the intake screening process, and, for example, the intake screening process does not appear to capture new inmates with severe trauma histories and associated clinically significant trauma-related mental health difficulties that render them at high risk of deterioration while incarcerated. However, the inmates should be captured during the mental health assessment that is conducted within three days of the admission.

**RECOMMENDATIONS:**

1. Track data to support evidence of successful implementation of the policy and demonstrate adequacy of the quality of the screening process.
2. Given that the availability of corrections officers to transport inmates at least appears to still be a problem, consideration should be given to identifying a private space in the intake area for the nurses to perform intake screenings so that new inmates don't have to be transported to the medical unit for intake screenings.
3. Continue to examine cases where an inmate with a negative mental health screen is later identified as an inmate in need of mental health services, and then explore options for altering the mental health screening process so as to minimize the number of such false negative mental health screenings.
4. Consider including a few questions in the mental health section of the intake screen designed to uncover any significant history of trauma.
5. Assure that the mental health training that will be eventually provided to corrections officers helps them to appreciate the importance of their use of the 'behavioral checklist' and enhances their ability to use the 'behavioral checklist'

6. Continue the practice of completing mental health assessments on all new admissions.

**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**: During this past visit, there was a Medical Director for the entire visit. For the months of June, July and most of August, there was no dependable physician/Medical Director presence. Therefore, the finding of noncompliance. The Medical Director started in late August, is on-call, and works 3 days a week at the facility.

**Patient #1**
This patient arrived on 7/15/15 and was screened on 7/16. This was a case where there was a delay in the medical screen. He had a history of sickle cell trait. His TB skin test was negative but he was listed as an acuity 2. He was released on 8/21, more than a month later, without having had a health assessment.

**Patient #2**
This patient arrived on 7/28/15 with a history of asthma and appeared to be symptomatic. He had a peak flow of 360 and a TB skin test of 12 mm. He was released on 8/10 without ever having had an initial assessment or an initial chronic disease encounter. His 12 mm skin test was not considered positive. If the program follows our recommendations, in the future a 12 mm induration will be considered a positive skin test.

**RECOMMENDATIONS:**
1. The Medical Director should provide feedback to the Director of Nursing and the nursing staff regarding the appropriateness of the assigned acuity level.
2. The new Medical Director has planned to be onsite three days per week. This leaves a gap that should be filled by a clinician at least one day per week so that the health assessments are not unnecessarily delayed. Therefore, some additional hours of clinician services should be added.
3. The Medical Director should consider a strategy in which she can document both a health assessment and an initial chronic clinic visit for individuals who enter with common chronic medical diseases.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As was reported in the last monitoring report, a 'psychosocial assessment intake log' has been developed to track when intake screenings and initial mental health assessments are performed. A review of this log revealed that initial mental health assessments were performed the day of or the day after the mental health unit received the intake screening, unless, of course, the inmate had been released. Therefore, in cases where inmates did not receive an initial mental assessment with 72 hours of intake, the delay was due to a delay in performing the intake screening and/or in sending the results of that screening to mental health staff.

As noted above, initial mental health assessments are now being performed on all new admissions. However, there are inmates who were initially incarcerated prior to the time that the current type of initial mental health assessment was being performed; some of those inmates are on the mental health treatment

list and some are not; and the mental health staff is currently trying to complete mental health assessments on such inmates.

The 'psychosocial assessment intake log' also indicates if and when, following the initial mental health assessment, a referral was made to the psychiatrist, as well as the reason for such a referral. Although the log does not indicate when referred inmates were actually evaluated by the psychiatrist, at least a sampling of charts indicates that psychiatric evaluations were usually performed in a timely manner. Exceptions to this occur when the psychiatrist, who is part-time, is not at the facility; in such cases, the psychiatrist is consulted over the telephone; but there is no mechanism, such as video conferencing, that would allow her to actually perform evaluations when she is off-site, which is of particular concern when the inmate's status is noted as urgent.

The initial mental health assessment form and samplings of its use were also reviewed. This review revealed that the initial mental health assessment is quite complete, except for an adequate assessment of any history of serious trauma and the presence of any resultant clinically significant trauma-related symptoms and developmental difficulties.

There does appear to be a small number of inmates who refuse to undergo an initial mental health assessment or are unwilling or unable to fully cooperate with such an assessment. There is no clear policy or procedure for dealing with such situations, and this is especially critical with regard to those who totally refuse to be assessed.

**RECOMMENDATIONS:**

1. 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, and this information should be included on the 'psychosocial assessment intake log'.
2. As noted above, continue performing initial mental health assessments on all new inmates, and continue efforts to perform such assessments on those who entered the facility prior to the time the current initial mental health assessments were being performed.
3. Develop a video conferencing mechanism that would allow the psychiatrist to perform psychiatric evaluations from an off-site location.
4. Expand the initial mental health assessment to include more about an inmate's trauma history and any associated clinically significant trauma-related symptoms, including developmental difficulties. The monitor has begun discussing this with the mental health team and remains available for further consultation on this issue.
5. Develop a protocol or procedure for responding to inmates who refuse to engage in an initial mental health assessment. Here, too, the monitor is available for consultation on this issue.

**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**, in part related to lack of availability of clinician resources to whom nurses can refer patients to be seen in a timely manner.

**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 consistently utilized and we are pleased to report that a nurse generally saw patients timely. As we understand, two

housing unit exam rooms contain exam tables that have been used by nursing staff to perform sick call. Other patients must continue to be escorted to the medical clinic until all housing units have appropriate exam space. There were some identified problems with nursing performance. However, this is to be expected and should improve with ongoing feedback. Problems identified included the absence of vital signs, the absence of documentation of a note, the identification of an abnormal vital sign that was never rechecked, the assessment listed by a nurse as "altered comfort," which is not a nursing diagnosis and, of course, the problem of lack of availability of clinician resources for timely follow up. We reviewed the records of 15 patients who had requested services for sick call over the prior three months.

**Patient #1**
This patient is a 46-year-old male with a history of gunshot wound to the chest, arm and groin and subsequent neuropathy. On 8/24/15, he complained of wisdom tooth pain that was 10 out of 10 on a pain scale. He was seen by a nurse who did not perform vital signs although did perform a good history and physical assessment. He returned on 9/1, but we could not find a nursing note. We discussed with the Director of Nursing the need for nurses to keep lists of patients they saw each day so a supervising nurse could review records to insure that the documentation was appropriate.

**Patient #2**
This patient is a 26-year-old female who requested sick call on 8/31/15 and was seen on 9/2. The patient's vital signs were normal but the pulse rate was 111 and there was no effort to recheck this abnormal pulse rate.

**Patient #3**
This patient is a 25-year-old male who on 7/3/15, requested attention for neck pain and knee pain. He also indicated he had pain in his fingers, knees and neck and the pain scale was 7 out of 10. The vital signs were normal but the nursing assessment was "altered comfort." This is not appropriate and in order to be a nursing diagnosis, it must include alteration in comfort as it relates to an organ system or a specific body part.

**Patient #4**
This patient is a 38-year-old male who on 8/20/15, complained of shortness of breath related to his asthma. His respirations were increased at 22 per minute, his pulse rate was 104 and his blood pressure was 141/91. Peak flow measurement was not obtained. However, two nebulization treatments were provided. The response from the physician who was called was not consistent with the latest acute asthma treatment recommendations.

**RECOMMENDATIONS:**
1. Complete the equipping of the housing unit exam rooms so that nurses and physicians are able to see patients in the housing unit exam rooms.
2. The Director of Nursing needs to continue to review the notes of the nurses and provide feedback as to how they can improve their performance.
3. An emphasis on peak flow measurements for patients with asthma should be initiated with the nursing staff.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS**: The 'mental health follow-up log' was reviewed. This log list all detainees and inmates who are on the mental health caseload; their psychiatric diagnosis; whether they have been on a suicide watch, placed in restraints or placed in seclusion; the date of their last psychiatric evaluation; any prescribed psychotropic medications; and the scheduled date for follow-up. The log lists 56 detainees and inmates who are housed at the facility, and 16 who are housed off island. Two questions emerged from this review. The first relates to the fact that the time between the last psychiatric evaluation and the next scheduled follow-up varied from approximately 2 months to 4 months. Given that the standard is about 3 months between evaluations, even for chronically ill but stabilized persons, 4 months between evaluations seems like a long period of time. It at least appears that those scheduled to have 2 months between evaluations were deemed to need closer monitoring. However, it was unclear, based on a review of a sampling of records, whether those deemed to need such closer monitoring actually needed to be evaluated even more frequently than every 2 months. This is of particular concern because it wasn't at all clear whether or not mental health staff, who see the inmates more frequently, are charged with reporting any difficulties with medication (i.e., compliance, efficacy and any adverse effects) to the psychiatrist. The second question relates to the fact that there were inmates and detainees listed on the log as suffering from major Axis 1 psychiatric disorders for which treatment with psychopharmacologic agents is indicated, yet were not on such medication. Exploration of this revealed that these inmates and detainees refused to take medication, but there is no clear protocol or procedure for dealing with inmates and detainees who need but refuse to take medication. This is particularly troubling because as a result, at least some of those inmates are being held in seclusion, unmedicated and acutely ill.

The 'behavioral checklist/sick call log' was also reviewed. This log lists all inmates for which a 'behavioral checklist' or a 'sick call request' was completed, the nature of the complaint, the date the form was received, the date the social work assessment was performed, if/when a referral to the psychiatrist was made, the date of any requested psychiatric evaluation, and the date for any required follow-up. Quite a few of these inmates are also on the mental health case load. This raises the question of whether or not these inmates are being seen frequently enough, and/or whether or not the therapeutic interventions being employed are adequate. These questions need further exploration. Others are not on the mental health case load and were apparently identified by the 'behavioral checklist' or their own request for services. At least one of the inmates in this group was initially referred via a 'behavioral checklist'. And although he was evaluated and scheduled for a follow-up, he returned via a 'sick call request' multiple times prior to the scheduled follow-up visit. Cases such as this one also must be reviewed with an eye towards assessing the efficacy of treatment and/or how frequently visits should be scheduled.

Non-psychopharmacologic treatment options have been expanded. There are now quite a few weekly group therapy sessions, and individual sessions can be scheduled for those who evidenced particular difficulties in a group session and/or are otherwise found to be in need of an individual session. It is expected that once the additional expected mental health staff person is hired, treatment options will be further expanded. This monitor attended two group therapy sessions, both of which were quite good. In both cases, participants were totally engaged. I learned that there were inmates who wanted to be placed on the mental health caseload so that they could attend groups, which would at least suggest that the word on the units is that the groups are a good thing. Although the group therapy program covers a wide range of issues, there are at least three types of groups that are not yet available. These include a psychoeducational group, focused on helping those with major mental health disorders learn about their disorders and how to best participate in the management of their disorder; a dual-diagnosis group,

focused on those with a substance abuse disorder and another major mental health disorder; and a support group for those with a history of exposure to severe trauma(s).

This monitor also met individually with a sampling of inmates who are on the mental health caseload. A couple of them had questions or concerns about their medication that need to be addressed. Of greater concern were the inmates seen who have refused medication and remain acutely ill, some of whom were being held in seclusion.

**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 body.
2. It has been previously recommended that the Medical Administration Committee, once formed and active, begin to address the security issue of access to substances that can induce psychotic conditions that then require psychiatric services. This monitor did not notice the previously reported odor of marijuana in housing units during this auditing visit. Hopefully this represents a substantial improvement on this issue.
3. The question of how frequently psychiatric follow-up sessions should be scheduled should be reviewed. Similarly, the question of how frequently inmates and detainees on the mental health case load need to be seen should be reviewed.
4. Continue to expand non-psychopharmacologic treatment options as noted above.
5. Develop a protocol or procedure for responding to inmates for whom psychopharmacologic intervention is indicated but yet refuse to take medication. This is especially important for those inmates who are being held in seclusion because they are so severely mentally ill. This monitor is available for consultation on the development of such a protocol or procedure.

**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;**

**MEDICAL FINDINGS:** We visited the medication area and availed ourselves of the opportunity to meet with the pharmacist who is in charge of the area. She has implemented a system in which patients with chronic diseases have their medications individually dispensed based on the prescription requirements. Thus, patients with hypertension on metoprolol twice a day have a series of small Ziploc bags dispensed with the labeled medication on it. It is our understanding that for new orders as patients come in, the program utilizes an offsite pharmacy to dispense the medications. Thus, nursing staff no longer are involved in dispensing and labeling medications. This is consistent with pharmacy practice acts around the United States, so there continues to be progress with regard to this particular issue. On the other hand, since our last visit there was a substantial gap in access to physician services. This gap stretched from June 1 through most of August and therefore the assessment has to be noncompliance. This impacts timely responses to orders for medications and laboratory tests as well as timely and routine physician review of medications and clinical practices as well as review for known side effects of

medications. We do not believe there is yet an organized strategy to insure discharge medications are always available to meet patient health needs.

We also observed medication administration with regard to the morning med pass in most of the housing units. A nurse accompanied by an officer now performs this. However, we are disappointed to report that there has been regression with regard primarily to, in our view, custody responsibilities. We observed patients in lockdown who were surprised when told that the lights in their rooms must be on when receiving medications. Patients were also surprised at the request to bring a container of water to their doorway. Furthermore, most of the inmates were surprised that not only did they have to ingest the medications with water or some liquid, but also that after ingestion they were required to cooperate with a mouth inspection. The latter two things were true for not only inmates housed in lockdown status but also true for patients in the general population. Several patients refused to cooperate with a mouth check when I also requested it of them and several inmates refused to ingest water at the time of the ingestion. If a program wants to discourage the availability of medication contraband, it thus requires lights to be on in the cells, official identification by a wristband or an identification card, simultaneous ingestion with water, and a mouth check after ingestion. These are the requirements for detainees and inmates to participate in the medication program in all correctional institutions. All inmates should be fully aware of these rules. They, of course, have a choice to participate or not in medication services, but they must all follow all of these rules if they do participate. Not only should custody administration inform the inmates and detainees of these requirements but also this should be written into the post orders of the officer whose assignment is to accompany the medication nurse. I was also informed that it is quite common for an officer trainee to be given this assignment. In my experience, when these rules are consistently and predictably enforced, there are no problems with the inmates. The use of trainees virtually guarantees problems with enforcement of these rules.

The medication nurse did perform reasonably well given the circumstances. At my request, she also documented after completing each housing unit medication pass. She also inspected the emergency bag available in each housing unit.

**RECOMMENDATIONS:**

1. The Medical Director should review this section and develop a methodology in order to document compliance with the elements in this section.
2. Custody leadership should inform the inmates/detainees of the rule requirements to participate in the medication program.
3. Custody leadership should insure that the post order for the officer that accompanies the medication nurse clearly stipulates these rules and the officer's role in enforcing these rules.
4. The Director of Nursing with the Medical Director should develop a system to insure documentation of the provision of release medications for the population that is released.
5. Officer trainees should not be assigned the responsibility of accompanying the medication nurse.
6. The Director of Nursing should monitor the performance of the medication administration process as part of the quality improvement program.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** See the discussion on medication administration in the housing units under medical findings.

As noted above, the time between medication reviews is quite variable, and this needs to be reviewed.

There were two types of medication compliance issues identified that raise two different issues. The first, as noted above, is related to those who totally refuse to take medication and therefore remain untreated. There is absence of a protocol or procedure for responding to those inmates. The other relates to those who periodically refuse to take their prescribed medication and whether or not the psychiatrist is informed of this lack of full compliance in a timely manner. In prior monitoring reports it has been noted that psychiatrist has not been notified about such lack of full compliance, in writing, in a timely manner. As the new mental health monitor, it is difficult for me to determine how much improvement there has been in this regard. I found cases where the psychiatrist believed there was full compliance when that was not the case. This clearly impacts the psychiatrist's review of the efficacy and safety of medications prescribed.

Although the psychiatrist reports periodic review for known side effects of medications, due to time constraints, the extent to which this is documented was not confirmed by a review of charts. However, this monitor will do such a review during the next monitoring visit. Also to be explored during the next monitoring visit is the extent to which other mental health staff have been trained to recognize medication adverse effects, and how any such recognized adverse effects are reported to the psychiatrist.

The breadth and depth of the formulary for psychopharmacologic agents continues to be an issue. Although this monitor is well aware of the need to consider cost-containment and cost-effectiveness, it has been well-established that although all of the various medications in any particular class of psychopharmacologic agents might be equally as effective, none of them is equally as effective in all individuals. Therefore, having only one or two agents from any given class of medications compromises efficacy for some patients. The same is known/operative with regard to safety, especially when one examines the adverse effect profile of some of the newer versus many of the older psychopharmacologic agents. While one way of managing concerns about cost is to limit the breadth and depth of the formulary, including mostly the older medications, a far better way of managing such cost concerns would be to focus on a better/more cost-effective purchasing plan for medication.

During the visit, this monitor did not review any charts for inmates who had been released after having been on the mental health caseload. The Territory's mental health team, however, informed this monitor that inmates who are released receive a sufficient supply of medication. This monitor is currently unable to determine whether or not such inmates were given a sufficient supply of medication upon their release. This will be explored during the next monitoring visit.

The issue of the high climate temperatures on the units as a particular concern to those taking psychopharmacologic agents (and other medications) that cause heat intolerance has been discussed in prior monitoring reports. To date, it does not appear that anything has been done to address this issue. However, it is my understanding that at least options are being considered, and those will be discussed in another section of this monitoring report.

**RECOMMENDATIONS:**

1. The use of the medication refusal forms to allow nursing staff to notify clinicians of any significant pattern of medication refusal and the review of such forms by prescribing clinicians should be tracked. It may also be helpful to have a place on the form where the prescribing clinician can sign, indicating that the form has been seen and reviewed.

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.
4. Regular assessment for medication adverse effects should be well-documented, and through training, such efforts should be expanded to involve all mental health staff in the identification of medication adverse effects.

**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:** The medical record policy has been approved and the training has occurred. We did find, however less frequently, documents that were either filed late or filed in the wrong section. Consistent with practice in the community, we believe the availability of an electronic record would greatly facilitate an improvement in care. We have talked with an IT company with whose work we are familiar and who indicated that there could be available to the Territory a substantial discount in cost of such an electronic record.

**RECOMMENDATIONS:**
1. Continue to improve the organization of the medical records, including the timeliness and appropriateness of medical document filing.
2. Begin to explore plans to implement an electronic record.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** There continues to be progress in organizing the mental health record for each inmate within his/her larger medical record. However, while doing chart reviews, there were still charts where some of the mental health record was filed in the wrong place, at least based on the medical records format that was provided to this monitor.

The revision to the approved 'treatment plan' form is a work in progress. Based on discussions with the mental health staff, it will hopefully soon reflect a multi-disciplinary approach to treatment planning, with a clear indication of which interventions are focused on addressing which problems. However, the concept of treatment planning will have to be expanded to include planned approaches to addressing those who have refused treatment.

A discussion was held regarding how much information about an individual's participation in a group therapy session should be included in his/her medical record, and the extent to which such entries increase one's understanding of how that individual is doing upon simply reading his/her medical record. As the number and nature of group therapy sessions expands, and as the number of other non-psychopharmacologic interventions increases, this issue will be even more relevant.

**RECOMMENDATIONS:**

1. When 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 organized chronologically.
3. The approved 'treatment plan' form needs further development, and should be expanded to describe planned interventions for those who have refused medication or other important therapeutic interventions.
4. The charting of group therapy sessions and other non-pharmacologic interventions requires further consideration.

**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 ad 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. It must be emphasized that the absence of timely physician services was a major contributor to this assessment

**RECOMMENDATIONS:** See letter (c) findings and recommendations.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** The 'sick call log' and sick call procedures have already been discussed, and as noted above, the response to sick call requests is consistently timely and complete. However, it should also be noted that the number of sick call requests for mental health continues to increase. Previously, it has been speculated that this increase is most likely attributed to the increased availability of mental health staff and programming. While this is likely a factor, it is also quite likely that those who were not receiving mental health services have heard from those who are receiving services that real help is available. This would also contribute to the increase in the number of those seeking services. Such discussions might also decrease the stigma that was associated with seeking mental health services, and may further contribute to the increase in the number of those seeking services.

**RECOMMENDATIONS:**

1. See section '1c' findings and recommendations.

**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. Again, we were provided a list and we did use it to review several records. We reviewed 10 records of patients seen by the chronic care physician. We identified the following types of problems: lengthy delays between follow-up visits, absence of following significant abnormal test results, inadequate subjective information compiled, and inadequate timeliness of follow up and lack of documentation of the assessment of disease control. Finally, there were several patients for whom the finding of fair or poor control did not result in a documented effort to improve the disease control.

**Patient #1**
This patient entered the facility in August 2014, with hypertension, depression and chronic paranoid delusions. His baseline chronic care visit was 9/5/14, and he was then seen in October of 2014, but not seen again until April 2015. On his baseline visit, there were several positive symptoms described but all of them lacked any detailed elaboration. In October, his hypertension was assessed as being in good control with a three-month follow up. However, he was not seen until six months later. One of his visits lacked any documented date. Also, in February 2015, his blood sugar was 190, but there was no effort to follow up with regard to this item.

**Patient #2**
This patient is a 44-year-old patient with hypertension, hyperlipidemia and bipolar disorder. His baseline was in November 2013, and he was next seen in October 2014, 11 months later. Subsequently, he was seen in March 2015, and then again in June. At his June visit, he complained of headaches but there was no documentation as to location, intensity or any associated signs or symptoms. There was no assessment of the degree of control of his hypertension at this visit.

**Patient #3**
This patient is a 63-year-old patient with hypertension and low back pain whose baseline visit was in November 2013, and his next visit was in October 2014. His blood pressure was 137/92 and his pulse was 110, but there was no change in regimen. Thyroid studies were done and interpreted as normal. His most recent visit was in March 2015, where the blood pressure was assessed as fair control, but there were no changes to the regimen. A 90-day follow up was ordered, but this has not occurred.

**Patient #4**
This patient is a 69-year-old with hypertension whose baseline visit was in January 2015. Although his blood pressure was 190/100, he was not seen in the chronic care program until 9/23/15, where fortunately his blood pressure had been lowered to 146/93.

**Patient #5**
This patient is a 47-year-old with hypertension and chronic left leg pain along with schizophrenia. His baseline assessment was not completed. His initial blood pressure was 148/98 and assessed correctly as fair control. He had a subsequent visit not dated in documentation. The blood pressure was 172/89, consistent with poor control, but there was no change in regimen.

**Patient #6**
This patient is a 43-year-old patient with asthma. His baseline is undated but probably took place in May 2015. His vital signs were normal but there was no peak flow measurement and he has not been seen since.

**RECOMMENDATIONS:**

1. We understand that the Medical Director will be seeing all of the chronic care patients, which we feel will substantially improve the quality of services.
2. The chronic care nurse should work closely with the Medical Director, insuring that all asthmatics have a peak flow measurement, all diabetics and hypertensives have the appropriate laboratory tests available at the time of the visit and insure that the follow up is consistent with the level of disease control.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted above, the 'mental health follow-up log' has been carefully maintained and is up to date. See Section '1c' for further discussion of the 'mental health follow-up log'.

**RECOMMENDATIONS:**

1. See section '1c' for recommendations regarding the 'mental health follow-up log'
2. In the last monitoring report, it was noted that it was the understanding of the monitor 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. Although a log of group therapy sessions was reviewed by this monitor, the development of such a treatment log for all non-psychopharmacologic interventions continues to be a recommendation.

**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).

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** See sections '1b', '1c', '1d', and '1f' sub-sections i and ii

**RECOMMENDATIONS:**

See sections '1b', '1c', '1d', and '1f' sub-sections i and ii

**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**

**MEDICAL FINDINGS:** We found it difficult to track onsite emergency services because they were logged in the sick call log but they were walk-ins. It would be preferable for them to be logged along with unscheduled offsite services so that the log contains both onsite and offsite services, relatively few of which require the patient to be sent offsite and the majority of which begin as onsite services, even when they are sent offsite. We did find medical response bags in the housing units; however, there was inconsistency in the documentation of checking the bags twice daily. It appeared that most commonly, it was not documented that bags were checked, especially on the weekends. We understand that the medication nurses have the responsibility to check these bags. Occasionally, the availability of the key to access the bags was not completely understood by the housing unit officer. This needs improvement as well. We discovered that some of the contents of the bags had expired.

We also became aware of the fact that since the Medical Director has started to be onsite regularly, one or two patients were sent out without notifying her. These occurred after midnight. In our discussion with the Medical Director, she clearly would like to be called before such patients are sent out. There is a possibility that a send out could be avoided based on her assessment and recommendations. The Warden assured us that staff would be notified of the requirement to contact her even when there are no nursing staff available on site.

We reviewed four records of patients sent offsite. In none of the records was there a timely follow-up visit with a clinician. This is not surprising given the absence of predictable physician availability until the Medical Director began. Although there were offsite service documents available, chart review of one patient with an episode of chest pain reveals the hospital never mentioned performing an electrocardiogram. The following patient records were reviewed.

**Patient #1**
This patient is a 49-year-old male with a history of gunshot wound and angina, who was sent to the ER on 8/4/15 for chest pain. He apparently walked into the clinic at 9:42 a.m. complaining of left-sided chest pain that he reported to be 8 out of 10 on the pain scale. Although his vital signs were normal, there was a nurse assessment and the patient was sent to the emergency room. Although the documents from the emergency room were available, they did not mention an electrocardiogram and there was no physician follow up.

**Patient #2**
This patient is a 43-year-old male with a history of reflux disease. On 8/17/15, he complained of abdominal pain. Although there was no nurse on site, the patient was sent to the emergency room without contacting the Medical Director, who had already begun her employment at the facility. The patient returned about 2:35 a.m. The patient was released later that day. The emergency room report was present.

**Patient #3**
This patient is a 43-year-old male with a history of hypertension, hyperlipidemia and reflux disease who at 3:45 p.m. on 6/1/15 complained of black tarry stools and a facial abscess. He was assessed by a nurse and sent to the emergency room. The stool was not tested onsite. The emergency room did test the stools and they were negative for blood. They did address the facial abscess, for which they performed an incision and drainage. There has been no physician follow up.

**RECOMMENDATIONS:**

1. Custody must make it clear to all correctional officers that before a patient is sent out emergently, the Medical Director must be contacted for her final decision.
2. The Director of Nursing should establish a system to insure that the offsite service documents are available (which does appear to be working) and when they are available, the patient's name should be placed on the list to be followed up with the Medical Director.
3. Emergency onsite care should be tracked in the same log as the offsite care or in a separate log for emergency onsite services.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS**: See medical findings and recommendations.

In addition, as noted above, when the psychiatrist is off-site, her ability to respond to emergencies is severely compromised by the lack of some type of video conferencing capability. At present, she is virtually always available for a telephone consultation, but of course, the quality of that consultation depends on the quality of the information presented to her. With video conferencing capability, she would be able to actually see and speak to the inmate directly, thereby substantially increasing the quality of an emergency assessment, and in turn, the appropriateness of an emergency intervention.

**RECOMMENDATIONS:**

1. Develop video conference capability that would allow the psychiatrist to assess inmates who are in urgent need of an assessment even when she is off site.

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

**ASSESSMENT: NONCOMPLIANCE**.

**MEDICAL FINDINGS:** There is a medical log that appears to be significantly more accurate than during our prior visit. We reviewed 12 records of patients who received consultation services or procedures, such as colonoscopies or CT scans. Again, the biggest problem was the frequent absence of clinician follow-up related to the unavailability of physician services until the Medical Director began. In almost all instances, the reports were available.

**Patient #1**

This patient is a 35-year-old male with hypertension, a history of a positive TB skin test and bipolar disorder. On 9/17/15, he was scheduled to have a CT scan of his head, ordered on 9/7. The CT scan was completed; however, there was no physician follow-up visit.

**Patient #2**

This patient is a 64-year-old male who was scheduled for a visit with a nephrologist on 9/16/15 as a follow up to a June visit. He has stage 3 chronic kidney disease secondary to HIV infection. He is a complicated patient for whom the Medical Director and I discussed the need for a one-page summary that accurately describes his conditions.

**Patient #3**
This patient is a 75-year-old male with hypertension and type 2 diabetes who was scheduled for an x-ray of his right hand on 6/26/15. The x-ray was performed on 7/1, and reviewed two weeks later by the cardiologist on 7/15. Again, there has been no follow-up visit.

**Patient #4**
This patient is a 55-year-old male with hypertension who was scheduled for a CT scan of his abdomen on 9/18/15. The CT report was in the chart but there has been no follow-up visit.

**Patient #5**
This patient is a 58-year-old male with HIV disease, hyperlipidemia and spinal stenosis. On 8/21/15, he was scheduled for an outpatient communicable disease clinic visit and although he did have a CD4 count of 334, there was no viral load report in the medical record. He needs follow up with the Medical Director as soon as is feasible.

**Patient #6**
This patient is a 31-year-old male with a history of gunshot wound to the right thigh and a history of bladder repair. He was scheduled for a neurology appointment on 8/26/15 but this clinic was delayed due to lack of availability of territorial plane tickets. This is an unacceptable reason for delayed services.

**Patient #7**
This patient is a 60-year-old male with hypertension and prostate enlargement. He saw urology on 7/27/15 and diagnosed with chronic prostatitis. He has a history of a diagnosis of a sarcoma with regard to a scrotal mass. He has had no recent follow up with the primary care provider since his urology visit.

**RECOMMENDATIONS:**
1. The scheduled offsite service coordinator should insure there are follow up visits with the Medical Director once the offsite service reports are available.
2. The Medical Director's visit with the patient should document a discussion of the findings and plan with regard to the offsite service.

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** This provision received noncompliance due to the absence of adequate physician resources, which we expect will be corrected by our next visit. This has also been discussed under f (v).

**RECOMMENDATIONS:** This has been discussed under f (v).

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** With regard to mental health, adequate follow-up care and treatment after return from referral for outside diagnosis and treatment is facilitated by the fact that the facility's

psychiatrist is also the psychiatrist at the hospital. Notwithstanding this fact, care must be given to formally referencing emergency assessments performed and treatment given at the hospital, and the linking of that to follow-up care and treatment.

**RECOMMENDATIONS:** Refer to medical findings and recommendations.

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** We did review the approved intoxication and detoxification policy. It does appear reasonable. The new Medical Director will have to provide specific training based on the policy and we were not aware of any cases where the assessment on intake resulted in an assessment of potential intoxication or detoxification problems.

**RECOMMENDATIONS:**
1. The Medical Director should provide training to the nursing staff with regard to the implementation of the monitoring system.
2. Once training has been provided, we presume that the nurses will utilize the CIWA and COWS assessment forms.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** See medical findings and recommendations.

In addition, it is important to note that there is a substantial sub-set of individuals suffering from substance abuse difficulties who also suffer from some other major psychiatric difficulty. Such other major psychiatric difficulties may be evident while the individual is intoxicated and/or they may become evident during detoxification. In either case, these other major psychiatric difficulties may have to be addressed. Medical staff persons who are managing intoxicated inmates and those undergoing detoxification must be able to rapidly consult with mental health staff and integrate mental health interventions into the treatment process when such is indicated.

**RECOMMENDATIONS:**
1. Assure the integration of mental health staff into the assessment and treatment of intoxicated inmates and those undergoing detoxification when there is evidence that the inmate is also suffering from other major psychiatric difficulties.

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

**ASSESSMENT: NONCOMPLIANCE.** This item requires training for the staff and the identification of an infection control nurse who will be responsible for overseeing the program.

**MEDICAL FINDINGS:** The training of the nursing staff and the oversight of the training of the officers should be the responsibility of the Medical Director. The issue that we raised with regard to intake

related to the potential change in definition of a positive TB skin test. We strongly recommend that the more conservative definition of a positive skin test, defined as 10 mm of induration, be retained because the population seen is such a high-risk population.

**RECOMMENDATIONS:**

1. The training of medical staff and correctional staff should be conducted under the direction of the Medical Director. She may choose to do this herself or designate someone who she adequately trains.

**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 metal health professional;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted above, a review of the 'behavioral checklist/sick call log' revealed that those referred to mental health by either mechanism were rapidly evaluated by the mental health staff, and when indicated, rapidly referred to and then evaluated by the psychiatrist. Of course, what this log doesn't reveal is how quickly corrections officers identified serious mental health needs and then completed a 'behavioral checklist', which is the other key element in addressing this issue.

A more detailed review of one inmate referred via a 'behavioral checklist' for suicidal ideation demonstrated the mental health unit's rapid and full response to such an emergency, but raised other concerns. In this case, an inmate not previously known to mental health became suicidal and cut both wrists after he was placed in disciplinary segregation about a month prior to his scheduled release date. Although he was rapidly evaluated and placed on an appropriate level of suicide watch, there was no evidence that his mental health status was taken into consideration when making decisions about disciplinary actions and/or the use of segregation, and mental health staff reported that they were not at all involved in these decisions. The parties and monitoring team had a conference call regarding the Territory's draft policy regarding inmate discipline and, among other things, the role of mental health staff. Under the current schedule, the Territory's revised draft policy is due December 4, 2015, and the parties and monitoring team will hold another conference call on the policy on either December 10 or 11.

**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. It is recognized that despite not having been trained, the security staff does an excellent job completing these forms when behavioral problems are identified. However, there should also be an assessment of how early in the process of the emergence of suicidal ideation or other mental health emergency that such difficulties are identified by security staff.
3. Mechanisms for better integrating information from mental health staff into the decision-making process regarding disciplinary actions and the use of segregation must be developed.

**(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 in place and being utilized.

**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**: Although suicide cut-down tools are in place and safely secured, it is not at all clear that they are readily available (i.e., can be quickly enough retrieved from their location to be useful in the event of a suicide attempt). Based on questioning security staff, it is not clear that all security staff are familiar with their use.

**RECOMMENDATIONS:**
1. Assure that rapid access to cut-down tools is possible.

**(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:** As noted above, it is not clear that all security staff are familiar with the use of cut-down tools and other suicide prevention emergency interventions.

**RECOMMENDATIONS:**
1. Complete training for all staff on suicide prevention, including training for security staff on the use of cut-down tools, followed by an assessment of competency to employ such suicide prevention efforts.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** A training schedule was previously adopted, with training scheduled to begin on 1 February 2016, and scheduled to be completed by 31 July 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 this 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.

**(vii) availability of suicide resistant cells;**

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** There is still no suicide resistant cell(s). As was noted in the last monitoring report, there is an area in the infirmary that has been earmarked for conversion into a suicide prevention housing area, but the transformation of those cells into suicide resistant cells has not yet occurred. Therefore, inmates placed on the highest levels of suicide watch are still kept on regular housing units, with the expectation that they will have the constant observation by security staff that is required to assure their safety there. However, based on a review of available observation records, such constant observation could not be confirmed, and it at least appears that observation continues to be intermittent and unpredictable at its best.

**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 3 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. Even when suicide-resistant cells are available, security staff will still need to be present in the suicide prevention housing area to monitor inmates on suicide prevention 24 hours per day. Appropriate logs for documenting security staff monitoring will have to be developed, maintained and then reviewed for compliance with policy and procedures.
3. Even when suicide-resistant cells are available, a nurse will have to be present in the suicide prevention housing area 24 hours a day to complete the required monitoring of the patient every shift. These records will also have to be reviewed for compliance with policy and procedures
4. Until such time that the proposed suicide prevention housing area has been fully renovated and become operational, security staff must provide *constant* observation of inmates placed on the highest levels of suicide watch, and document that such constant observation is taking place. Such documentation should be reviewed for compliance with policy and procedures.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** The medical/mental health records and a log maintained by the mental health coordinator clearly track and provide information obtained from ongoing evaluations regarding indications for the various levels of suicide watch ordered. A review of medical/mental health records and the tracking log indicates that the protocol for the mental health supervision of actively suicidal inmates is clear, consistent with current standards of medical practice, and carefully followed. However, as noted above (in section vii), it is impossible to document the extent to which security staff is providing the level of observation required to ensure the safety of inmates placed on suicide watch, and it at least appears that the level of observation by security staff continues to be intermittent and unpredictable at its best.

**RECOMMENDATIONS:**

1. Complete the process of training on suicide prevention and observation policy, implementation and monitoring.
2. System-wide training for this provision will be the last of the medical trainings offered because security must also be included. However, the facility is **strongly urged** to consider a method to ensure that inmates placed on suicide watch, between now and the time training is completed, are adequately supervised and that this supervision is documented according to policy.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted above (under section viii), the protocol for the ongoing mental health evaluation of suicidal inmates and the care of such inmates, including their placement on and removal from suicide watch, is being carefully followed by the mental health staff. Furthermore, a review of their work in this regard indicates that clinical decisions have been consistently appropriate, both during the period of an inmate's active suicidality and during the prescribed period of follow-up after an active level of suicidality has remitted. However, there continues to be concern about the implementation of directives that result from the evaluation and the development of care plans for suicidal inmates when such directives must be implemented by staff outside of the mental health unit.

**RECOMMENDATIONS:**

1. Assure that appropriate mechanisms are in place to facilitate the notification of all medical staff, especially nursing staff, of mental health directives and care plans for suicidal inmates; monitor the effectiveness of such mechanisms for notification; and monitor the implementation of the directives that nursing and any other medical staff are responsible for.
3. Assure that appropriate mechanisms are in place to facilitate the notification of security staff of mental health directives and care plans for suicidal inmates; monitor the effectiveness of such mechanisms for notification; and monitor the implementation of the directives that security staff are responsible for.

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** With the addition of the Medical Director, only the midnight shift between midnight and 8:00 a.m. seven days a week is currently vacant. We do know that the Bureau is actively recruiting and we anticipate that this hiring can be completed and the staff in place prior to our next visit. We also recognize that the effort made to rectify the situation of the Health Care Administrator has been successful. With the Medical Director in place, the only medical position remaining is that of nursing hours (eight hours per day) to complete the RN staffing.

**RECOMMENDATIONS**:

1. Fill the nursing hours to complete 24/7 RN staffing.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** At present, the mental health staff includes the mental health coordinator (Ms. Murray, LCSW), a part time psychiatrist (Dr. Sang), a mental health counselor (Mr. Rosas, MHC), and at least a substantial amount of time of one of the nurses (Ms. Randolph, RN).

At least one additional staff person is required to address all of the provisions of this agreement. It is my understanding that an additional mental health counselor has been identified and is somewhere in the process of negotiation and/or review by human resources, but it remains unclear to me if and/or when this additional staff person might actually start working.

**RECOMMENDATIONS:**
1. Fill the currently available slot for an additional mental health staff person as quickly as possible.
2. As mental health staff continue efforts to address all of the provisions of this agreement, staffing analyses should continue to assure adequate staffing of the mental health unit.

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** There still are problems with regard to intake and sick call and dental services related to adequate available officer staffing.

**RECOMMENDATIONS:**
1. Complete the officer training.
2. Stabilize the officer assignments for those officers posted to assist medical and enable them to be trained on the particular aspects of their assignments.

**MENTAL HEALTH FINDINGS**: As per medical findings.

**RECOMMENDATIONS**: As per medical recommendations.

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** The medical program now has a dedicated Medical Director in place who can provide leadership for the quality improvement program. The Medical Director should especially focus on professional performance, both by the nursing staff as well as the additional physician who adds the extra day on site. With regard to timeliness of services, the program committee should look at these with regard to each major service, such as intake, sick call, chronic care, unscheduled services and scheduled offsite services.

**RECOMMENDATIONS:**
1. As described above, the QI program should present data to me at my next visit looking at the intake process, the sick call program and the scheduled and unscheduled offsite services.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Except for the exceptions noted above, the mental health team is now collecting adequate data that can be used to assess compliance with policies and procedures regarding the identification, handling, and care of detainees and prisoners with serious mental health

conditions. When the above noted exceptions are addressed, the team will also have the data required to assess the overall quality of services provided, and thereby identify any policies or procedures that need to be revised in order to assure quality mental health service delivery.

Given the now ready availability of such data, the current focus should be on the development of a meaningful periodic review of this data for compliance with policies and procedures, and the development of an approach for employing this data to assess overall quality of mental health care.

It must be noted however that quality assurance with regard to mental health care is not entirely under the control of the mental health staff. For example, assuring the safety and adequate care of suicidal inmates requires the availability of suicide-resistant cells and monitoring by security staff. In addition, the appropriate care of many of the seriously mentally ill inmates who are amenable to treatment requires access to a unit designed for inmates with such special needs that would allow for enhanced mental health programming, and those who refuse treatment require a mechanism to obtain treatment for them.

**RECOMMENDATIONS:**

1. The mental health staff should develop compliance reports that indicate any failures to comply with developed policies and procedures, and the result of investigations into the reasons any such failures to comply occurred.
2. The mental health team should also assess the overall quality of the mental health services provided, with an eye towards identifying, developing, and implementing any quality improvements that should be made.
3. Monthly or quarterly management meetings with medical staff and other department leaders should be occurring. Mental health staff should be using these meetings as an opportunity to continue to raise quality assurance issues that are not totally under their control. Raising such issues and any identified approaches to addressing such issues should be documented in the minutes of these management meetings.

**m. Adequate dental care;**

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS**: We found two types of problems with regard to dental access. First of all, the dental staff had problems being available based on the ability of the Bureau to timely purchase tickets on flights that would allow them to be available for the full day. This needs to be rectified and should be addressed by the Health Service Administrator. The second issue has been some slippage with regard to officer escorts, so that the percent available has recently been as low as 60% of scheduled appointments.

**RECOMMENDATIONS:**

1. Continue to monitor the access to dental care by documenting scheduled versus seen, and the reasons why not seen.
2. Report the number of restorations each month as well as the number of extractions, with a goal of getting closer to 1:1.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As was noted in prior monitoring reports, mentally ill inmates, especially those suffering from serious yet untreated mental illness, may not focus on their need for dental services and therefore not seek the dental services that they require, even if they are in pain. Therefore, GGACF health, mental health and dental services must be proactive in monitoring the dental hygiene of this vulnerable population.

**RECOMMENDATIONS:**

1. GGACF officials should ensure protocols are in place and practices that ensure proactive oral health assessment of mentally ill inmates.

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

**ASSESSMENT: NONCOMPLIANCE**. No substantive improvement from previous assessment.

**MEDICAL FINDINGS:** Now that there is a Medical Director in place, all deaths and any significant hospitalizations that may be problematic must be reviewed per this policy.

**RECOMMENDATIONS:**

1. Have the new Medical Director perform a review of the care provided at GGACF for the patient who died.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Although there were no inmate deaths to review, there was a serious suicide attempt, which was made by an inmate who had not been on the mental health caseload prior to the attempt. However, there was no morbidity review of the suicide attempt to determine such things as whether or not underlying mental health difficulties had been missed and if so why; whether or not clinically significant suicidal ideation could have been identified prior to the actual suicide attempt; and whether or not there were any other issues raised by this case, such as the process by which decisions are made to place an individual in segregation. The suicide attempt also had not been previously reported to the Monitor and USDOJ as required by the Settlement Agreement, notwithstanding repeated USDOJ requests for that information.

**RECOMMENDATIONS:**

1. The clinical directors, Director of Nursing and Health Services Administrator should develop mechanisms to identify and review all cases of mortality and serious morbidity as part of the Quality Improvement process. These reviews should also include security leadership.
2. When such reviews result in the identification of issues that need to be addressed (whether they be a failure to comply with policies and procedures, or the possible inadequacy of existing policies and procedures), a plan for corrective action should be developed.

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

**ASSESSMENT: NONCOMPLIANCE**
**MEDICAL FINDINGS:** As we understand it, a nurse is making rounds three days per week and documenting in the medical record for those patients who have issues that require the nurse to address. We would like to be able to facilitate our review of this item by the nursing and mental health staff identifying names of people and the date seen for which they wrote a note in the medical record.

**RECOMMENDATIONS:**
1. Maintain documentation of patients referred for care by either medical or mental health as a result of the segregation rounds made weekly.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** There is currently weekly mental health rounding in isolation/segregation cells performed by Mr. Rosas, and monthly mental health rounding in isolation/segregation cells performed by Ms. Murray. In both cases, all inmates in isolation/segregation are seen – not just those on the mental health caseload – and there are logs kept for both sets of rounding that indicate when the inmate was seen, the inmate's general well-being, the condition of the inmate's cell, and any specific mental health needs that the inmate might have.

Although on this monitoring visit I was unable to accompany Mr. Rosas or Ms. Murray on these rounds, I plan to do this the next monitoring visit. My focus will be on the assessment of the impact of isolation/segregation on the inmate's mental health status; the development of a recommended plan for any inmates whose mental health has been adversely impacted upon by isolation/segregation, including recommendations with regard to whether or not they should continue to be placed in isolation/segregation; and the appropriateness and feasibility of any such developed plan. However, it should be noted that the prior monitor did accompany Ms. Murray on her rounds, and noted that the rounds were conducted in a "competent and effective manner".

**RECOMMENDATIONS:**
1. The Mental Health Coordinator will keep documentation of weekly and monthly rounds.
2. This provision will be more closely monitored at the time of the next site visit as described above.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Despite this prohibition, there are still inmates with serious mental illness who are being held in isolation/segregation, and some of them have been held in isolation/segregation for many, many years. The seriously mentally ill inmates being held in isolation/segregation fall into several sub-groups, each of which raises different issues/concerns.

First of all, there are seriously mentally ill inmates who are not receiving any type of mental health treatment because they have reportedly refused such treatment, and as a result they continue to be acutely psychotic and/or otherwise seriously mentally ill. At issue for this subgroup is the documentation by mental health staff (during the rounding process) of their mental status and their need for an intervention other than locking them in isolation/segregation, and a clear protocol for addressing the mental health needs of such inmates.

There is another group of seriously mentally ill inmates who are in treatment, but reportedly are being held in isolation/segregation because, despite treatment, they continue to be too vulnerable to be placed in general population. In other words, they are reportedly being protected by being placed in isolation/segregation. These inmates are allowed two hours/day of congregant out-of-cell unstructured time and at least some of them are also now participating in the new group therapy program. However, to date, there is no planned housing alternative that would provide protection for such inmates, such as an open unit for this population of patients and others who might require similar protections. There is also no enhanced programming for seriously mentally ill inmates that would be a therapeutically sound alternative to locking them in isolation/segregation for the overwhelming majority of the day.

Then there is the group of seriously mentally ill inmates who are in isolation/segregation as a disciplinary sanction. As discussed below, there is no evidence that the mental health status of these inmates was considered when reviewing their disciplinary infraction and/or when deciding whether or not isolation/segregation was the most appropriate response to their disciplinary infraction.

**RECOMMENDATIONS:**

1. As per the provisions of this Settlement Agreement, inmates with serious mental illnesses may not be placed in isolation. This infraction should be repeatedly documented during the rounds of isolation/segregation cells performed by the mental health staff, and corrective action taken.
2. For those seriously mentally ill inmates who refuse treatment, the mental health staff needs to opine as to whether or not such inmates are a sufficient danger to themselves or others that they would require isolation/segregation. In addition, a protocol must be developed for that subset of inmates that are a danger to themselves or others, focused on attempting to get them to voluntarily accept treatment and outlining steps that should be taken for those who ultimately continue to refuse treatment.
3. With regard to those seriously mentally ill inmates who are currently in isolation/segregation for their own protection, the Bureau of Corrections needs to develop a corrective action plan with specific recommendations for capital improvements that will provide a more appropriate housing unit for such inmates, with dates to remedy this deficiency. In addition, once an alternative to the isolation/segregation of such inmates has been developed, mental health staff will need to develop enhanced programming for them.
4. With regard to those seriously mentally ill inmates with an alleged disciplinary infraction, see the next section of this report.
5. During the time that inmates with serious mental illnesses remain in segregation, mental health staff should be aware that these inmates should be offered a minimum of 10 hours a week of unstructured out-of-cell time by security. Additionally, mental health staff is encouraged to develop supportive group or individual therapeutic activities, generally recommended being a minimum of 10 hours per week per inmate in order to support the inmate's mental state as well as assist inmates in acquiring skills to move them off the segregated status and sustain themselves in the general population setting.
6. Mental health staff need to repeatedly raise all of these concerns during management and administrative meetings as a reminder to all levels of staff that these concerns must be addressed.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Such a review by and/or consultation with mental health staff does not occur.

**RECOMMENDATIONS:**

1. GGACF needs to develop an effective policy and process to provide mental health review and input into the disciplinary process.
2. Mental health staff must be prepared to quickly assess inmates with alleged disciplinary infractions, with an eye towards determining whether or not the alleged infraction was likely a product of any mental illness that the inmate might be suffering from, and the likely impact of potential sanctions on the inmate's mental health status.
3. GGACF should develop a form that can be sent to the Mental Health Coordinator, completed by mental health staff and submitted to the disciplinary committee, which outlines the findings of the mental health assessment. The committee can use the same form to communicate back to the mental health staff the outcome of the hearing proceeding.
4. Mitigating factors discovered by the mental health professional must be considered by the disciplinary committee.
5. Mental health services should track the effectiveness of their input in mitigating sanctions or terminating sanctions as appropriate.
6. Alternative housing and treatment services are an essential component in diverting seriously mentally ill inmates committing infractions due to their impaired judgment and mental processing.
7. Again, it is recommended that GGACF provide appropriate staffing and housing alternatives for this population. (See V.1.p.)

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

**ASSESSMENT: NONCOMPLIANCE**

**MEDICAL FINDINGS:** There is some improvement with regard to the availability of the exam rooms within the housing units. Two rooms in housing units are now ready for use. They each need additional chairs; otherwise, they are fully ready. One room is being used both by the nurse who does sick call as well as by the medication nurse. There are six rooms that require exam tables, of which we were told should be available the week after our visit. On the other hand, we did not observe any work being completed with regard to the remaining issues in the infirmary.

**RECOMMENDATIONS:**
1. We strongly recommend that the Medical Director and Health Services Administrator jointly develop a plan to expedite the completion of the infirmary renovations and the implementation of the dental and mental health rooms as well as medical patient rooms.
2. Complete the exam rooms in all of the housing units.

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** The renovation of examination offices on each of the housing units has been virtually completed. It is presumed that mental health staff will have access to these offices for individual sessions with inmates and psychiatric visits when other medical staff are not utilizing them, but the logistics of this (such as scheduling and the availability of keys to those offices) will have to be worked out. However, the renovation of space for other mental health programming still needs to be completed, such as the renovation of multipurpose rooms on the segregation units so that the space can be used for mental health programming; the renovation of cells in the infirmary to make them suicide-resistant; and the identification of space for an expanded group therapy program.

**RECOMMENDATIONS:**
1. Continue with current renovation plans.
2. Continue to assess the need for additional space for developing mental health programming.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Most of the issues related to the timely, current, and adequate development of mental health treatment plans have already been discussed under other provision of this agreement. In summary, at the next monitoring visit I will be reviewing the revised treatment plan document; reviewing records and logs to assess the timely completion of treatment plans; review treatment plans to determine to what extent they were developed by the mental health treatment team as a whole, and to what extent they were reviewed with and understood by the inmate/patient; and reviewing the relationship between the information obtained during the assessment process and the treatment plan in order to assess the adequacy of the treatment plan with regard to the inmates presenting problems.

It must again be noted that this monitor recognizes that the adequacy of treatment plans might at times be compromised by some of the above noted problems that are outside of the control of mental health staff. When this is the case, this monitor will expect to see any such required compromises noted in the treatment plan, so as to make it clear that there is a more appropriate intervention that is simply not currently available.

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

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

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As has been already noted above, mental health programming has been expanded to include various group therapy programs. Although I have recommended the expansion of the group therapy program, it is clear that the existing program has already proven itself to be quite beneficial to many of the inmates in need of mental health services.

As noted above, enhanced programming for seriously mentally ill inmates, especially those currently in isolation (both while they remain in isolation and even when a suitable alternative to isolation has been developed), must be developed. In addition, a step-wise program of interventions for those who refuse treatment must be developed and implemented.

**RECOMMENDATIONS:**

1. The mental health team will need to develop a global treatment menu designed to meet the needs of inmates at different levels of housing and treatment needs.
2. Group programming should be designed to meet the clinical needs of individuals who should be assigned to those programs based on their needs assessment and their individual treatment plan.
3. The facility should consider how it might create a special population housing unit that would provide a safe housing alternative to vulnerable mentally ill inmates and make the delivery of services more efficient to those who require enhanced mental health services.
4. Those who refuse needed treatment must be further assessed to determine if they are a danger to themselves or others; this assessment should be used to determine whether or not they require placement in isolation/segregation and whether or not a court intervention should be obtained that would require them to undergo treatment; and all the while, efforts should continue to convince such inmates to voluntarily accept treatment.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** For the most part, the medical records indicate that the psychiatrist is monitoring inmates for medication adverse effects, but a more routine way of reporting such monitoring might simplify chart reviews performed for the purpose of quality assurance. However, a review of the records at least appears to indicate that the psychiatrist is not always totally aware of the extent to which an inmate has been compliant with the medication as prescribed. It is not clear from the records that inmates have consistently given 'informed' consent for such treatment. Additionally, it does not appear that other medical and mental health staff have been charged with the responsibility for also monitoring for medication adverse effects, and/or trained to assume such a responsibility.

**RECOMMENDATIONS:**

1. Assure communication between nursing staff and the psychiatrist with regard to inmate compliance with psychotropic medication orders.
2. Confirm the obtaining of 'informed consent' for medication in the medical records or consider a special form for this purpose.
3. Assure that medical and mental health staff are trained to suspect the presence of psychotropic medication adverse effects and report such a suspicion to the psychiatrist in a timely manner.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** Although this training has not yet occurred, correctional staff are completing the 'behavioral checklists' and making referrals for mental health services for both inmates who are already on the mental health services caseload and those who are not. Hopefully, this training will also help security staff better appreciate the role that mental health staff should be playing in decisions regarding the addressing of disciplinary matters, the review of situations where there was use of force, the use of isolation/segregation, and the classification of inmates.

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**RECOMMENDATIONS:**

1. Continue to utilize the Behavioral Checklist process.
2. Finalize and present mental health training for security staff.
3. Improve the incorporation of information obtainable from mental health assessments into security decision-making and review regarding disciplinary matters, the review of situations where there was use of force, the use of isolation/segregation, and the classification of inmates.
4. Conduct a facility quality improvement morbidity review that can be submitted to the monitoring team for review.

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

**ASSESSMENT: NONCOMPLIANCE**

**MENTAL HEALTH FINDINGS:** As noted above, seriously mentally ill inmates continue to be placed in isolation/segregation. Most such inmates are not receiving adequate mental health services, and some of them are not receiving any mental health services at all.

**RECOMMENDATIONS:**

1. The Health Services Administrator needs to coordinate monthly Medical Administration Committee (MAC) and Quality Improvement meetings, documented by minutes and attendance sign-in sheets. This issue should be an important agenda item for such meetings. These meetings should include the Warden or the Warden's designee in order to assure that plans for addressing this issue take all aspects of the problem into consideration.

## VI. FIRE AND LIFE SAFETY

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

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

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

**ASSESSMENT: NONCOMPLIANCE** - No substantive improvement from the previous assessment. However, with the assignment of a full-time fire safety officer, we continue to see incremental improvement in the conducting of monthly fire safety inspections of all areas of the facility and soliciting the expertise of the Fire Safety Marshal to help develop the GGACF fire safety program. The monthly fire safety inspections are conducted in a consistent manner and deficiencies are being identified. However, corrective action on noted deficiencies needs to be addressed. We noted fire related fire safety discrepancies dating back to May 2015 that have not yet been corrected.

**FINDINGS:** The Territory reported that they have been working with Corrections Corporation of America (CCA) to help develop the facility policies and procedures. Since the last visit, the draft policy was sent to the Monitor and United States for review and returned to the Territory for further revisions. The Territory has since revised and policy and returned the same to the Monitor and Unites States for review. The finalization, approval, staff training and implementation of these policies and procedures remains vital Inadequate housing unit staffing levels and contraband control practices continue to enable inmates to ignite various materials in the housing units as evidenced by our September 2015 inspection of the housing units. During these inspections, I continue to observe lit wicks and smoke emanating from them in several housing units. Supposedly, inmates use the smoke from the lit wicks to ward off insects. However, aside from the contraband problem stemming from the use of wicks, it also continues to create fire hazards. It appears that staff have relented to the use of lit wicks by inmates and do not prohibit their use.

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

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

During our inspection, I also observed exposed electrical wiring in various areas of the Facility, including the kitchen, housing units and maintenance shops. In the kitchen I continue to observe boxes stacked in

the dry storage area nearly up to the ceiling (should be stacked no higher than 30 inches below the ceiling). This was an identical finding in our last three reports. These findings, in addition to previous findings, reveal the urgent need to develop and implement a comprehensive fire safety program at GGACF.

Officer Samuel has been assigned as the full-time fire safety for the facility. There is still no documentation available to demonstrate that evacuation plans have been approved by the VI Fire Marshall. The fire evacuation diagrams within the Facility remain woefully outdated and offer no assurance that they would be effective in routing staff and inmates from a fire or smoke related emergency. In fact, some diagrams do not outline the appropriate route. On a positive note, Officer Samuel continues to conduct his systematic inspections of fire safety needs for the facility. A comprehensive fire evacuation plan that that would incorporate all areas and buildings within the confines of GGACF and the contents of the overall fire safety program, such as the fire safety policies and procedures, still needs to be developed and provided to the VI Fire Marshal for review.

Staff reported and documents reflect that the BOC has secured an MOA with the VI Fire Service for helping GGACF come into compliance with the fire safety provisions of the SA. However, as we reported in our previous reports, it must be expressed that the BOC/GGACF are the primary entities for demonstrating compliance with the fire safety provisions of the Settlement Agreement.

**RECOMMENDATIONS:**

The Monitor continues to request the reports for all drills and exercises conducted. It is also imperative that when the GGACF Fire Safety Program and the Fire Safety Plan are finalized and that they be provided to the Fire Marshal and with a copy to the Monitor and USDOJ.

1. Finalize and implement fire safety policies once approved and according to the agreed schedule.
2. Repair/replace/install fire detection and suppression systems throughout the entire campus and structures.
3. Train all staff on this plan.
4. Install self-contained breath apparatuses (SCBAs) or an appropriate alternative at all locations where staff would need to search for or evacuate people.
5. Conduct and document quarterly fire drills for all shifts and document those activities.
6. Officials must continue to critically review staffing levels to ensure adequate inmate supervision and flammable contraband control in the housing units, fire detection, response, suppression, evacuation, and incident security.
7. Additional part-time fire safety officers should be selected from the officer corps, trained, and participate in the administration of a comprehensive fire safety program. It is unrealistic to expect one expert to develop and oversee such a complex program.
8. Supervisors should conduct routine, scheduled and unscheduled physical inspections of occupied structures, taking particular note of fire risks and hazards, document and report those findings to administration for timely and appropriate corrective action.
9. The fire inspection program was detailed in the draft fire safety policies and procedures that the monitor provided to the parties, and they should become a fundamental element of pre-and inservice training once policies and procedures are finalized, approved, and implemented. It is anticipated that the new policies and procedures that CCA is helping the BOC develop meet all of the requirements of Settlement Agreement.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Almost identical to previous Monitor's reports, we found that the Housing unit fire control panels remain inoperable, the primary fire suppression system remains broken, and cell and housing unit sprinklers are non-functional. We noted an improvement in the housing units whereby inmates were not using the fire sprinklers to support personal clotheslines. The primary fire detection and suppression system was designed to automatically detect and extinguish fires within most of the housing areas. However, the older housing units are not equipped with this system. The detection system does not function and the sprinklers are either broken or clogged by inmates. The only way to alert staff and inmates of a fire or smoke hazard is to use hand-held air horns that are located in the control rooms of the housing units.

Adequate supplies of handheld fire extinguishers were found in housing units, kitchen areas, the medical unit, and shops. All devices were tagged showing current inspections and all gauges showed positive pressures. The Fire Safety Officer has incorporated the inspecting of fire extinguishers in his monthly inspection reports, which is a positive step in improving fire safety.

GGACF staff continue to indicate that sprinkler heads may be replaced in the "newer" buildings at some point in 2015. During previous inspections, we were provided with a letter, dated November 24, 2014, directed to the Department of Interior from the BOC Director requesting to allocate funding to aid in the replacement of the fire suppression system and for refurbishing the Kitchen at GGACF. During this inspection, the Director gave us an update on progress in these areas. For example, the scope of work for the kitchen is now more defined. They are in the process of receiving a cost estimate for exhaust and blower fans for the housing units, among other important capital projects. However, the scope of work for the fire suppression system seems to only include the purchase and installation of fire sprinkler heads and related parts in areas of the Facility where there is a fire sprinkler system, but does not seem to address the need to install a fire sprinkler system such as in the old housing units where there is no fire sprinkler system. This needs to be clarified. Moreover, GGACF plans to continue to house individuals in the "older" buildings, and has no plans to update or install fire suppression equipment in those buildings. As reported in earlier monitoring reports, GGACF will never come into compliance with these provisions if that remains the case.

Although it was commendable that the Fire Safety Officer has systematically embarked in identifying fire safety discrepancies and fire safety needs, the resources to correct those deficiencies must be provided. For example, the Monthly Fire Safety Inspection Reports for the month of July and August 2015 identified missing or non-functional smoke alarms; therefore, funds need to be made available in order to purchase missing smoke alarms and for purchasing adequate stocks of batteries for them.

**RECOMMENDATIONS:**

1. Refer to recommendations above (a).

2. Consider purchasing fire safety program software from NFPA and/or the American Correctional Association to assist in program development and monitoring.
3. Continue to support fire safety officer.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Documentation demonstrating compliance with this Provision was not provided during this assessment. In our previous report, GGACF staff indicated that fire drills have not been conducted on a regular basis. The Fire Safety Officer has commenced a process for conducting fire drills. It is laudable that the Fire Safety Officer is addressing the necessity to conduct fire drills. The failure of GGACF staff to conduct fire drills on a regular basis of all facility areas continues to put inmates at risk of injury or death, should a fire break out that cannot be suppressed by the hand-held fire extinguishers present in the officer control pods of housing units.

During this site visit it appeared that security staff had a better awareness of emergency key management. With a few exceptions, staff were able to open emergency doors with keys. In the housing units we inspected, there were emergency keys available. However, this area needs continuous monitoring and staff need to be trained and retrained on a continuous basis on the Key Control Policy and Fire Safety policies once they are approved. In future site visits we will continue to inspect this area of fire safety. In the housing units that have cell slider doors (Units L and K) the tool used for opening cell doors are still not readily available. Staff are using a long screw driver for this purpose. A special tool for opening these doors manually is now available, but staff have not been trained on the proper use of the tool. The Fire Safety Officer and security management should conduct drills to see how prompt these type of cell doors can be manually be unlocked. There needs to be a clear and concise understanding by all security staff as to where the facility emergency keys are kept as well as having the tool to open the cell slider doors readily available and to ensure that staff are trained and retrained on the final Key Control Policy and Fire Safety policies.

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

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

There is not a written preventative maintenance program or a regular security inspection program in place for checking that cell locks are functional and are not jammed from the inside or outside of the cell, nor a system for ensuring that all facility remote locking cell mechanisms are functional. During this monitoring visit we were pleased to observe no evidence of inmates compromising the cell locks by inserting various materials in the locking mechanisms. We did, however continue to observe numerous housing unit grills whereby the locking mechanism was inoperable and the grills left open.

**RECOMMENDATIONS:** Same as above.
1. Also refer to recommendations related to security provisions, contraband, and inmate manipulation of cell door locking systems.
2. Repair all remote cell locking notification technology.

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** No records have been provided to verify that all staff have been trained and tested on safety procedures. The new Fire Safety Officer reported that some hands-on training on the fire extinguisher still needs to be addressed. However, this provision of the Settlement Agreement requires a more comprehensive program for testing of all staff regarding fire and life safety procedures.

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

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

**ASSESSMENT: NONCOMPLIANCE**

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

The new Director reported that he is prioritizing the installation of a fire alert notification system.

**RECOMMENDATIONS:**
1. Install and routinely test the stored file alert notification system without delay.

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

**ASSESSMENT: NONCOMPLIANCE**

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

**RECOMMENDATIONS:**
1. Develop and implement an annual full scale evacuation exercise that involves community emergency, health, and social services responders.

**h. Fire suppression;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Same as previously stated. There is no functional fire suppression system, with the exception of the kitchen's cooking area.

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

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

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: The requirements for this provision need to be addressed in the final Fire and Life Safety Policies and procedures. Once the policies and procedures are approved, staff must be trained on them and they need to be fully implemented.

**RECOMMENDATIONS:**

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

**j. Control of highly flammable materials.**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS:** Many inmate cells contain considerable personal property, thus creating a fire and safety risk. However, it appears that that this issue is being addressed by the new Director by purchasing bins for prisoners to store their personal belongings. Identical to previous reporting, flammable storage areas/cabinets in the Carpentry shops do not appear to be properly vented.

**RECOMMENDATIONS:**

1. It is anticipated that the control of highly flammable materials will be addressed in the revised CCA policies and procedures and that staff will be trained on them and that they be fully implemented.

## VII. ENVIRONMENTAL HEALTH AND SAFETY

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

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

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Documentation in the form of logbooks and memorandum was provided during this monitoring visit that demonstrated ongoing efforts by GGACF officials and maintenance staff to assess, improve, and monitor facility sanitation and hygiene. Cleaning supplies were more readily available in the housing units. Some housing units and cells were cleaner than others and the need to consistently conduct routine and sustained cleaning of all facility areas remains a challenge to GGACF staff.

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

The Maintenance Supervisor maintains preventative maintenance schedules for various components of the GGACF physical plant, including the emergency generator. The emergency generator has been problematic for some time. The Maintenance Supervisor has ordered a radiator to repair it.

However, during this inspection we continued to observe inoperable doors and grills, inoperable showers, mold in showers, non-functioning water fountains and plumbing leaks. The new Director has started to address the perimeter of the facility and security fencing needs.

**RECOMMENDATIONS**:

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

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

**b. Adequate ventilation throughout the facility;**

**ASSESSMENT: NONCOMPLIANCE**

**FINDINGS**: As stated in previous reports, ventilation throughout all housing units remains troubling. High summer temperatures and humidity make the housing units and cells constantly uncomfortable for breathing. High temperatures and poor ventilation can contribute to and exacerbate pulmonary illness, and potentially jeopardize the health of inmates on psychotropic medications (many such medications can cause harmful reactions when body temperatures are elevated). During this site visit we took random heat index reading of some housing unit dayrooms and cells. The heat indices remain unacceptably high. For example, in the common area of Unit 9B, the heat index was 107.6 F at 3.25 pm, with a large fan blowing. Heat indices of 110.9 F, 111.6 F, and 109.4 F were measured in Unit 9A.

Most of the housing unit exhaust fans remain inoperable. This is especially harmful for inmates unable to afford to purchase fans and inmates with serious mental illness on certain medications. One indigent inmate, who has been diagnosed with "mental retardation/schizophrenia" and is taking Haldol and Cogentin, continued to be held in segregation without a fan in his cell. This inmate also did not have a fan during the June 2015 site visit. We recorded the heat index in his cell during this visit as 103.6 F. We were informed that he had been given a fan after the June 2015 visit, but somehow had managed to sell the fan to another inmate for a cigarette butt, despite being locked in his cell and despite the fact that the fan is too large to fit through the cell window or food port.

The new Director is prioritizing the installation of exhaust and blowers fans for the housing units.

**RECOMMENDATIONS:**

1. Timely complete an air quality assessment performed by a qualified provider.
2. Implement necessary improvements that reduce housing area and cell temperatures and increase air flow.
3. Medical and mental health staff should monitor all inmates for heat and airflow-related health risks. All inmates in segregation or who are locked in their cells should be monitored by medical and mental health staff for signs of health conditions.
4. Train all staff in detecting and responding to health conditions related to heat and air circulation contributors.

5. Install environmental health condition monitoring devices, e.g., temperature, humidity, and air quality readers. Require regular monitoring and recording of readings and take timely action to mitigate environmental conditions that create health risks caused by those conditions.
6. Medical and mental health professionals should closely monitor inmates being administered medications that are adversely affected by high body temperatures and take appropriate steps to eliminate adverse effects.

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

**ASSESSMENT: PARTIAL COMPLIANCE**

**FINDINGS:** Attention to lighting repair and replacement remains positive. However, security staff continue to allow inmates/detainees to cover their cell lights, which is creating a fire hazard. However, we did note improvement in this area from previous inspections.

**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 continue lighting "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**
**FINDINGS**: There was no substantive improvement 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 this Provision; nor is there 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.

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:
2. OSHA and CDC standards and protocols for biohazard safety and exposure control;

3. Written and enforced procedures and protocols for biohazard handling; cleaning, disposal, storage, inspections, and clean-up;
4. Staffing and inmate training on the plan and proper handling and disposal of biohazards;
5. Consistently maintain adequate supplies of feminine hygiene products and disposal bags for all bio-waste;
6. 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;
7. Provide appropriate clean-up apparel and training in the use of that apparel.
8. 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.
9. Develop a bio hazardous control program that involves regular inspections of all potential contamination areas.
10. GGACF officials should consult an environmental specialist to assess these conditions and assist them in developing appropriate mitigation plans and policies.
11. 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 policies and procedures, once approved, 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. In addition, Material Safety Data Sheets had not been updated, as recommended during the June 2015 compliance tour. The Territory has, however, drafted a chemical control policy for review by the Monitor and the United States

**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. However, we did not observe inmates drying these items in their cells using clotheslines anchored to fire sprinkler heads, walls, window frames, bunks, etc. This was a positive development. 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:** The new Director reported his plans to refurbish the Kitchen with the necessary capital improvements is underway. This is a very positive development. In addition, the Territory drafted the food services policy and provided the same to the Monitor and the United States for review.

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. Overall, the kitchen was cleaner than it was during previous site visits, with the exception of the floor drains. The dishwasher has not been working properly for some time. Apparently the dishwasher needs a door.

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. During the inspection of the Kitchen, I observed a mouse darting from the cooking area into the inoperable walk-in refrigerator.

There is still 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. However, staff reported that the food service vendor recently provided training to staff on kitchen sanitation, food temperature control, among other food related topics. Further, the Territory indicated that staff will commence documenting food temperatures in October 2015.

The kitchen doors are not rodent proof. We observed evidence of mold and rust in various areas of the Kitchen that staff is 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 still working on finalizing a chit check out system for the utensils and dangerous implements. Facility staff reported that they are also in the process of purchasing the needed food service equipment to ensure that food remains at proper temperatures at feeding time. The Facility purchased the needed food service equipment, which includes thermal trays and storage warmer bags. The food warmers are located in the housing units.

**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. Similar to previous reporting, 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 two visits 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 two 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 must include the required content listed in this provision.

Training curricula and training has been conducted for the approved health care-related policies and procedures. However, documentation has not yet been provided to this Monitor that demonstrates 95% of required staff completed all training with minimum passing score of 80%.

**RECOMMENDATIONS: Previous recommendations remain appropriate.**

1. Implement training policies and curricula once approved.
2. Provide this Monitor and United States 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:** As previously stated, Territory progress toward compliance remains very slow but intentional.

**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.

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

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

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

**FINDINGS:** The Territory has complied with this requirement and has remained dutiful in timely collaboration with USDOJ and this Monitor with regard to policy and procedure modifications.

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

**FINDINGS:** The Territory's status reports remain anemic for describing progress. During the September 24th status conference the court instructed the Territory to include in its status report all provisions of the agreement and to notate any progress toward compliance with each.

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

**FINDINGS:** The Territory provides monthly medical emergency reports and notifications required under this requirement. However, follow-up documentation should be made more timely. In addition, during the September compliance tour, the Monitor discovered through document review that a serious suicide attempt had occurred. The Territory had not informed either the Monitor or USDOJ of this attempt, as required by the policy.

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

**FINDINGS:** The Territory continues to revise and develop new documents to demonstrate compliance with this Agreement. However, quality management of many records remains problematic. These issues include, for example, incident reports, shift rosters, segregation review forms, and the grievance log. The Territory is encouraged to implement the Monitor's recommendations regarding document quality

assurance and management. Doing this will significantly support the Territory's ability to demonstrate compliance.

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

**FINDINGS:** The Territory continues to cooperate in providing access to the facility and needed documents as requested.

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

**FINDINGS:** The Territory continues to provide access to requested records.

## X. Monitoring

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

**FINDINGS:** This Monitor wishes to thank Territory officials for submitting monthly compliance reports, even as the document request grows.

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

**FINDINGS:** The Territory has provided this Monitor and monitoring team full and complete access to GGACF as required under this provision.

## APPENDIX A
## ASSESSMENT METHODOLOGY

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

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

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

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

In general, compliance assessment will include the following activities:

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

I. Examination of agency motor fleet including all cars, busses, trucks, vans, and any other motorized vehicle used for correctional operations purposes.

J. Examination of any and all available records, data, and/or information relevant to compliance and compliance monitoring not limited to the following:

- Administration
- Budget
- Personnel
- Operations
- Training
- Facility construction, renovation, repairs, and maintenance
- Equipment, supplies, and materials
- Inmate case files
- Medical and mental health screenings, assessments, evaluations, diagnoses, treatment plans, progress charts and notes, medication logs and records, drug formularies, appointment calendars, invoices, etc.
- Labor contracts
- Incident reports and logs
- Evidence / contraband reports and logs
- Use of force incidents and logs
- Inmate grievances and disciplinary records and actions
- Policies, procedures, protocols, guidelines, post-orders, logs, memos, and other documents and information that support accurate compliance assessment and progress determinations
- Employee complaints, grievances, claims, etc. directly or indirectly related to the compliance provisions
- Other information required to determine compliance and compliance progress

The information described above is intended to assist the Monitor to determine compliance and the degree to which each of the compliance ratings (Noncompliance, Partial Compliance, and Substantial Compliance) apply to each provision assessed. Additionally, the Monitor will collaborate with the parties to develop metrics and core measures for qualitative and quantitative measurement of progress and compliance. Core measures and metrics should specifically pertain to the conditions set forth in the Settlement Agreement, and generally consider accepted standards and recommendations promulgated by the National Correctional Association, American Jail Association, National Commission of Correctional Health Care, American Psychiatric Association, American Nursing Association, ASIS International, National Fire Protection Association, Centers for Disease Control (CDC), OSHA, Territory regulations, and other nationally accepted standards for compliance assessment and management. Additionally, specific measures articulated in the Order of the Court dated May 14, 2013 [Dkt 742] (the "Order") shall be followed. The following compliance management terms are suggested for assessment and compliance monitoring:

- Compliance Control: Implies activities designed and intended to inspect and reject defective or deficient performance, processes, services, equipment, etc. when applied.
- Compliance Assurance: Implies activities designed and intended to identify performance and services that assure compliance when applied.

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

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

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

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

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

It is understood that the Territory will use existing records systems and processes to provide routine reports. However, new records and information systems and methods may become necessary to accurately report progress compliance and related performance. It is this Monitor's desire to assist the Territory in developing records and information methods and processes that yield accurate, complete, and efficient reporting of compliance efforts and progress. Therefore, it is assumed that the compliance reporting process will evolve throughout the life of the Order.

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

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

**A) Corrections Information:**

1. The most recent census report.
2. Last five (years) admission, release, average daily inmate population.
3. The housing unit floor plans for all facilities and housing units.
4. A copy of the facility's policies and procedures manual(s), including the facility's Use of Force policy. [If you have the policies and procedures in electronic form, we would request all of them prior to our visit. Otherwise, we request only the Use of Force policy prior to our arrival].
5. The Use of Force Log for the past twelve (12) months and a few sample Use of Force packages [we request only the Use of Force Log prior to our arrival]. Please indicate any use of force on an inmate on the mental health case list.
6. The Serious Incident Report Log for the past twelve (12) months.
7. The Inmate Disciplinary Log for the past twelve (12) months.
8. The Contraband Log for the past twelve (12) months.
9. The Administrative Investigations Log for the past twelve (12) months.
10. A copy of the Inmate Grievance Policy.
11. A copy of the Inmate Grievance Log for the past twelve (12) months.
12. All forms and documents used by staff for inmate intake, assessment, classification, release, housing, supervision, disciplining, etc. Generally speaking, any form, report, log book, etc. used in the course of a corrections officers work day.
13. Documentation reflecting the current classification system, including policies and procedures related to such classification system.
14. Documentation reflecting any training facility staff has received, including any corrections officer training manuals, pre-service and in-service training completed by all staff over the past 36 months.
15. Current staffing schedules for security positions and shifts.
16. Job descriptions for all non-health care staff.
17. Copies of any self-evaluation reports, grand jury reports, American Correctional Association surveys, National Institute of Corrections reports/evaluations, National Commission on Correctional Health Care reports/evaluations, or any other outside consultant reports regarding the facility.
18. Any questionnaires, intake forms, or inmate handbooks provided to inmates upon their entry to the facility or during their stay in the facility.
19. The most recent Staff Manpower Report/Matrix that shows all authorized positions and which ones are vacant.
20. Reports and data showing turnover information and statistics for security, medical, mental health, and other staff positions budgeted and authorized for the previous 36 months.
21. Any staffing improvement plan, applications for technical assistance, and Territory budget proposals/authorizations to address staffing shortfalls.
22. Facility maintenance requests and work orders for the past 12 months.
23. Records and/or lists of physical improvements, repairs, and renovation completed to correct security problems and deficiencies over the past 36 months.
24. Past 36 months of agency budgets.
25. List and contact information for any and all community vendors who provide services of any kind to GGACF and contracts or professional services agreement authorizing those services.

26. List and contact information for community regulatory agencies who inspect, review, approve, and/or provide consultation to the GGACF i.e., health inspections, fire inspections, etc., and any inter-local agreements involved in these services.

**B) Medical and Mental Health Information:**

27. A mock or blank chart containing all forms used, filed in appropriate order.
28. The infection control policies.
29. The names of inmates who have died in the past year, and access to/or copy of both their records and mortality review.
30. The names of any inmates diagnosed with active TB in the past year and access to/or a copy of their records.
31. To the extent not provided above, the policies and procedures governing medical and mental health care.
32. A staffing roster with titles and status, part time or full time, and if part time, how many hours worked per week.
33. The staffing schedule for the past two (2) months for nursing and providers, including on-call schedules for the same time period.
34. Job descriptions for medical staff and copies of current contracts with all medical care providers, including hospitals, referral physicians, and mental health staff.
35. Inter-local professional services agreements with health care providers, companies, to include health care policies under which those persons and/or entities provide inmate health care.
36. Tracking Logs for consults and outside specialty care services provided, chronic illness, PPD testing, health assessments, and inmates sent to the emergency room or off-site for hospitalization listing where applicable name, date of service, diagnosis and service provided.
37. A list of all persons with chronic illness listing name, location, and name of chronic illness.
38. A schedule of all mental health groups offered.
39. Minutes of any meeting that has taken place between security and medical for the past year.
40. Quality assurance and Medical Administration Committee minutes and documents for the past year.
41. A list of all emergency equipment at the facility.
42. A list of current medical diets.
43. Sick call logs (i.e., lists of all persons handing in requests for non-urgent medical care to include in the log presenting complaint, name, date of request, date triaged, and disposition) and chronic illness appointments for the past two (2) months.
44. A copy of the nursing protocols.
45. To the extent not provided above, a copy of any training documentation for security and medical staff on policies and procedures and emergency equipment.
46. A list of all the inmates housed at the facility by birthdate, entry date, and cell location.
47. To the extent not provided above, external and internal reviews or studies of medical or mental health services including needs assessments and any American Correctional Association and National Commission on Correctional Healthcare reports.
48. List of all inmates placed in restraints, and all inmates receiving mental health treatments, under suicide watch, or taking psychotropic drugs.

49. Current mental health case list including inmate name, number, diagnosis, date of intake, last psychiatric appointment, next psychiatric appointment, and any case lists of inmates followed only by counseling staff with last appointment date and follow-up appointment.
50. Documentation reflecting any training that facility staff have received on suicide prevention, including certificates and training materials.
51. All documents related to the any suicide occurring within the past year.
52. List of all persons on warfarin, Plavix, digoxin.

**C) <u>Suicide Prevention Information</u>:**

53. All policies and directives relevant to suicide prevention.
54. All intake screening, health evaluation, mental health assessment, and any other forms utilized for the identification of suicide risk and mental illness.
55. Any suicide prevention training curriculum regarding pre-service and in-service staff training, as well as any handouts.
56. Listing of all staff (officers, medical staff, and mental health personnel) trained in the following areas within the past year: first aid, CPR/AED, and suicide prevention.
57. The entire case files (institutional, medical and mental health), autopsy reports, and investigative reports of all inmate suicide victims within the past three years.
58. List of all serious suicide attempts (incidents resulting in medical treatment and/or hospitalization) within the past year.
59. List of names of all inmates on suicide precautions (watch) within the past year.
60. The suicide watch logs for the past year.
61. Clinical Seclusion logs for the past year.
62. Use of clinical restraint logs for the past three years.
63. Any descriptions of special mental health programs offered.
64. A list of all uses of emergency and forced psychotropic medications in the past year
65. A list of any use of force associated with the administration of psychiatric medications for the past year.
66. A description of medical and mental health's involvement/input into the disciplinary process and clearance for placement in segregation.
67. List of all inmates referred for off-site psychiatric hospitalization in the past three years.

It is also understood that the above lists are not all inclusive and the Monitor retains the discretion to request additional information and documents deemed necessary for legitimate monitoring purposes and within the scope of conditions provided within the Agreement.